Article from
Health Watch
October 2017
Issue 84

Commercial Health Care: What's Next?

A Health Section Strategic Initiative

By David Dillon

In June 2017, the Society of Actuaries (SOA) Health Section released a new strategic initiative entitled Commercial Health Care: What's Next? This initiative was designed to be an anthology series of white papers and articles focusing on education and research concerning key issues concerning health care reform. This article contains a condensed summary and excerpts from the first three white papers that were released. The full articles and newly released companion pieces are located at *http://www.theactuarymagazine.org/category/web-exclusives/commercial-health-care-whats-next/*.

THE NEXT-GENERATION HIGH-RISK POOL

By Liz Leif FSA, FCA, MAAA, and Cecil Bykerk, FSA, FCA, HonFIA, MAAA

Traditional high-risk pools were designed in the era prior to the guaranteed access requirement of the Affordable Care Act (ACA). The goal was to provide the additional funding needed for high-risk individuals through a separate funding mechanism, while keeping the cost for the majority of insured individuals at a lower level.

High-risk reinsurance pools also focus on financing the cost of health care for high-risk individuals. In this approach, high-risk individuals remain in the commercial market, but behind the scenes the insurance carrier cedes all or part of its risk exposure for those individuals to the reinsurance pool. Because the existence of the funding mechanism is invisible to the high-risk individual and the approach allows individuals with preexisting conditions access to the commercial market, it recently has gained favor at both the federal and state levels.

HIGH-RISK POOLS: ACCOLADES

- High-risk pools are a good mechanism for keeping rates lower in the individual market, because the cost of the highest-risk individuals is segregated from the insured risk pool and funded in a different way.
- When high-risk pools are funded through a broad-based mechanism, such as assessing carriers in all markets or using state general funds, the shared cost is less for all.
- High-risk pools have no profit motivation, and their goal is to serve the needs of this specialized population.
- The existence of a high-risk reinsurance program is invisible to the insured individual, so there is no stigma attached to the source or type of insurance coverage.
- With high-risk reinsurance, the high-risk individual's premium rate level is the same as other individuals with the same plan, age and geographic location. The reinsured high-risk individual has the same plan choices as others in the same geographic location.

HIGH-RISK POOLS: CRITICISMS

- The high-risk pool concept is often criticized for not being self-sustaining and always requiring outside funding.
- Traditional high-risk pools typically do not offer multiple carrier choices, since they operate as self-funded rather than fully insured programs. This criticism is resolved in the high-risk reinsurance approach, since the individual purchases coverage in the commercial market.
- Traditional high-risk pools result in the segregation of high-risk individuals from other individuals who can purchase lower-cost policies directly from the insurance market.
- Traditional high-risk pool premium rates historically have been high because of statutory rules allowing for the price to be set at a multiple above the standard risk rate.
- High-risk reinsurance programs that reimburse insurers for the payment of large claims leave the insurer with less incentive to appropriately manage care and seek cost-saving alternatives.

Is There a Future for High-Risk Pools?

If the ACA was to be repealed in its entirety—or modified to eliminate guaranteed access or to allow carriers to charge higher rates for high-risk individuals—the traditional high-risk pool concept could make a comeback. Whether these programs will play a role on a broader basis in the future is still an open question.

THE OLD AND THE BEAUTIFUL

By Doug Norris, FSA, MAAA, Ph.D., Hans Leida, FSA, MAAA, Ph.D., Erica Rode, ASA, MAAA, Ph.D., and T. J. Gray, FSA, MAAA

All forms of insurance involve some level of concurrent subsidization—in health care, everyone signs up for coverage, and those who end up healthy during the year subsidize those who fall ill. For the individual and small group commercial major medical markets, the ACA mandates an additional prospective subsidization (based upon age and gender), prescribing a maximum premium variation (between adults purchasing the same benefit plan in the same area) of no greater than 3 to 1 (and no premium variation between males and females of the same age). This restriction is built into the ACA's risk adjustment program, in order that carriers with a disproportionate share of older individuals can be compensated from other market carriers.

> The existence of a high-risk reinsurance program is invisible to the insured individual, so there is no stigma attached to the source or type of insurance coverage.

