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ASOPs, Anti-Selection, Affordability and ACA Alternatives

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In August 2015, the Society of Actuaries (SOA) Health Section published *The ACA@5: An Actuarial Retrospective*. This one-time publication provided a comprehensive look back at the work of actuaries related to the implementation of the Affordable Care Act (ACA). At the time, there was a general sense of cautious optimism regarding the ACA. The early implementation struggles had been resolved; market participation was active for buyers and sellers; and several legal battles that reached the U.S. Supreme Court had been weathered.

In the last year, numerous complications have increased concern and discussion among actuaries and other market observers regarding the long-term sustainability of the ACA individual market. A sampling of the adverse list[1] includes:

- Financial failure of two-thirds of Consumer Operated and Oriented plans (CO-OP)
- No appropriation for cost-sharing reduction funding
- Complaints of inequities in the risk adjustment transfer formula (disadvantage to new carriers, no recognition of pharmacy claims, under-diagnosis for partial-year enrollees, use of statewide premium average in formulas, transfer of administrative expenses)
- Risk corridor funding of only 12.6 percent of amounts due
- Little enrollment growth in 2016, resulting in enrollment about half of original expectation
- Lack of special enrollment verification
- Large financial insurer losses and market exits across the country
- High premium increases in 2017
- High morbidity in markets due to transitional policy presence
- Numerous exemptions to individual mandate penalty
- Need to regulate short-term plans due to growth

A *Politico* article by Paul Demko suggested that the various problems with the ACA were the fault of three guilty parties: "self-inflicted wounds" from President Obama and his administration, undercutting of safeguards from Republican "saboteurs," and (this one will sting a little) "one big miscalculation" by the health insurance industry.[2] Demko may not have had actuaries directly in mind, but discussions with "calculations" and "insurance" in the same sentence customarily point in our direction. As stated in prior articles, I believe that the ACA has created greater professional and reputational risks for health actuaries than any prior market development,[3] and public reporting of "miscalculations" supports that argument. Professional risk is being discussed more among health actuaries recently, and it will be a covered topic at the 2016 SOA Annual Meeting & Exhibit, as several health sessions including the Health Section Breakfast will focus on lessons we have learned from the ACA.

As actuaries who are experts at predicting and managing risk, it is appropriate to ask ourselves: How much of this was predictable? I had some front-end thoughts on market dynamics that I expressed in 2014.[4] As I considered what we have learned and what we know now, I thought about my experiences with the ACA over the past six years. As I reflected on a variety of topics, I traveled down a path where I was not necessarily expecting to go. As background, I have worked with ACA products since inception, have been a very active volunteer with the SOA since becoming a fellow in 1998, and have done some occasional volunteer work on behalf of the American Academy of Actuaries (Academy). In 2014, I accepted an invitation to join a task force for the purpose of exploring whether an Actuarial Standard of Practice (ASOP) should be developed relating to minimum value and actuarial value under the ACA. The final result of this journey was the milestone ASOP No. 50, which fortuitously highlighted the Academy's 50th-year celebration. I had obviously read prior ASOPs and related comments in the past, but my first experience serving on a task force committee gave me a new appreciation of the amount of effort and diligent thought that goes into ASOP development.

ASOPs

This brought me back to my question: How much of this was predictable? If separate groups of bright, experienced actuaries had been through the same year-long experience that I went through 50 times (and we had the benefit of their work), does our body of knowledge include any foretelling indications of what we might have expected with the ACA? It occurred to me that other ASOPs, constructed with general actuarial principles of risk management with perhaps no relation to the ACA, might provide some real insight. This led me, in a sense, to a review of

all of the ASOPs with an ACA focus in mind, and more generally, an expedition into the wondrous history of our profession.

As we all know, the guidance in the ASOPs is to "identify what the actuary should consider, document, and disclose when performing an actuarial assignment."[5] These standards have guided our work since 1989 and cover many facets of the profession. Two ASOPs have directly addressed the ACA:

- ASOP No. 8
- ASOP No. 50, as discussed, provided guidance on actuarial value and minimum value

ASOP NO. 8

ASOP No. 8, dealing with regulatory filings for health benefits, was updated to reflect the ACA rate review process. It addresses one of the most notable challenges of the ACA pricing actuary: "The actuary should consider the impact of future changes in the underlying covered population on the projected claims. These changes may include, but are not limited to, changes in demographics, risk profile, or family composition."[6]

ASOP NO. 12

Interestingly, the ASOP that captured my attention was not one of the 16 developed by the Health Committee of the Actuarial Standards Board. ASOP No. 12, originally titled "Concerning Risk Classification," was initially adopted in 1989 but the history is much older. As described in the Appendix 1 background:

