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The ACA Exchange and Medicare Part D: A Comparison of Financial Risk

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As we wait for the initial financial results on the Affordable Care Act (ACA) exchanges, many policymakers are making a comparison between the Medicare Part D program and the ACA exchanges. In drawing this comparison, the policymakers have suggested that the ultimate performance of the ACA exchange will mirror the relatively successful financial results in the Medicare Part D program. As I will discuss in this article, although the two programs share common elements, several features inherent in the programs make any meaningful financial forecast of the ACA exchange using the Medicare Part D experience very difficult.

THE SIMILARITIES AND DIFFERENCES BETWEEN THE PROGRAMS

At first blush, the initial rollout of the Medicare Part D program has many similarities with the ACA exchanges. These features include no individual underwriting, no historical experience at the beginning of the program, online enrollment within a defined open enrollment period through an exchange, similar financial risk protections offered by the government, penalties for not participating, and a subsidy for low-income individuals. While these similarities can provide a meaningful comparison for some aspects of the program, these features are not sufficient to use the Medicare Part D program as a means to predict the financial success of the ACA exchange program. The factors contributing to this challenge include:

- The uncertainties in predicting the ultimate risk pool in the ACA exchanges
- The potential cost variability at the health plan level
- The differences in the risk adjustment methodologies used in the two programs.

RISK POOL UNCERTAINTY

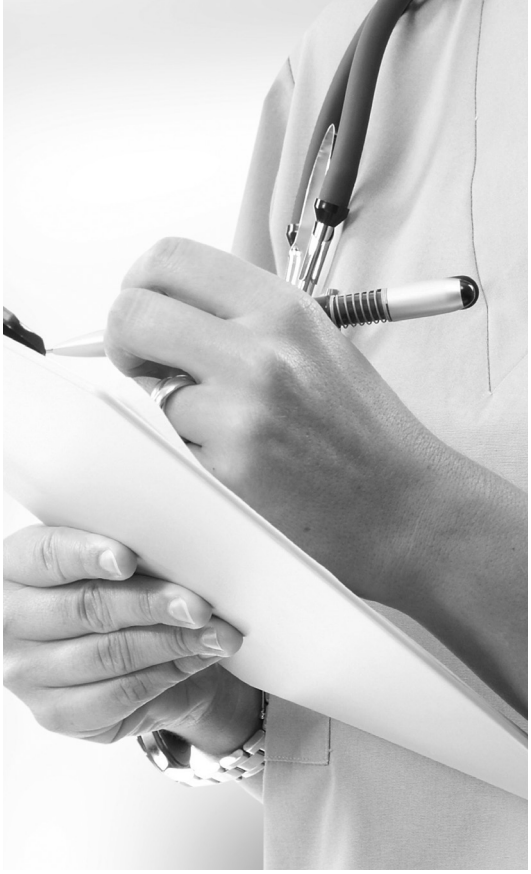
Consistent with any actuarial analysis, one of the most important prerequisites in estimating the cost for a population is understanding who will be included in the risk pool. If the underlying population varies from the initially assumed risk, the results could differ significantly—particularly if individuals with lower costs can selectively remain outside of the risk pool.

While the Medicare Part D program enrolled a relatively broad senior population, the ACA exchanges have features that could lead to enrollment that is a much more narrow slice of the risk pool in relation to the Part D program. The specific factors that could contribute to a more narrow risk pool include:

Transitional plans. While the Medicare Part D program did not offer a choice between an existing fully underwritten plan and one offered under the Part D program for most participants, the ACA exchange program allowed this additional choice in half the states. By allowing this choice, individuals with lower expected costs could rationally choose the lower-cost option—typically their existing fully underwritten individual plan—and completely avoid the ACA risk pool. Because the original ACA premiums were developed assuming broad participation among those who were healthy and already had individual insurance, the originally developed premiums offered in the ACA exchange have the potential to underestimate the true costs of the program.

Total out-of-pocket premium costs to the member. The Medicare Part D program provides an implicit subsidy for all participants, as well as a more generous subsidy for lower-income participants that eliminates the member premium and a vast majority of the cost sharing. This subsidy, combined with a benefit package that only includes drugs, produces an aggregate premium that is much lower than a typical premium for a comprehensive medical policy. The ACA exchange, on the other hand, does not subsidize all participants and the overall premium for the comprehensive policy (medical and pharmacy) has the potential to be much higher. The net effect is that this premium difference could be significant enough to lower participation in the ACA exchange program as consumers respond to the higher overall premium by not enrolling in the program.

Buyer characteristics. The eligible members among the programs differ significantly—the Medicare Part D program is primarily designed for seniors, while the ACA exchange is designed for the entire non-senior population who needs individual coverage.



As one would expect, the willingness to purchase an insurance product will depend on the probability that an individual will incur claims and use the insurance product. Because the exchange is designed for a population that includes the young and healthy, we can reasonably expect lower participation and greater uncertainty regarding the ultimate risk pool in the ACA exchange relative to the Medicare Part D program.

