Article from

Health Watch

March 2017
Issue 82

The Evolution of the Individual Market (Part I)

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The election of Donald Trump as the president of the United States and the subsequent nomination of Tom Price, MD, as the secretary of the Department of Health and Human Services (HHS) signal major alterations to an already turbulent individual health care market. Actuaries and other stakeholders have many questions about upcoming changes; most revolve around what will happen and when.

This article is Part I of a two-part chronological series concerning the evolution of the individual market. It begins with some background of how we arrived where we are today and concludes with the final regulations implemented by the Obama administration. In Part II, we will discuss the transition from the current market rules to a more decentralized system that seeks to offer coverage incentives with more flexible choices, a likely scenario under a Trump administration. Part II will be featured in a future issue of *Health Watch*.

PRE-ACA PROBLEMS

Prior to the Patient Protection and Affordable Care Act (ACA), individual health insurance premiums were aligned with risks. Older people paid more than younger people. Young women paid more than young men, and older women paid less than older men. Healthy people paid less than people with chronic conditions. Unless precluded by state regulation, insurers generally had the freedom and flexibility to analyze their data and determine the appropriate factors for these rating variables.

Some individuals had medical conditions at the time of application that caused insurers concern; either the expected risk was difficult to quantify or it was known to be at such a high level that a risk-based insurance contract would look more like prefunding of medical care. From an insurer's perspective, the risk/reward equation was off balance beyond a certain projected claims level (or for certain conditions where costs were either unpredictable or unknown), so the coverage application was declined. As insurers had similar underwriting policies, a declination from one carrier generally meant being deemed uninsurable by all carriers or being insured only for costs unrelated to a known condition.

However, not all uninsured individuals were in poor health. As medical costs increased faster than wages and general inflation, health insurance became less affordable and less attractive for individuals, and the uninsured rate increased steadily beginning in 1980. Additionally, individual health insurance premiums did not have the tax deductibility provisions that were present in the group market, making the individual market relatively less attractive. The high rate of uninsured Americans, due to personal choices, costs, and pre-existing health conditions, was viewed as a social problem that some policymakers believed required federal attention.

In spite of significant cost challenges, this recognition prompted a divided Congress, with direction from the Obama administration, to inject federal funding into the individual health market and overhaul the market rules and pricing structures in the process.[1]

ACA PROBLEMS

The ACA increased individual market premiums with guaranteed issue and essential health benefit requirements. Additionally, a three-to-one unisex rated age curve (3:1) increased rates for young adults, primarily young males.

As an offset to the higher costs, premium and cost-sharing subsidies of different amounts were provided to some individuals. Before discussing the mechanics and development of the premium subsidies, it is instructive to consider what they are not.

First, as a nation with a strong belief in liberty, we have historically been cautious about mandating individual behavior. At the same time, we have historically utilized tax laws to encourage some behaviors and discourage others. Prime examples are the interest deduction on owner-occupied homes, something we encourage, and sin taxes on tobacco products, something we discourage. Health insurance is encouraged and tax-favored in the group market. While ACA premium subsidies do in fact use tax law and make coverage more attractive, they are not universally available and were not specifically designed as behavioral incentives.

Second, the subsidies were not developed to offset additional premium costs triggered by the ACA. For example, a young man is not going to be subsidized the difference between the 3:1 rate and his appropriate risk rate. It is important to note this, as the resulting misalignment of risk and net premium rates creates the potential for a skewed market.

The idea behind the ACA premium subsidies was to make individual insurance "affordable." Affordability was defined as a sliding scale percentage of income up to 400 percent of the federal poverty level. Individuals with higher incomes presumably would be able to afford an appropriate level of coverage at unsubsidized market rates. As the affordability measure was based solely on income, all subsidy-eligible individuals in the same geographic area with the same income would pay the same premium for the "benchmark" plan. An unintended consequence of the mathematics involved is that older individuals actually pay less than younger individuals at the same income level for coverage priced lower than the "benchmark" plan.[2]

In effect, the misalignment of premiums and risk combined with the unequal subsidy distribution created varying degrees of enrollment incentives for different individuals. This has resulted in a skewed marketplace, notably one that is less attractive to young adults at middle- to upper-income levels.