Prior to 2014, states were typically the ones who decided what age/gender premium limitations would be imposed in their individual and small group commercial markets. Most states had either no age restrictions at all, or had restrictions that were less compressed than the ACA's 3 to 1 requirement (and most states did not require unisex rates).

Under some forms of insurance, the issue of age subsidization is mitigated by the fact that a policy remains in force for a substantial portion of an enrollee's lifetime, with future costs prefunded over the first years of the policy. In commercial health insurance, both the insurable event ("health") and the benefit amount are difficult to predict over that long of a time frame. For a number of reasons including this, commercial health products have evolved to the point where a one-year contract has become the standard.

Although Actuarial Standard of Practice 12 (Risk Classification) gives us some guidance in this situation, the question of how much commercial market subsidization is appropriate is not so much an actuarial question, but a societal question. However, society's answer to this question has actuarial repercussions. On average, older enrollees do have more medical conditions (and consume more health care services) than their younger counterparts. On the other hand, all younger people presumably aspire to one day be older people (or at least would likely agree that growing old beats the alternative). If the commercial market is age subsidized to a low degree (or not at all), then it becomes more difficult for older enrollees to afford coverage; the greater the subsidization, the more difficult it becomes to entice younger enrollees to purchase coverage. As of this writing, proposed reforms to the ACA have included a lower subsidization level (of 5 to 1) between younger and older enrollees.

Tied to all of this is the effectiveness of the individual mandate. When individuals do not believe that they are required to have health coverage, then they are more likely to purchase insurance if they feel that they will need it during the coming year. Additionally, the level of premium subsidy that some enrollees receive through the ACA (or through its successor) will impact the affordability of coverage.

HOW SMALL EMPLOYERS WILL BE IMPACTED BY REFORM

By Trey Swacker, FSA, MAAA

As the federal government debates the U.S. health care system and specifically the future of the ACA, the majority of the media

coverage and attention has been focused on the uncertain future of the individual market. This article spotlights the potential impacts to health coverage for small employers.

The small employer market has already been through a period of dramatic change under the ACA. Changes to the availability of plan options, rating rules and the federal risk adjustment program have increased premiums significantly in many cases. Will new benefit strategies be available? Can I continue to keep my plan? Can I buy plans sold in other states? Can I self-insure? Can I join a purchasing alliance? Can my employees afford coverage in the individual market? These are just some of the questions that small employers and brokers in the market are thinking about.

The number of small employers offering fully insured medical coverage has been declining for several years, but the trend has increased since the implementation of the ACA's rating rules and premium stabilization programs in 2014. Some smaller employers have chosen to self-insure their benefits, but it would appear more small employers have chosen to allow their employees to purchase coverage in the individual market.

Various versions of ACA repeal-and-replace legislation have stalled in the House and Senate, but there are other pieces of legislation that have passed (or enjoy stronger support) that will have some impacts on small employers.

The 21st Century Cures Act, which became law in December 2016, will allow small employers to fund Health Reimbursement Accounts that their employees can use to fund premiums for policies on the individual market.

The Self-Insurance Protection Act, which passed the House with bipartisan support, clarifies the ERISA preemption for employers who self-insure their medical benefits and purchase stop-loss protection. ERISA challenges had largely been upheld to date, but many states have implemented or are considering minimum thresholds for stop-loss policies.

The Small Business Health Fairness Act passed the House along partisan lines, and the bill outlines a structure for "Association Health Plans" that would preempt state regulation of insurance. This provides the structure for small employers to band together to purchase health coverage. It is not as sweeping as the policy proposals to allow sales of health insurance across state lines, but is viewed as a litmus test for that issue.

The more comprehensive House (American Health Care Act) and Senate (Better Care Reconciliation Act) bills to reform health care appear stalled at the moment. While the future of the ACA and health care reform in general remain uncertain, it's never too soon to start explaining the different scenarios and impacts of proposed legislation. Small employers are key to the economic engine of the United States. Meeting their health care needs is imperative under any regulatory framework. ■

David Dillon, FSA, MAAA, is vice president and principal at Lewis & Ellis Inc. He can be reached at *ddillon@lewisellis.com*. David has been appointed to lead the Commercial Health Care: What's Next? strategic initiative by the Health Section Council.