Penalty differences. The Medicare Part D program has a financial penalty that increases each year that a senior does not enroll in the program. In contrast, the ACA exchange has a small immediate financial penalty for not enrolling in the exchange that does not accumulate and is much smaller than the total cost of the unsubsidized premium for almost all participants other than those with high incomes. As a result, an individual's cost benefit calculation is much different between the programs—for the Medicare Part D program, an individual has a more compelling incentive to purchase insurance immediately while the prospective exchange member has a greater incentive to avoid purchasing insurance until it is needed and save on the more costly exchange premium.

HEALTH PLAN COST VARIABILITY

In addition to differences among the risk pools, the expected total costs for the ACA exchange population will be much more variable for health plans than the Medicare Part D program. Several features in each program contribute to this difference, including:

Reinsurance subsidy. The Medicare Part D program provides unlimited reinsurance protection, while the ACA reinsurance provides protection up to $250,000 for the first three years of the program and then no protection beginning in 2017. In both cases, the reinsurance begins after a defined threshold has been met. This difference in financial risk protection can produce much higher costs and risk for insurance organizations in the ACA exchanges relative to the Part D program—particularly if an insurance organization attracts sicker individuals.

Magnifying inadequate premiums through member migration. As discussed above, a higher overall premium level can be a powerful incentive for a low-utilizing member to avoid participating in the ACA exchange. In a similar fashion, a higher overall premium level could also create a powerful incentive to switch to the plan offering the most attractive benefits at a particular premium level. Given the structure of the ACA exchange, this incentive could be significant for both unsubsidized and subsidized plans. While the unsubsidized plan could offer a significant out-of-pocket differential for higher-income participants, a subsidized plan could create a significant percentage differential in premiums in a given year and over time that could prompt switching to lower-cost plans.

The following example from a Milliman briefing paper "The Proposed Federal Exchange Auto-Enrollment Process: Implications for Consumers and Insurers" by Susan Pantely and Paul Houchens highlights this issue. 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.

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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	$295
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.

This migration has the potential to magnify the impact of inadequate premium rates as individuals move to these plans and increase the losses for insurance organizations. While this dynamic has also occurred with the Part D plans, the relative extent is likely to be less extreme simply because the premium level is much lower and the impact of the subsidy less significant.

Demographic and benefit package differences. The ACA exchange will be more likely to have greater cost variability because the benefit package includes medical and pharmacy benefits as compared to one with only pharmacy benefits.

Taken in total, for the ACA exchanges, the claims distribution at the individual health plan level will be much more like a traditional claims probability distribution (log normal) where there exists a much greater potential for claims costs to far exceed expected costs. In contrast, the Part D program is much less likely to have claims that far exceed expectations. Similar to the potential variability associated when estimating the risk pool composition, these inherent differences introduce greater risk and increase the probability that an insurance organization will have claims costs that far exceed its original estimates.

RISK ADJUSTMENT PAYMENT DIFFERENCES

While the preceding discussion highlighted the many structural challenges that could produce greater variability in the ACA exchange program, the program also offers a risk adjustment program that could mitigate this variability. The ACA exchange program uses an allocation method that compares a health plan's specific risk score to the overall pool to develop a risk adjustment payment (or cost) that is contributed (or paid to) by other health plans whose risk adjustment also differs from the pool average. This payment methodology uses concurrent risk scores to develop payments that are made in the middle of the next calendar year after all the claims information, demographics and plan design information are compared among the health plans. The Medicare Part D program, in contrast, uses risk scores that are largely known by the health plan and are based on a member's historical medical claims. These differences highlight the additional risks asso-

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Given the nature of the two programs, the insurance organizations participating in the ACA exchange are much more likely to have volatile claims costs as well as total claims costs that exceed the initial predictions as compared to the Medicare Part D program.

ciated with the ACA program relative the Medicare Part D program, including:

Risk pool estimation risk. While the Part D program was developed to ensure that the risk scores are calibrated and are largely known to the insurer in the coverage period, the ACA exchange requires a health plan to estimate its own risk score relative to the broader risk pool. As we discussed in the first section of this paper, this risk pool estimate is difficult and subject to more significant error.

Feedback on emerging results. Similar to any business, a health plan needs to understand how its emerging results compare with expected results to make the necessary pricing or operational changes to improve results. Unlike the Medicare Part D program, however, the ACA exchange does not allow this immediate feedback because the reconciliation process is not completed until the next year. This delay limits an accurate comparison between projected and actual results and makes the pricing process for the next calendar year much more difficult because the true results are not completely understood until the following year.

Overall, although the risk adjustment in the ACA exchanges has the potential to mitigate the variability concerns raised in this article, this protection is not as effective at minimizing this risk relative to the Medicare Part D program.

CONCLUSION

From a financial risk perspective, the ACA and Medicare Part D programs are much different, and any comparisons between the programs should consider the more traditional actuarial considerations that are discussed in this article—uncertainty in predicting the risk pool, total cost variability for health plans, and risk adjustment payment differences. Given the nature of the two programs, the insurance organizations participating in the ACA exchange are much more likely to have volatile claims costs as well as total claims costs that exceed the initial predictions as compared to the Medicare Part D program.