To the extent that gross premiums are not aligned with risk, the risk adjustment methodology is intended to provide balance from the insurer's perspective. Risk adjustment is inconsequential to the consumer; the relative attractiveness of the market is the consideration of net premiums to risk level. There is interrelation here, as market attractiveness will influence enrollment and the market enrollment will determine the average level of the risk pool, which impacts the results of the risk adjustment process.

FINAL REGULATIONS FROM THE OBAMA ADMINISTRATION

After a rough implementation start followed by some relatively smooth sailing,[3] problems with the ACA began to publicly arise again in 2016.[4] The Obama administration recognized two major concerns, which it addressed in an annual update of changes to ACA marketplaces. The first is in regards to the risk adjustment model, which has resulted in many surprises and accusations of inequities in the methodology. This is a concern in both the individual and small-group markets. The second is in regards to the individual market dynamics discussed in the previous section. While the majority of regulatory changes primarily occur in 2018, some take effect in 2017 or 2019. At the time of this article, it is too early to anticipate whether the Trump administration will alter or obstruct these regulatory changes; their impact is discussed assuming no interference.

2018 Payment Notice

The final Obama regulation is the Patient Protection and Affordable Care Act HHS Notice of Benefit and Payment Parameters for 2018 (payment notice); the proposed rule was published in the Federal Register by the Department of Health and Human Services (HHS) on September 6, 2016.[5] The annual update of technical changes was on an earlier schedule than

prior cycles with the obvious intention of finalizing rules before a new administration takes control. The final rule was published December 22, 2016. [6]

Despite the simple title, the payment notice is much more than an annual update of benefit and payment parameters for the individual and small-group markets. A large part of the discussion (294 pages in proposed rule) highlights ongoing concerns expressed by stakeholders. Many of the substantive proposals are intended to improve the future of the risk adjustment program. The proposals related to risk adjustment principally address concerns that have been voiced since program inception, although the magnitude of the risk adjustment results has surprised health plans and state regulators alike.

In addition to risk adjustment enhancements, the other major goal of these proposals is improving the risk pool and enrollment growth in the individual market. Unfortunately, the proposals ignore the structural problems and are limited to enforcing special enrollment rules and continuing existing "outreach" efforts. Consequently, the remaining discussion is primarily focused on the impact of the risk adjustment updates and the ongoing concerns.

RISK ADJUSTMENT

The ACA expands access to health insurance by prohibiting insurers in the individual and small-group markets from using

health status as an eligibility criterion or as a rating variable. As insurers are not able to select or appropriately rate for the risks they accept, a risk adjustment mechanism is included to appropriately compensate insurers for the risks they enroll.

This ideal is intended to have insurers compete on their ability to provide quality affordable care and an efficient administrative system, while neutralizing the impact of competition based on enrollee selection. A well-constructed program will foster market stability and predictable results. While largely untested in the commercial market prior to the ACA, risk adjustment programs have existed in Medicare Advantage and various state Medicaid programs for many years.

The risk adjustment program applied to ACA markets, intended to stabilize the new marketplaces, has produced surprising (and arguably inequitable and destabilizing) results for many stakeholders, some of which have been legally challenged. The Centers for Medicare and Medicaid Services (CMS), the HHS agency responsible for the risk adjustment methodology, signaled recognition of the concerns well before the payment notice release. In March 2016, CMS released a white paper and facilitated an industry conference to discuss the ongoing concerns. Many of the proposals in the payment notice related to risk adjustment were introduced in the white paper.[7]

The risk adjustment methodology developed by CMS can be thought of as a two-step process. First, each enrollee in the marketplace is assessed a risk score based on demographics, benefit plan, and any identified high-cost health conditions. Second, to account for risk characteristics that cannot be differentiated by premium rates under the market rules, a "transfer payment" methodology is developed to transfer money from insurers that enroll lower-risk people to insurers that enroll higher-risk people. CMS designed this methodology to be budget neutral; therefore, all transfer payments are offset by transfer receipts. These two phases are discussed separately.