> Risk classification has been a fundamental part of actuarial practice since the beginning of the profession. The financial distress and inequity that can result from ignoring the impact of differences in risk characteristics [were] dramatically illustrated by the failure of the nineteenth century assessment societies, where life insurance was provided at rates that disregarded age. Failure to adhere to actuarial principles regarding risk classification for voluntary coverages can result in underutilization of the financial or personal security system by, and thus lack of coverage for, lower risk individuals, and can result in coverage at insufficient rates for higher risk individuals, which threatens the viability of the entire system.[7]

Actuarial literatures around risk classification date back to *Selection of Risks* by Shepherd and Webster, 1957. Other works on risk classification and actuarial principles followed and the study of risk classification continues to be updated by scientific improvements and technology. Regardless of the era, risk classification has been a bedrock principle of actuarial science and has been "used to treat participants with similar risk characteristics in a consistent manner, to permit economic incentives to operate and thereby encourage widespread availability of coverage, and to protect the soundness of the system."[8]

One reason for the ACA sustainability challenge relative to other government programs is the "voluntary" nature of the program as highlighted in ASOP No. 12. Compared to other health programs, such as Medicare and Medicaid, there is a substantial portion of the premium required to be paid by some beneficiaries that may result in selective enrollment patterns.[9] ASOP No. 12 provides clear direction: "The actuary should select risk characteristics that are related to expected outcomes" and strive for "sufficient homogeneity with respect to expected outcomes."[10]

To the extent risk characteristics are not allowable rating factors (i.e., health status, gender) and eligible enrollees are responsible for a significant premium contribution, anti-selection is a strong potential. The corollary in the group market is anti-selective enrollment for dependents who are responsible for a larger share of their premiums than employees. The ASOP goes on to define a "fair" and "equitable" market as one where "differences in rates reflect material differences in expected cost for risk characteristics."[11]

It is important to recognize that health plan ACA premium revenue received is different from the net premium payment of the beneficiary, due to federal premium subsidies and risk adjustment transfer payments. A health plan assessment of "fair" revenue related to a beneficiary may not be consistent with that beneficiary's assessment of a "fair" premium. Therefore, it is incumbent upon health plans to recognize the beneficiaries' financial viewpoint when developing enrollment and market projections. Related to this, an actuary should consider the revenue impact of the risk adjustment results on a changing market enrollment.

ANTI-SELECTION

Anti-selection (adverse selection) is defined in ASOP No. 12 as, "Actions taken by one party using risk characteristics or other information known to or suspected by that party that cause a financial disadvantage to the financial or personal security system."[12]

Warnings and implications of adverse selection are provided:

- 3.3.2.a: "If the variation in expected outcomes within a risk class is too great, adverse selection is likely to occur."
- 3.4.1: "Adverse selection can potentially threaten the long-term viability of a financial or personal security system. The actuary should assess the potential effects of adverse selection that may result or have resulted from the design or implementation of the risk classification system."
- Background section in Appendix 1: "Classes that are overly broad may produce unexpected changes in the distribution of risk characteristics."[13]

According to Demko, adverse selection is occurring in the individual market as "the biggest problem plaguing the exchanges is that for many states, the balance has turned out to be way off. Fewer individuals signed up for coverage than projected, and they've proven sicker and more expensive than insurers had expected."[14]

So, what is our responsibility when we see inherent challenges in the financial structures that we have been asked to manage? I think that was articulated quite well in another SOA section publication in 2013: "We build and manage systems and structures that are designed to be sustainable and are not built to fail. We understand and can demonstrate the consequences of building weak structures and systems. In cases where there are obstacles to sustainability, it is imperative that we objectively opine and seek to overcome these obstacles."[15] In the next two sections, I will offer my opinion on the challenges of ACA individual market sustainability and the sustainability impact of other new approaches relative to the ACA framework.

AFFORDABILITY

A simple question to ponder for a minute: Do people necessarily purchase products or services because they can "afford" them? Or do their consumption patterns reflect their desires and perceived needs, even if that requires an occasional stretching of their personal budgets?

