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The Individual Market and ACA Products: Starting from First Actuarial Principles

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It has been an amazing five years since the Patient Protection and Affordable Care Act (ACA) was passed. Like many in our profession, I have watched with interest as the public discussion has moved from one ACA-related topic to another. After starting with a broad ideological focus on the proper role of government in health care, the discussion moved to operational concerns regarding the exchange website and now to developing an interpretation of the rate increases associated with the ACA products. This debate has also been played out as court cases have been considered that could materially impact the rules and funding of the exchanges. Unfortunately, as the public discussion has changed, we have not paid nearly enough attention to the long-term sustainability of the exchange—particularly the question of whether health insurers can accurately rate the exchange population once two of the three risk protections are removed.[1]

In response, this article will review the ACA exchanges following the elimination of two of the three risk protections (reinsurance and risk corridors) in 2017 according to a set of simple actuarial principles. In addition to defining these core principles, this article will compare these features relative to the other major lines of business in health insurance. Combining the actuarial first principles with an analysis of the major lines of business, I then make an evaluation of the risk associated with the exchange relative to other product lines. As I suggest, the relative risk assumed under the exchange has the potential to impact the willingness of health insurers to participate on the exchanges in 2017.

ACTUARIAL FIRST PRINCIPLES: CONSIDERATIONS WHEN ESTIMATING THE RISK OF A POPULATION

Although the populations and rating rules differ among the major lines of business, we still have basic characteristics that we look for in rating a population—whether it is an employer group or an individual in a government-sponsored program. These characteristics are the prime determinants on whether a population can be accurately rated and represent the most important drivers on whether an insurance company will accept this risk. These include:

Historical data. The lifeblood of actuarial science is historical data that can be linked to a population. This historical claims information provides the most important guidance on the prospective claims costs for a population and—along with a trend estimate—provides the basis for rating a population. Without this historical information, actuaries are typically required to use historical data from another population to serve as a proxy for the covered population. As the connection becomes further removed from the covered population, our estimates become less reliable.

Consistent population. When we have information on a population that is expected to be consistent from one period to the next, our estimates can be accurate and largely relied upon when developing cost estimates. However, if the population is not stable, we have to make assumptions about the expected population in the rating period or draw a connection between the cost of the expected population and another population. Similar to the challenges without sufficient historical data, this further limits our ability to develop accurate rates.

Revenue uncertainty. Similar to any business, we need to know our revenue and costs in order to make judgments about the true financial performance of a product. This feedback on the financial performance of a product line can then be used to make important operational changes in provider contracting, medical management and pricing. Without this feedback, important operational deficiencies have the potential to continue without the necessary improvements required to ensure the long-term viability of a product line. As highlighted below, the revenue structure across the medical lines of business includes three primary models:

- Revenue that is based on the contract terms agreed to prior to the beginning of the contract year (large group, pre-ACA small and individual). In this case, the revenue stream is known with certainty and is based on the expected claims costs for the specific group or individual at the time of rating.
- Revenue that can be accurately predicted based on the historical performance of the risk adjustment program (Medicare Advantage). As highlighted in the sidebar on the Medicare program, the risk adjustment payment is initially estimated and then further refined over a period of time.
- Revenue that will not be determined until a comparison with other health plans occurs six months after the conclusion of the policy year (ACA exchange). See side bar for a description of the risk adjustment process for the exchanges.

ACTUARIAL FIRST PRINCIPLES APPLIED BY LINE OF BUSINESS

Using these principles as a basis, the following chart highlights the characteristics among the most important lines of business.