Risk Assessment

As insurers are not able to select risks or set prices based on the risks received, they must rely on the CMS methodology for an appropriate and adequate financial accommodation. It is therefore very important that the operational methodology is precise and impartial. The risk adjustment process should accurately assess risk based on health status and related predicted claim costs, and not be influenced by other factors. A risk assessment model requires both appropriate data and appropriate methodology to function properly.

The historical data used to calibrate a model should be reflective of the expected population. The current MarketScan commercial database utilizes data that are not representative of the expected populations. Individuals in this experience base did not have a large concentration of the short enrollment durations that are found in the marketplaces. Additionally, medical diagnoses that would result in higher risk scores are less present in the MarketScan data, as insurer revenue was not dependent on this data. For benefit year 2019, HHS proposes to use actual 2016 marketplace data. This should result in a more appropriate approximation of the individual and small-group marketplaces.

The risk-scoring methodology relies on Hierarchical Condition Categories (HCC), which are used to assign a quantitative health-cost risk to each enrollee. The current risk adjustment model overstates the risk/cost for individuals with at least one HCC. As the model is developed to be budget neutral, this necessarily understates the risk/cost of individuals without any HCCs. This bias encourages competition based on enrollee health status and effectively punishes efficient insurers or those who attract health-conscious consumers.

The risk adjustment methodology also fails to recognize measurable performance differences as they relate to care management. In my actuarial practice, I often see wide variances in utilization and claim costs unrelated to risk. A Care Management Effectiveness Index (CME Index) can be used to determine an appropriate measure of utilization. An efficient health plan with a favorable CME Index might be inappropriately associated with lower risk due to quality care management. For example, a plan with a high CME Index might effectively prevent more individuals with diabetes from developing complications that would yield HCC diagnoses. The ACA risk adjustment process will not recognize this occurrence.

HHS does offer potential remedies for the overcompensation of HCCs, including implementing a complicated "constrained regression" approach that is not explained in detail but appears to underpredict young enrollees without HCCs. A simpler, straightforward approach that replaces the biased scores with appropriate coefficients has been offered by former CMS Chief Actuary Richard Foster.[8] An American Academy of Actuaries workgroup also offered comments on these remedies.[9] In the final rule, HHS states no adjustments will be made at this time but different modeling approaches will continue to be explored.

Partial-year Enrollment

The current methodology does not address the impact of partial-year enrollment. In the marketplaces, a larger portion of enrollees are in the market for a short period of time relative to the group market data on which the risk adjustment methodology is based. Unlike the Medicare Advantage program, diagnoses are not tracked by a centralized source, so enrollees that change health plans are subsequently counted as not having any HCCs. As claims are episodic in nature, this is problematic for two reasons:

1. When an individual is enrolled for only part of the year, a diagnosis related to higher health care costs may be missed.
2. Even if the diagnosis is captured, the risk adjustment model assumes a full year of enrollment and accordingly transfers an inadequate amount.

Using a simplified example to illustrate each of these issues, assume that an individual has a medical condition diagnosed in October that will cost $12,000 in December. If the risk adjustment methodology provided $1,000 each month, an insurer that enrolled the individual for the full year would receive $1,000 each month, or $12,000, which would offset the higher cost for this individual. An insurer that enrolled the individual in October, however, would only receive $3,000 and would still be responsible for the $12,000 claim. An insurer that enrolled the individual in November would receive no risk adjustment benefit, as the condition would not be diagnosed, but the insurer would still be responsible for the $12,000 claim.

HHS recognizes this inequity for insurers that have a larger volume of short-duration enrollees, which are generally new or growing carriers. HHS has proposed durational factors to increase risk scores of short duration periods. Notably, these factors are less adequate than factors that have been used for a similar purpose in the Massachusetts risk adjustment model but extend for longer durations.