In my opinion, our public policy has generally exaggerated the linkage between "affordability" and the purchase of health insurance. It is a rather simplistic notion to suggest that "people would have health insurance if they could afford it." President Obama admitted in 2014 that it was actually a more complicated decision. When asked about consumer choices, he said, "If you looked at that person's budget, and you looked at their cable bill, their telephone, their cell phone bill, it may turn out that it's just they haven't prioritized health care because right now everybody's healthy. Nobody actually wants to spend money on health insurance until they get sick."[16]

The ACA is built on the concept of affordability; after all, it's in the name. The ACA framework is intended to provide a guaranteed level of coverage (second-lowest-priced silver plan in geographic area) for a graded "affordable" percentage of income up to a threshold; anyone above the threshold presumably could afford health insurance without government assistance and would be inclined to do so. There was little consideration in the ACA methodology to determine whether that fixed percentage of income (or market premiums for individuals above the income threshold) would provide "value," perhaps from an expected-claims-to-premium-ratio perspective, and how this calculation might change for various age and income levels. Is it reasonable to expect a younger person and an older person at the same income level to have the same willingness to pay the same premium for the same coverage? As demonstrated in several examples, older adults actually pay less than young adults at the same income level for the same coverage for some plans,[17] undoubtedly shifting the risk pool.

In a free market society, people will rationally purchase products that provide "value" to them. Our focus, consistent with the equity and promotion of widespread availability of coverage discussed in ASOP No. 12, should be on offering products with attractive value for all, rather than relying on promotional efforts to certain groups to balance the risk pool with other groups who are arguably receiving excessive value.

Unfortunately, the ongoing challenge of encouraging young people to enroll in the ACA markets is being magnified by recent market results indicating that the risk adjustment transfer methodology results are driving poor health plan financial performance for enrollees without high-cost medical conditions. To put it rather bluntly, we seem to be in a situation where we all want young people to enroll in the market with only two exceptions: young people and the health plan that would likely enroll them.

Opportunities for innovation and market improvement through value creation are on the horizon and available at the state level in 2017. Some of the unbalanced federal subsidies can be adjusted by the implementation of state innovation waivers.[18] Within limits, states can use the federal funds provided through the ACA and redistribute them in a more efficient, equitable manner to provide incentives across a broader market; at the time of this article, no explicit state plans regarding this effort are publicly available. The next section considers some specific alternatives at the federal level, including numerical comparisons to ACA products.

ACA ALTERNATIVES

Over the last few years, various federal alternatives to the ACA have been proposed in Congress. Two of the most notable proposals have been developed by Rep. Tom Price of Georgia and

Rep. Fred Upton of Michigan. Price, an orthopedic surgeon and chair of the House Committee on the Budget, was a presenter at the 2015 SOA Health Meeting. Upton is chair of the Committee on Energy and Commerce. Similar to the ACA, both proposals recognize the correlation of age and health care costs and feature age-based tax credits. Both proposals also allow a steeper age curve of 5:1, which is more reflective of actual costs, rather than the ACA 3:1 limit. Unlike the ACA, the proposals from Price and Upton provide tax credits that are directly determined and independent of premium rates in the marketplace. Each proposal also avoids the so-called "family glitch," and the Price proposal would remove both of the ACA complications of an Internal Revenue Service (IRS) reconciliation with tax returns and the enrollee burden and risk of estimating personal income each year.

Price's proposal (*Empowering Patients First Act*) "provides for refundable, age adjusted tax credits with amounts tied to average insurance on individual market adjusted for inflation."[19]

- $1,200 for those between 18 to 35 years of age
- $2,100 for those between 35 and 50 years of age
- $3,000 for those who are 50 years and older
- $900 per child up to age 18

Upton's proposal (*The Patient Choice, Affordability, Responsibility, and Empowerment Act*) is similar to the Price proposal but is not universal and is more complex. Upton proposes tax credits similar to Price but only to individuals at below 300 percent (and graded down linearly from 200 percent) of the federal poverty level (FPL) who do not work for employers that provide health insurance and that employ more than 100 people.[20] Upton's plan does not include a specific child credit but offers a higher family deduction (individual/family):

- $1,970/$4,290 for those between 18 and 34 years of age
- $3,190/$8,330 for those between 35 and 49 years of age
- $4,690/$11,110 for those between 50 and 64 years of age

My 2014 *Health Watch* article examined the ACA impact on net premiums and expected total cost (ETC) for an exchange enrollee after considering cost sharing.[21] The conclusions from the analysis indicated that the premium and cost-sharing subsidies were far more generous to lower-income and older enrollees and had the potential to create an imbalanced marketplace. In fact, the calculations indicated that most older enrollees should enroll (based on ETC analysis) in bronze or silver plans and most younger people would have lower ETC without procuring coverage or retaining coverage on a pre-ACA plan.