Line of Business	Historical Experience	Population Consistency	Revenue Certainty
Large Group (100+)	Provided by the large group employer.	With the exception of layoffs, large group populations are generally stable.	Contract terms are agreed to prior to the beginning of the contract year.
Small Group—Pre ACA	Available across the entire segment. Although group-level information is not considered credible, the rates can be varied based on the specific medical conditions of the group. (The extent the rates can vary differs by state.)	Generally stable but less stable than large group.	Contract terms are agreed to prior to the beginning of the contract year.
Individual—Pre ACA	Available across the entire segment. Although individual-level historical information is not considered credible, the individual rate is initially based on an in-depth medical underwriting process.	Because this population is required to pass an initial medical screen, this group is more likely to remain on their existing policy than move to another underwritten policy.	Contract terms are agreed to prior to the beginning of the contract year.
Medicare	Available across the entire segment, but not used to develop individual-specific rates. The risk adjustment process is designed to account for the expected cost differences among individuals.	The Medicare population has traditionally had a very high retention level.	Risk-adjusted revenue is initially based on historical data and then updated during and after the policy year. (See Medicare sidebar for additional detail.)
Small Group—ACA	In states with no transitional relief, the historical pre-ACA population could serve as a reasonable proxy for the broader ACA population—assuming the population has a similar risk profile as the ACA population.[2] In states allowing transitional relief, a judgment must be made on the expected migration to the ACA products.	Potential for greater instability as groups exit the ACA pool through either self-funding or eliminating insurance.	Because the risk adjustment mechanism does not provide a final estimate until the middle of the following year, the revenue is not known with certainty until the release of the risk adjustment transfer. (See exchange sidebar.)
Individual—ACA	Only data on existing individual policies were available at the beginning of the program at the health-plan level. This information did not include data on the previously uninsured. Because of the timing for rate filings, a complete year of historical ACA information for specific health plans will not be available until pricing for the 2016 contract year occurs. Market-level information will not be available until the 2017 rating period—following the release of the risk adjustment transfer in the summer of 2015.	Extremely difficult to quantify—largely dependent on the mandate, the influx of transitional members, and the reaction of individuals to rate increases net of any subsidy changes.	Because the risk adjustment mechanism does not provide a final estimate until the middle of the following year, the revenue is not known with certainty until the release of the risk adjustment transfer. (See exchange sidebar.)

Using the criteria to the left as the basis, the ACA exchanges can then be compared across all the lines of business.

Historical data. Relative to the other lines of business, the exchanges have far less historical information to serve as the basis for the rate development through the initial period of the program (2014 to 2016). In the small group segment, health plans could rely on their existing book under the assumption that the risk profile would match the broader ACA population. On the other hand, for the individual product line, the historical information on individual plan members is much less useful because of the entrance of previously uninsured individuals into the risk pool in 2014. Looking forward to the 2017 rating period and the elimination of two of the risk protections, the historical claims information for a specific health plan will be available for two periods (2014 and 2015) and the data for the entire risk pool will be available for one period (2014) following the release of the risk adjustment transfers in the summer of 2015.[3] In the other lines of business, historical data has been available for an extended period of time.

Population consistency. Under employer-based plans, most populations remain consistent from one period to the next with the one exception being in the case of significant layoffs. With guaranteed eligibility and a strong incentive to participate in the program based on age-related health conditions,

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Medicare plans have traditionally had a stable population. In contrast, the individual exchange population has the potential to change significantly based on a wide range of factors, including changes in the mandate, the influx of transitional plan members, and the response of individuals to significant net premium changes.

Revenue certainty. As suggested in the above charts and in the sidebars, the large group, pre-ACA individual and small group, and Medicare Advantage product lines provide a relatively predictable revenue stream. In contrast, because the exchange is based on a concurrent methodology that is compared with other plans following the conclusion of the policy year, the exchange population is subject to significant variation following the conclusion of the policy year.

Taken in total, following the elimination of the reinsurance and risk corridor programs in 2017, the ACA products will represent the riskiest line of business in a health insurer's portfolio.

CONCLUSION

Like a difficult math problem without a simple solution, it's sometimes useful to go back to first principles to help identify the most important parts of a problem. By following a similar approach with the ACA products and actuarial first principles, a similarly simple conclusion could be developed. While the absolute level of risk could be debated, the ACA products are relatively more risky than the other traditional lines of business as the two risk protections are removed. As we consider the long-term implications in 2017, this additional risk could impact the willingness of insurers to participate in the program—particularly among those organizations with a more modest risk tolerance or capital—and compromise the long-term sustainability of the program. ■

MEDICARE ADVANTAGE RISK ADJUSTMENT

The Medicare program uses the Hierarchical Condition Category (HCC) risk adjustment methodology with historical diagnosis information as the basis to adjust premium revenue for the next calendar year. Although the mechanics of the development are somewhat complicated, the broad intent is to ensure that the risk score for an individual is properly calibrated against a fee-for-service population using historical data to adjust prospective rates. Because the risk scores are based on historical data and a published methodology, the health plans can have a reasonably accurate picture of their revenue for the upcoming year.

