SOCIETY OF ACTUARIES

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Soundbites

from the American Academy of Actuaries' Health Practice Council

by Heather Jerbi and Tim Mahony

What's New

Implementation of the provisions in the Affordable Care Act (ACA) continues to be a priority for the Academy's Health Practice Council (HPC). The council has created a number of work groups charged with providing input and responding to requests for information from the Department of Health and Human Services (HHS), the National Association of Insurance Commissioners (NAIC) and other interested parties, as well as commenting on proposed and final regulations issued on the various provisions of ACA.

While the HPC is now looking at some of the provisions that will be effective in 2014, most of its recent work has been focused on those provisions that go into effect in 2010 and 2011. These provisions include medical loss ratio (MLR) reporting and rebates, rate review and disclosure of "unreasonable" rate increases, and many near term changes to benefits and eligibility.

During the summer and fall, members of the HPC's health reform implementation work groups had conversations with HHS representatives, senior White House officials, Government Accountability Office (GAO) and congressional staff to discuss a variety of topics including MLR issues such as the potential for disruption in the individual market and credibility concerns; rate review and the type of information available in actuarial memoranda that could be used to inform consumers about the factors behind premium increases; the temporary reinsurance program (Sec. 1341); and the effect of the elimination of annual and lifetime limits on premiums.

While health reform implementation is a significant priority, HPC work groups continue to work on other relevant issues, as well. The Medicaid Work Group continues to engage with the Centers for Medicare & Medicaid Services (CMS) regarding the development of a new rate-setting checklist for Medicaid. In addition, several HPC work groups are working with the NAIC on various projects including the development of a long-term care valuation table, an update of the cancer cost tables and a review of the MedSupp refund formula.

Some of the more recent communications to HHS and the NAIC on many of these issues are highlighted below.

Medical Loss Ratio Reporting and Rebates

The Academy's Medical Loss Ratio Regulation (MLR) Work Group has been active since the enactment of ACA, providing input to both HHS and NAIC. Most recently, the activity has focused on clarifying concerns and recommendations highlighted in the work group's initial comment letters. On Aug. 20, the work group submitted a comment letter to HHS as a follow-up to a conference call on credibility issues for the purpose of calculating rebates under the new MLR requirements. The work group provided HHS with input on a NAIC proposal that would have created a hierarchy for applying credibility and pooling techniques in the implementation of these rebates.

On Oct. 4, the NAIC's actuarial subgroup approved draft regulation on medical loss ratios, which would promulgate uniform definitions and a standardized calculation methodology for rebates in accordance with ACA. The draft regulation was sent to the NAIC's B Committee, which then exposed the draft for additional comment. On Oct. 8, the Academy's MLR Work Group sent a letter to the NAIC identifying areas of agreement with the draft regulation, as well as issues that deserve further consideration (e.g., magnitude of credibility adjustments and methodologies for contract reserves) or still need to be addressed (e.g., transition guidance and identification of rebate recipients).

Editor's Note: since this article was drafted, HHS has released the interim final regulation related to medical loss ratio rebates and reporting, as well as proposed regulations on rate review and disclosure of unreasonable rate increases.

Premium Review

Sec. 2794 of PHSA, which was created by the enactment of ACA, requires the HHS secretary to work with states to establish an annual review of unreasonable rate increases, to monitor premium increases, and to award grants to states to carry out their rate review processes. As noted, the members of the Academy's Premium Review

Work Group have had conversations with HHS regarding rate review and, in particular, the information available in actuarial memoranda. As a follow-up to those conversations, members of the work group provided examples of publicly available rate filings and actuarial memoranda from different states and markets. In addition to providing input to HHS, on July 14, the work group offered comments to the NAIC on its exposure draft of a rate filing disclosure form, which is intended to facilitate the reporting of "unreasonable" rate increases to HHS.

On a related issue, the work group also sent a letter to the leadership of the Massachusetts legislature on Senate bill 2447, which included a provision that would deem "excessive" any health insurance premium increase that exceeds 150 percent of the percentage increase in medical CPI. The work group's comments noted some of the limitations of medical CPI as a measure of the reasonableness of a premium increase.

Reinsurance

On Sept. 22, the Academy's Risk Sharing Work Group sent a letter to HHS on Section 1341 of ACA, which tasks the Academy with providing recommendations related to the 2014 temporary reinsurance mechanism. In its letter, the work group provided initial input on potential approaches for identifying high-risk individuals and determining reinsurance payments.