Using the same illustrative example in the referenced article, the following analyses compare the impact of the Price and Upton proposals to the existing ACA provisions. Similar to Figures 12 and 13 in the referenced article, Figure 1 displays the ETC in 2016 of having no coverage (which includes the cost of the "individual mandate" tax penalty), ACA-level coverage, and the Price and the Upton proposals. The bronze and the silver plans have the lowest ETC of the exchange metal-level options. The bronze ETC is generally the lowest among metal-level plans except when cost-sharing subsidies (only available for silver plans) are sufficiently large. The Price and Upton results are illustrated assuming bronze-level coverage.

Figure 1
Expected Total Cost

	No Coverage	Bronze	Silver	Price	Upton
Age 24					
175% FPL	176.89	87.49	80.74	72.13	54.00
275% FPL	200.83	232.22	248.43	72.13	131.08
375% FPL	224.77	232.22	248.43	72.13	172.13
Age 44					
175% FPL	379.39	147.52	97.89	213.13	135.00
275% FPL	403.33	292.29	300.03	213.13	321.67
375% FPL	427.27	383.98	391.73	213.13	388.13
Age 64					
175% FPL	851.89	187.50	122.29	664.63	523.79
275% FPL	875.83	396.64	404.75	664.63	816.92
375% FPL	899.77	506.69	514.80	664.63	914.63

Several observations regarding the ETC include:

1. The Price results do not vary by income as the tax credits are universal and not based on income.
2. Both the Price and the Upton results are lower than the ACA levels at age 24 for each income level.
3. Both the Price and the Upton results are higher than the ACA levels at age 64 for each income level.
4. Only the Price proposal results in lower cost than forgoing coverage for each age and income level.

Let's discuss the impact of these proposals with a major caveat. There are many relevant factors that are not a part of this analysis. For example, it is beyond the scope of this article to measure the cost to the federal government of each of these proposals. Obviously, higher government spending for one proposal would provide an advantage of being able to achieve lower enrollee ETC. There are also many other policy-related issues that are out of scope. For example, ACA tax credits are only available for a prescribed level of coverage and specific benefits sold through an exchange. The Price and Upton tax credits are more generally available. Our evaluation is narrowly focused on evaluating

the net premiums and resulting ETC of each proposal and understanding how that might impact market enrollment and program stability.

Figure 2 displays the ETC relationship of each plan to the "no coverage" costs. For each age/income cell, a lower percentage indicates a greater value and a likelihood of higher enrollment. The results illustrate the current challenge of enrolling young people above 200 percent of FPL and the market attractiveness to older enrollees in the ACA exchanges.

Figure 2
ETC Relation to No Coverage

	Bronze	Silver	Price	Upton
Age 24				
175% FPL	49%	46%	41%	31%
275% FPL	116%	124%	36%	65%
375% FPL	103%	111%	32%	77%
Age 44				
175% FPL	39%	26%	56%	36%
275% FPL	72%	74%	53%	80%
375% FPL	90%	92%	50%	91%
Age 64				
175% FPL	22%	14%	78%	61%
275% FPL	45%	46%	76%	93%
375% FPL	56%	57%	74%	102%

Due to the steeper age slope and more balanced tax credits, more young eligible enrollees would likely enroll under the Price and Upton proposals than the current ACA framework.

Figure 3 displays statistics of the results in Figure 2. Based on a straight average of the nine data points, the Price proposal offers the best value. The Price proposal also produces the lowest median, the lowest standard deviation, the lowest maximum and the highest minimum. Based on this illustration, it appears that the Price tax credits provide a more "efficient use of funds," better "aligned incentives," and greater "equity among participants" in line with actuarial requirements of sustainable financing programs.[22]

Figure 3
ETC Relation to No Coverage

	Bronze	Silver	Price	Upton
Minimum	22%	14%	32%	31%
Maximum	116%	124%	78%	102%
Average	66%	66%	55%	71%
Median	56%	57%	53%	77%
Std Deviation	31%	37%	17%	25%

CONCLUSION

The ASOPs have guided our profession well since 1989. In our primary duty of analyzing risk, adverse selection is almost always a consideration in some fashion. Our input to develop and maintain sustainable programs should focus on minimizing adverse selection. To the extent obstacles to sustainability exist in the financial systems that we manage, we should apply our expertise to manage that risk and offer our opinions to facilitate a better-functioning marketplace.

The ACA individual market is the only long-term health insurance option[23] for people who do not have insurance through their employer or a government program. It is in the public interest for this market to be attractive to health insurers and for the rating structure and associated tax credits to provide value to attract all eligible consumers. In the middle of 2016, neither of these appears to be true.

Using the sample calculations, the proposal from Price seems to attract the most people across the age and income spectrum. In particular, the changes from a 3:1 to a 5:1 age ratio and the provision of universal tax credits for all enrollees provide incentives for younger individuals to enroll that are lacking under the current ACA framework. Additionally, it does not involve an IRS reconciliation and is administratively simpler than the ACA.