Risk score adjustments to revenue. Health plans in the Medicare program receive an immediate risk score for each enrollee at the beginning of the plan year. This initial risk score is then updated with two additional reviews that allow updated data and additional run-out from the historical experience period. The following schedule highlights the risk analysis for the calendar year 2014:

Risk Score Basis	Applicable Payment Period	Historical Experience Basis for the Risk Score Development
Initial risk score	Jan. 1, 2014 to July 1, 2014	July 1, 2012 to July 1, 2013
Midyear adjustment—initial risk score adjusted and the risk score adjusted for the remainder of the calendar year	Jan. 1, 2014 to July 1, 2014 (retrospectively adjusted) July 1, 2014 to Dec. 31, 2014 (adjusted to account for new information)	Jan. 1, 2013 to Dec. 31, 2013—with paid claims through March 15, 2014
Final adjustment	Jan. 1, 2014 to Dec. 31, 2014	Jan. 1, 2013 to Dec. 31, 2013—with paid claims through Jan. 31, 2015

Consistency of risk scores. The risk scores are also likely to be relatively consistent from one year to the next because a health plan's Medicare population is not likely to undergo substantial change from one year to the next—relative to other populations, seniors are much less likely to move from one plan to another. In addition to ensuring a bid consistent with the underlying risk and revenue of the population, this consistency also helps the health plan ensure adequate medical management support and allow for accurate budget estimates.

The net effect of these features is a risk adjustment program that is known in advance of developing the Medicare bid and a revenue stream that can be predicted with some certainty after the open enrollment period. Most importantly, this program creates a feedback loop that ensures a health plan can make changes in the operations—including contracting or medical management activities—that could influence both the quality of care and financial results. ■

Taken in total, following the elimination of the reinsurance and risk corridor programs in 2017, the ACA products will represent the riskiest line of business in a health insurer's portfolio.

ACA EXCHANGE

While the Medicare program allows health plans to have visibility into their premium, in the exchange program, health plans are required to rely on risk scores that will not be known until after the calendar year, and the actual revenue impact will not be developed until a final reconciliation is completed relative to the other health plans. In this final reconciliation, the risk scores are compared among the plans and payments are either made or received among the health plans depending on the relative risk attracted to each health plan. The specific features are highlighted below:

Concurrent risk scores. Although the model uses a similar HCC methodology as Medicare, the model is based on the diagnosis information within the policy year rather than from the prior historical period. While this method provides a theoretically more accurate approach to adjusting premium, this mechanism does not allow health plans to have information on their own risk scores until their experience matures throughout the plan year.

Risk adjustment timing. While the Medicare model provides an immediate impact on revenue, the true impact of the ACA exchange revenue payments is not known until the risk level is compared with other health plans in the middle of the following calendar year (June 30, 2015, for the final invoice with the final settlements made later). In the meantime, unlike in the Medicare program, the ultimate premium levels during the current calendar year will be unknown. This potential uncertainty in payments will also be magnified by the potential changes in the exchange risk pool and the potential for consumer switching among health plans. ■

ENDNOTES

1. The risk protections provide protection for health plans that attract high-cost claimants (reinsurance), sicker-than-average individuals (risk adjustment), and incorrectly estimate the cost of the exchange population (risk corridors). After the initial three years of the program, only the self-financing risk adjustment program will continue to be implemented. In this program, health plans reallocate money among themselves based on the relative risk attracted to each health plan. The broad intent of the risk protection policy is to allow insurance companies the opportunity to better understand the underlying cost of this population and ensure rates can be developed without the reinsurance or risk corridor protections that will sunset after the 2016 calendar year.
2. Because the exchange program was developed to eliminate adverse selection among insurers through the risk adjustment program, health plans have been instructed to develop rates based on the expected risk for the entire risk pool. As a result, historical information within a health plan—while accurate for rating their own population—may not accurately reflect the cost for the entire risk pool and could lead to inaccurate rates after accounting for the risk adjustment payment.
3. In order to estimate the expected cost for the entire risk pool, the risk adjustment transfer is necessary to adjust the historical claims specific to a health plan.

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