Benefit and Eligibility Changes

A number of ACA provisions related to changes to certain benefits and eligibility requirements became effective on Sept. 23. As such, the Academy's Benefits and Eligibility Work Group actively responded to the release of interim final regulations (IFR) on many of these provisions. On July 12, the work group submitted a comment letter to HHS on the IFR related to the extension of dependent coverage to age 26. The work group's comments focused on age-rating for dependents, limitations on coverage to dependents not eligible for employer-sponsored insurance, and the definition of dependent. In addition, the work group noted some concerns related to the economic impact section of the IFR, specifically whether the financial impact of the issues addressed in

the letter actually were reflected in the economic impact analysis.

On Aug. 27, the work group provided comments to HHS on the IFR regarding the elimination of preexisting condition exclusions for children younger than 19, the elimination of lifetime benefits and the restriction on annual limits, and other patient protections.

On Sept. 17, the work group submitted a letter with comments on the IFR related to the requirement that preventive services be covered without cost sharing. The letter requested clarification on the services covered and the frequency at which they are covered. The letter also examined the economic impact of first-dollar coverage of these services.

On Aug. 16, the Grandfathering Provisions Work Group responded to the IFR that addressed the status of health insurance coverage as a grandfathered plan. In addition to responding to specific requests for comments within the IFR, the work group provided comments on transitional rules, the maintenance of grandfathered status, and the applicability of the IFR to individual coverage and plan rolls.

Exchanges

On Oct. 4, the Academy's Exchanges Work Group responded to a request for comments from HHS on the exchange-related provisions in Title 1 of

CONTINUED ON **PAGE 12**

ACA. The letter included responses to questions related to qualified health plans, actuarial value, increasing and facilitating participation in the exchanges, enrollment and eligibility, quality standards and risk adjustment.

NAIC and other Academy Activities
On Oct. 4, the Joint Committee on Retiree Health and the Pension Accounting Committee sent a joint letter to the NAIC to provide comment on the exposure draft of Statement of Statutory Accounting Principles (SSAP) 92 and the proposed revisions to SSAP 89, which are intended to replace existing standards governing accounting for pensions and OPEBs. The comments focused on the potential need for SSAP accounting treatment to distinguish between long-term benefits that are binding and those that are not.

On Sept. 30, the Academy's Deferred Tax Assets (DTA) Bridge Group submitted a requested final report to the NAIC Capital Adequacy Task Force showing the appropriate treatment of the DTA in the risk-based capital formulas for life, property/casualty and health.

In September, the Academy's Health Practice Financial Reporting Committee issued a new practice note, Practices for Preparing Health Contract Reserves.

Ongoing Activities

The Academy's Health Practice Council has many ongoing activities. Below is a snapshot of some current projects.

Health Practice Financial Reporting Committee (Darrell Knapp, Chairperson). The committee has updated the practice note on actuarial opinions to reflect recent changes by the NAIC.

Long-Term Care Principles-Based Work Group (Bob Yee, Chairperson). This work group has formed a joint Academy/SOA task force to develop and recommend valuation morbidity tables for long-term care insurance at the request of the NAIC's Accident and Health Working Group. The group is working with a company to help solicit the data for, and determine the structure of, the morbidity tables.

Stop-Loss Work Group (Eric Smithback, Chairperson). This work group is continuing to update a 1994 report to the NAIC on stop-loss factors, and is currently checking data calculations prior to restarting the modeling phase of their work.

Disease Management Work Group (Ian Duncan, Chairperson). This work group is in the final stages of developing a public statement on evaluating wellness programs.

Medicare Supplement Work Group (Michael Carstens, Chairperson). This work group has submitted recommended changes to the Medicare Supplement Refund Formula to the NAIC's Medicare Supplement Refund Formula Subgroup, of the Accident and Health Working Group, and continues to work with the NAIC to develop a refund formula.

Solvency Work Group (Donna Novak, Chairperson). The work group continues to evaluate the current health RBC covariance calculation for potential changes to the calculation or methodology and the impact of health reform on the health RBC formula.

Academy/SOA Cancer Claims Cost Tables Work Group (Brad Spenney, Chairperson). The work group has been charged with evaluating and updating the 1985 cancer claims cost tables.

Health Practice International Task Force (April Choi, Chairperson). A subgroup of the task force published articles in the September issue of Contingencies on the health care systems in Japan and Singapore. The task force is finalizing an article on risk adjustment that would be included in the January/February issue of Contingencies.

If you want to participate in any of these activities or if you want more information about the work of the Academy's Health Practice Council, contact Heather Jerbi at *Jerbi@actuary.org* or Tim Mahony at *mahony@actuary.org*. ■

Getting Actuaries More Engaged in Population Health

by Robert Lieberthal

Today's health actuaries are expected to be experts in managing the health of insured populations. It is no longer sufficient to select assumptions, calculate premiums and manage deviations from expectations. Health insurance plans include new benefits, such as disease management programs, and the new health law includes new forms of health insurance, such as accountable care organizations. Learning more about these population health programs will give actuaries the opportunity to have a "seat at the table" when the programs are designed, and give actuaries an inside view of the actuarial implications of the new health care landscape.

