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Frequently Asked Questions about the Cost of the Future Newly Insured under the Affordable Care Act (ACA) SOA Study—And Other Things You Might Not Know by Just Reading the Executive Summary

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In March 2013, the Society of Actuaries released a modeling study titled “Cost of the Future Newly Insured under the Affordable Care Act (ACA).” This study garnered quite a bit of media and political attention when it was released, but much of that coverage focused on the high-level findings, particularly those summarized in the executive summary. In the intervening months, I have had the opportunity to present the findings of this study to a number of audiences and also to participate in several question-and-answer sessions with various interested actuarial groups. In this article, I will cover some of the most frequently asked questions about the findings and methodology used for this modeling study, as well as highlight some of the more interesting findings that might not be evident without a deeper reading of the entire report.

Question: In some states, the enrollment in certain subpopulations prior to the ACA is very different from what is reported by other sources. What data source was used for this study and why might it be different from other sources?

This study was performed using The Lewin Group’s Health Benefit Simulation Model (HBSM) which is a micro-simulation model of the U.S. health care system that has been used for over 20 years to model the likely effects of different health reform proposals on the enrollment and cost of care. Because we need to model the entire health care system, this model requires a data source that includes information about the currently uninsured population. The HBSM uses data from the Current Population Survey (CPS), which provides detailed demographic and source-of-coverage information. This data is coupled with data from the Medical Expenditure Panel Survey (MEPS), which includes similar demographic data as well as detailed cost of medical care data. Over time, we have found these two sources to be the best comprehensive sources of data that cover all populations of interest. The CPS data has the added advantage of being done

consistently at a state level that allows for more granular analysis.

Two subpopulations that are often identified as different from the CPS results are Medicaid and the uninsured. When comparing the results from other data sources, it is important to understand how membership was counted (each month or at a particular point in time), which is the most common reason for differences. In most cases, other sources of data are not available consistently in all states, or are only available for certain populations (e.g., Medicaid), which makes them difficult to use for this type of modeling. An in-depth discussion of all potential data sources and their feasibility for this type of modeling was outside the scope of this study.

That said, it is important to point out that the timing for the data pull was based on 2008 to 2010 CPS data that we pooled together to increase the sample size at the state level. Because the data for the uninsured was based on 2008 to 2010 proportions, when the uninsured rate was somewhat higher than it is right now in many states, this means that some of the states’ claims costs may be higher than what were modeled given a strengthening economy (the composite effect of the uninsured subpopulation generally helped to offset or mitigate the other compositional changes anticipated).

Question: What definition of “cost” was used in this study?

In the HBSM, health care costs are developed from the MEPS data. Our focus for this report was the change in morbidity of the underlying populations as members moved between coverage choices and from uninsured to insured status as a result of the provisions of ACA. Health care cost for this purpose was the equivalent of allowed charge as measured by the MEPS data. This should be distinguished from other



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potential cost measures such as premium, which could include other elements such as administrative expenses, taxes, financial assistance to issuers from risk mitigation programs, and premium subsidies available to individuals.

Question: *Did you model the “pent-up demand” for health care services in the newly insured population?*

Our results are presented on a fully implemented basis after the compositional changes have stabilized (the model does not attempt to predict 2014 claims cost though 2014 was used as a static reference year), so we do not explicitly attempt to model the phase-in of enrollment or the ramp-up of utilization and expense over time. From this perspective, we did not attempt to analyze the effect of pent-up demand for health care services.

However, for members who were formerly uninsured, we modeled their future expense levels using currently insured members with similar characteristics. We expect the cost of the uninsured to eventually increase to the level of currently insured members, so while we do not attempt to model the pattern of pent-up demand leading to higher costs in the first few months of enrollment, we do model claims at an ultimate level consistent with an insured population.

Question: *In the report, detailed results were provided for Wisconsin and results for other states were summarized. Why was Wisconsin chosen?*

In order to keep the size of the report manageable, we were only able to provide detail and discussion in the body of the report for a single state. Wisconsin was chosen as a good example because several members of the project oversight group (POG) were familiar with the market in that state. It was also determined to be a suitable example because it had a more “typical” pre-ACA regulatory environment where individual product pricing and regulation were neither overly restrictive nor overly loose.

Detailed data tables were provided for all states plus the District of Columbia for many of the detailed tables presented in the body of the report. The readers are left to draw their own conclusions regarding the state-level details for the other states, although the considerations would be similar to Wisconsin.

Question: *Some media coverage has criticized the report for not considering the impact of subsidies for low-income populations under ACA. Did the report consider the impact of individual ACA subsidies?*

Our modeling approach considered the impact of subsidies in terms of choice of coverage and whether a particular individual chooses to purchase indi-

vidual coverage or to remain uninsured. This study used two different approaches to model member-level choices of coverage. One approach is price elasticity where the net cost of coverage pre-ACA is compared to the net cost of coverage post-ACA. The second approach uses a utility method to also include the perceived value or utility of having insurance coverage rather than not having coverage. In both approaches, we factored in the reduced cost of coverage under ACA for those individuals who are eligible for subsidies.