Challenges remain with respect to the principles of risk classification. The days of aligning premium rates with the risk characteristic of health status in the individual market seem to be behind us. In this environment, appropriate incentives are needed to attract a cross section of eligible enrollees.

The ACA has demonstrated that the allotment of federal funds into a marketplace, combined with heavy promotion, a coverage mandate and a guarantee issue market, will initially increase the market size. It is also clear that the ACA subsidies, as currently structured, are targeted toward an older, low-income population and the ACA marketplace has not attracted the desired cross section of eligible enrollees into the individual market. New proposals that are being considered provide broader tax incentives across the age/income spectrum and should facilitate a more robust, stable marketplace. ■

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Continued on page 20

ENDNOTES

1. This article is primarily focused on the ACA individual market. Some of these complications (i.e., risk adjustment) apply to the ACA small group market as well.
2. "Obamacare's Sinking Safety Net," *http://www.politico.com/agenda/story/2016/07/obamacare-exchanges-states-north-carolina-000162*
3. "The Sustainability of the New American Entitlement: Actuarial Values and the ACA," *https://www.soa.org/sipf/*
4. "Implications of Individual Subsidies in the Affordable Care Act—What Stakeholders Need to Understand," *https://soa.org/news-and-publications/newsletters/health/pub-health-section-newsletters-details.aspx*
5. *http://www.actuarialstandardsboard.org/about-asb/*
6. *http://www.actuarialstandardsboard.org/wp-content/uploads/2014/08/asop008_176.pdf*
7. *http://www.actuarialstandardsboard.org/asops/risk-classification-practice-areas/*
8. *Ibid.*
9. *Supra*, note 3.
10. *Supra*, note 7.
11. *Supra*, note 7. The ACA explicitly recognizes a gap between risk characteristics and allowable rates and attempts to bridge that gap through the risk adjustment transfer mechanism. The methodology is intended to address the ASOP No. 12 concern of "insufficient rates for higher risk individuals" but not the related concern of "lack of coverage for lower risk individuals." Most of the complaints related to the risk adjustment methodology seek revenue shifting between health plans and do not specifically address the larger issue of fostering a balanced risk pool.
12. *Supra*, note 7.
13. *Supra*, note 7.
14. *Supra*, note 2.
15. "Actuarial Values," *https://soa.org/news-and-publications/newsletters/sipf/pub-sipf-newsletter-details.aspx*. See Publications: January 2013.
16. *https://www.youtube.com/watch?v=gRlfyR4v0rE*
17. "The True Cost of Coverage," *www.theactuarymagazine.org/archives*
18. "Section 1332 Waivers. Coming Soon to a State Near You?" *http://healthwatch.soa.org/?issueID=1&pageID=33*
19. *http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf*
20. *https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf*
21. *Supra*, note 4; *http://www.actuarialstandardsboard.org/table-contents-standards-library/*
22. *Supra*, note 18.
23. Medi-Share and Samaritan Ministries offer non-insurance "products" that provide reimbursement for medical costs. Their customers receive an exemption from the individual mandate tax penalty.

Join the RWJF Actuarial Challenge!

The Affordable Care Act (ACA) has brought extensive changes to the individual health insurance market, resulting in improved access to health insurance coverage. As the market evolves under the new structure, challenges have emerged related to provider choice, unexpectedly high costs and issuers exiting the market.

In light of these observations, the Robert Wood Johnson Foundation (RWJF) is sponsoring a collaborative actuarial challenge to identify possible paths forward by testing different approaches to improving the market. This actuarial challenge is meant to elicit innovative ideas and proposals for how the ACA could evolve or be reformed to move the individual market further toward the goal of universal access to quality health services and providers in a financially secure and stable way, with consideration of the costs the solution places upon various health-sector stakeholders.

This challenge is open to all actuaries. If you're passionate about these issues and have ideas on how to reform our individual health care system, join in the Challenge! Join a team or form your own team. You will have an opportunity to have your ideas discussed, and, in some cases—through use of a common simulation model—you'll be able to quantify how your approach will promote increased enrollment and stable, affordable costs.

The successful conclusion to the challenge will see realistic, innovative solutions proposed, which further stimulate discussion about moving the individual health insurance market forward toward addressing the challenges stated above. RWJF will make public those papers that best meet these goals.

More information about the Challenge will be available on *SOA.org*, or contact *Darleen.Jeske@ActuarialChallenge.com*.

Act fast since deadlines are approaching.