Prescription Drug Claims

There are many benefits to incorporating prescription drug claims in risk adjustment methodology. Pharmacy data are readily available and complete very quickly. They can identify enrollees with HCCs when diagnoses are not coded and also determine severity. Pharmacy data are fairly uniform across the industry and do not have many of the erroneous issues associated with diagnosis data. Inclusion of prescription drug data also results in quicker recognition of high-cost conditions and facilitates a more even playing field for new insurers who don't have medical histories and insurers who are less experienced and less aggressive with financially driven diagnosis-coding techniques.

HHS has been reluctant to use pharmacy data due to gaming concerns. It is a little surprising that HHS appears to be more concerned with pharmacy gaming than the ongoing subjective process of establishing diagnoses, as prescription drug claims cannot be altered after the fact by third parties. HHS intends to cautiously introduce the use of pharmacy data in 2018 with a limited selection of drugs.

This limited selection may overcompensate the predicted costs for the highest-cost enrollees (similar to the HCC concern), and therefore undercompensate the predicted costs for other enrollees. Similar to the partial-year enrollment durational factor, a wider acceptance of prescription drug data levels the playing field more rapidly and creates a better environment to attract insurers to the marketplaces.

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Transfer Formula

The purpose of the transfer formula is to transfer appropriate amounts based on risk. Even with a perfect model of risk assessment, a biased formula will have equity problems. The applied methodology uses a statewide average premium (SWAP) to calculate transfer amounts and results in imbalanced transfers that harm low-cost and efficient insurers. The formula transfers significant sums of money based on items that are not predictable and not based on actuarial risk.

The "statewide" nature of the formula does not recognize regional practice variations. Regional practices are different and coding patterns are often higher in major metropolitan areas, which causes risk transfer payments to be based on regional physician practice patterns rather than health status or actuarial risk.

The "average" nature of the formula exaggerates risk transfers for efficient insurers by mandating an inflated transfer amount relative to their cost structure. This particularly impacts small insurers who experience the most unpredictability and volatility with risk adjustment results.

The "premium" nature of the formula necessarily incorporates nonrisk items into the calculation. The inclusion of administrative costs in the formula penalizes efficient insurers. As transfer payments are based on premium amounts rather than claims, low-cost insurers pay an inflated amount based on reasons unrelated to claims risk. Many other risk adjustment methodologies, including Medicare Advantage, recognize only the claims portion of the costs. In the final rule, HHS implemented a SWAP formula change to recognize 14 percent of the premium as administrative expenses not related to actuarial risk. This policy is effective for plan year 2018, and reduces transfer payments by 14 percent.

Low-cost insurers often offer plan options that attract the type of individuals that improve the overall risk pool, yet they are penalized by a methodology that necessitates price increases.

This unintended consequence may limit insurers' ability to attract low-cost enrollees.

To illustrate these dynamics, we begin with an American Academy of Actuaries subcommittee example,[10] then change some variables to demonstrate the formula impact. Table 1 shows the impact of using a SWAP rather than an insurer's own premium. From the perspective of Insurer A, a premium PMPM of $270 and a relative risk of –10 percent should result in a risk adjusted premium of $270 * (1 – 10%) = $243. Since the SWAP is $300, the Insurer A transfer payment is $30 ($300 * 10%) and the risk adjusted premium is $240, resulting in a $3 inadequacy.

Table 1
American Academy of Actuaries Example of Risk Adjustment Payments and Receipts

	Insurer A	Insurer B	Insurer C	Entire Market
Market share	15%	70%	15%	100%
Premium	270.00	300.00	330.00	300.00
Relative risk	−10.0%	0.0%	10.0%	0.0%
Expected net premium	243.00	300.00	363.00	300.90
Transfer PMPM	−30.00	0.00	30.00	0.00
Actual net premium	240.00	300.00	360.00	300.00
Required transfer PMPM	−27.00	0.00	33.00	0.90
Excess/(shortfall)	(3.00)	0.00	(3.00)	(0.90)

The pricing obligations of the ACA risk adjustment methodology require insurers to base rates on the market profile rather than their own population. For small insurers, this is a monumental challenge as they are not privy to other insurers' enrollment data. Tables 2–4 illustrate the elements that could cause the risk adjustment results to change, each of which are not relevant to the risk of an insurer's population nor reasonable to project in the pricing process.