While it is true that we did not illustrate the net cost of coverage after subsidies in our exhibits, we did explicitly account for the availability of these subsidies in modeling member-level choice of coverage. The focus of this report was on the most difficult assumptions that issuers faced in pricing under a swiftly changing environment: the effect of membership composition shifts and consequent morbidity shift caused by the ACA. Even focusing the study on this targeted modeling took well over nine months to accomplish.

Question: *The report focuses on the individual market, and only briefly touches on the impact on the large and small group markets. Why did the report focus on the individual market rather than other market segments? Are the results included in the detailed tables for the group market appropriate for estimating the impact on those populations?*

In order to keep the size of the report manageable, we needed to focus on the segment of the market that we thought would be most interesting and useful for the actuarial profession and other interested parties. The POG felt that the individual market was where the most significant impact of the provisions of ACA would be felt, and where the least current research was available. In particular, the change in morbidity in the individual market was believed to be the most critical change, and that was where we focused our attention for the report.

While not the focus of the report, the results for other subpopulations are valid and can be used to estimate the impact of ACA on those populations.

Question: *Did you model the impact of different coverage choices among the metallic benefit options? Did you include the effect of increased Essential Health Benefit (EHB) requirements for individual plans post-ACA?*

Because the focus of this study was on the change in morbidity of the different populations affected by ACA, we did not model the impact of benefit choice at the metallic benefit levels required by ACA. Costs were modeled at the allowed level, so member cost-sharing features were not factored in. For premium calculations pre- and post-ACA, we assumed the same benefit design in calculating the change in premium before and after ACA, so the change in premium level was driven by the ACA rating provisions and the morbidity of the population, rather than changes in plan design or covered benefits.

It should be further noted that the cost measures presented in this study are intended to reflect the change in morbidity only, and do not consider many other factors that could affect final premium rates. These include changes in covered benefits as a result of EHB requirements, network differences, competition, transparency, minimum actuarial values to satisfy metallic benefit level, additional taxes and fees, temporary reinsurance program recoveries, and premium and cost-sharing subsidies for low-income members.

Question: *The state-level results summarized in the report vary a great deal from state to state. Within a particular state, how much variation can we expect from the values included in the study?*

It is not possible to put exact parameters around the expected variation, or to establish a reasonable expectation of variability in this type of modeling. We can only state what assumptions we used and show a range of sensitivity to different levels or types of assumptions, which are included in the detailed Excel table outputs included with the report. Because many of the provisions of ACA have never been applied historically, we have no way of know-

ing in advance how much variation we might see when actual enrollment occurs. It is safe to say that there is a very wide range of possible outcomes, depending on the level of assumptions chosen and who actually enrolls in the individual market post-ACA. We would encourage the readers to use judgment in applying the results of this report to their particular situations. Other modeling approaches or assumption sets may yield different results.

The SOA's modeling study was uniformly and consistently sourced, and assumptions and methods were uniformly and consistently applied throughout the model, so it is very important to point out that one of the key findings—that the ACA will have remarkably different influences on morbidity from state to state—was a new and unique insight at the time, and had received little to no attention before the study was released. While a lot of the reasons for this variation have to do with state differences such as age, income levels and health costs, a lot of the variation also is due to states having remarkably different starting points in their current individual markets. Some actuaries found that the gathering of the initial source data into one single place in itself helped them understand variability better, and that the modeling of 50 states plus the District of Columbia in itself created some interesting and enlightening correlations to think about.

Question: *What are the most commonly overlooked findings of this study?*

Many of the common questions addressed above are actually covered in some detail in the body or appendices of the report. I would encourage users of the report to read the report in its entirety and also to review the accompanying Excel tables. While much attention has been paid to the baseline differences by state that are summarized in the executive summary of the report, there is a lot of interesting detail that can easily be overlooked. While the body of the report discusses the findings for Wisconsin only, there is a great deal of detail included in the accompanying Excel tables for each of the 50 states.

In addition to the baseline assumption set results, the Excel tables provide results under five sets of alternative assumptions, including: no Medicaid expansion, no ACA subsidies, and three sets of assumptions using variations of a utility methodology rather than price elasticity. In particular, the expected variation in enrollment and morbidity for the no Medicaid expansion scenario will be important in states that have decided to not implement the Medicaid expansion under ACA.

For all users, it is important to understand the enrollment and cost results for the various subpopulations that build up to the post-ACA individual population and whether those results are reasonable for a particular plan or market. Adjustments can and should be made to fit the specific circumstances of a particular user. ■