Population health is a collaborative discipline that seeks to leverage all the determinants of health to maximize the health of populations. Population health inputs include personal behaviors, medical care and the public health infrastructure, as well as the social and economic context at the community and national level.[1] The debate over insurer rating of doctors for cost and quality is driven by the complexity of separating provider performance from other population health factors outside doctors' control.[2] Those opposed to rating schemes are correct that genetic factors, peer effects and other outside influences all affect health, and that claims data is necessarily limited to insured medical care. However, actuaries know that claims data can be a powerful tool for monitoring health as well as costs and is often more accurate than clinical records or patient perceptions of physician quality. Justifying the use of retrospective claims analysis data could improve population health and reward high quality care.

Population health determinants like public health and health policy often have actuarial implications. The public health system is delivering behavioral interventions, focusing on environmental health issues and developing community care systems, which have the potential to change the health care costs of insured populations. Health policy changes may also drive costs up (or down). In Philadelphia, the Department of Public Health received an American Recovery and Reinvestment Act (ARRA) stimulus grant to promote healthy lifestyles through neighborhood-level interventions, including working with the owners of corner stores to encourage them to carry more fresh produce.[3] If these microlevel population health interventions lead to healthier behaviors, they could lead to reduced short-term health care costs as utilization decreases or increased costs in the long term as people live longer. Actuaries have the chance to engage with the people designing interventions, to help predict the financial consequences of health interventions and maximize bang for the buck.

My university started a new school to serve as a locus for the research and teaching needed to improve population health. Thomas Jefferson University, located in downtown Philadelphia, is widely known for its large private medical school and elite care by clinician-researchers. The Jefferson School of Population Health, led by our dean, David Nash, M.D. M.B.A., includes a research faculty from fields as diverse as pharmacy, public health, epidemiology and health economics, with a common goal that "…interdisciplinary collaboration will strengthen the foundation of the population health infrastructure and lead to improved population health management."[4]

Our teaching offerings include novel continuing professional education and academic programs centered on population health. Our College for Value Based Purchasing is "…a practical, inten-

CONTINUED ON **PAGE 14**

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1 Kindig, D. and Stoddart, G. 2003. What is Population Health? *American Journal of Public Health* 93(3): 380–383, March.

2 Yee, C.M. 2010. AMA Battles Insurers over Doctor Ratings." *Minneapolis-St. Paul Star Tribune*, July 19. http://www.startribune.com/lifestyle/health/98797709.html

3 Mallya, G. 2010. "Get Healthy Philly: Policy and System Change to Promote Healthy Eating, Active Living and Tobacco Control." Presentation, Jefferson School of Population Health. Health Policy Forum, Oct. 13.

4 Nash, D.B., et al. 2011. *Population Health: Creating a Culture of Wellness.* Sudbury, Mass.: Jones and Bartlett Learning.

sive 3-day program to help employee benefit managers meet the growing challenges of providing high quality health benefits and managing rising benefit costs." We developed the program by partnering with the National Business Coalition on Health and HealthCare 21 to fill an unmet educational need of benefits managers. Our master's in chronic care management is a first-in-the-nation program designed specifically for managed care and disease management leaders struggling to deal with a new world of pay for performance.

Our research projects are focused on population health problems that are of interest to both payers and providers. One example is our migraine quality measurement project. The aims of the project were to improve quality measures for migraine care to improve care and to reduce preventable health care and disability costs.[5] The end result is a set of outcome measures in diagnosis, utilization and volume of care, and other quality indicators that is being tested in health plans for usability and effect on costs. We are also responsible for editing four peer-reviewed journals, including *Population Health Management*, the official journal of DMAA: The Care Continuum Alliance.

Our School of Population Health is one of a growing number of settings where researchers, payers and practitioners are collaborating to improve health. Many population health priorities are the same nontraditional practice areas that the Society of Actuaries has identified as growth areas with limited actuarial representation.[6] Our teaching goal is to work with health professionals who want to "develop and enhance" population health skills to help them identify and learn these skills. Our research goal is to partner with the ideal set of collaborators for all population health research projects. I see opportunities for many such teaching and research collaborations with actuaries looking to become more engaged in population health. ■

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[5] Leas, B.F., et al. 2008. Assessing Quality of Care for Migraineurs: A Model Health Plan Measurement Set. *Population Health Management* 11(4): 203–208, August.

[6] Society of Actuaries. "Untapped Opportunities for Actuaries in Health Care: Market Research Summary Report to Membership." http://www.soa.org/files/pdf/prof-int-health-untapped-opp.pdf