Maintaining the perspective of Insurer A, consider the scenario where Insurer B exits the market and all of Insurer B's members enroll with Insurer C. Insurer A's population does not change, but the SWAP is increased as members move to a higher-cost insurer. Insurer A's PMPM risk adjustment transfer assessment increases from $30.00 to $32.10 with no changes in the risk pool, simply due to differing enrollment decisions amongst other insurers. Note that this concept is also true if Insurer B remained in the marketplace and there was simply migration of members from Insurer B to Insurer C or vice versa.

Table 2
Impact of Insurer B Exiting Market on Risk Adjustment Transfer Payments and Receipts

	Insurer A	Insurer B	Insurer C	Entire Market
Market share	15%	0%	85%	100%
Premium	270.00	300.00	330.00	321.00
Relative risk	−10.0%	0.0%	1.8%	0.0%
Expected net premium	243.00	300.00	335.82	321.90
Transfer PMPM	−32.10	0.00	5.66	0.00
Actual net premium	237.90	300.00	335.66	321.00

Now consider if Insurer C has a premium rate of $350 rather than $330, as illustrated in Table 3. As the SWAP is increased, Insurer A's PMPM risk adjustment transfer assessment increases from $32.10 to $33.80. There has been no change in the risk population of either Insurer A or Insurer C, yet both have different risk adjustment transfer settlements solely because of the premium change for Insurer C. It is also troubling that Insurer C could increase its risk adjustment payment simply by increasing its premium rate.

Table 3
Impact of Premium Changes on Risk Adjustment Transfer Payments and Receipts

	Insurer A	Insurer B	Insurer C	Entire Market
Market share	15%	0%	85%	100%
Premium	270.00	300.00	350.00	338.00
Relative risk	−10.0%	0.0%	1.8%	0.0%
Expected net premium	243.00	300.00	356.18	339.20
Transfer PMPM	−33.80	0.00	5.96	0.00
Actual net premium	236.20	300.00	355.96	338.00

The final illustration (in Table 4) hypothesizes the first change in the risk pool. Assume that Insurer C's 85 percent market share is made up of 60 percent of the market with a relative risk of 6.7 percent, and 25 percent of the market with a relative risk of –10.0 percent. Due to the high rates, the 25 percent with a relative risk of –10 percent exits the marketplace. Insurer A has a larger market share in the reduced market. Since enrollees with a low relative risk have left the market, Insurer A's relative risk profile is now lower, even though its enrolled population

did not change. The PMPM transfer is now $43.10 due to changes in enrollment in the overall market.

Table 4
Impact of Risk Pool Changes on Risk Adjustment Transfer Payments and Receipts

	Insurer A	Insurer B	Insurer C	Entire Market
Market share	20%	0%	80%	100%
Premium	270.00	300.00	350.00	334.00
Relative risk	−12.9%	0.0%	3.2%	0.0%
Expected net premium	235.16	300.00	361.29	336.06
Transfer PMPM	−43.10	0.00	10.77	0.00
Actual net premium	226.90	300.00	360.77	334.00

With the current fluctuation in the markets, these examples illustrating insurer exits and enrollee migration between plans and on and off the marketplaces are very realistic and yet unpredictable. The risk adjustment methodology applied by HHS has introduced many more variables to the transfer formula that are not related to claims risk and are unreasonable for pricing actuaries to project.

Unpredictability

The unpredictability of risk adjustment transfer amounts continues to put upward pressure on premiums. The timing of risk adjustment determinations relative to premium submission due dates continues to cause concern. The lack of health plan stability in markets and transfers of membership exacerbate the unpredictable nature of risk adjustment transfer payments.

Many insurers have exited the market, have contemplated such a decision, or have become insolvent due to financial results and predictability concerns. The risk adjustment results have often been cited as the "surprise" financial item in poor results. The marketplaces initially attracted new health plans, and these have been subject to transfer amounts that represent a significant portion of their premium.

As it exists today, the unpredictability of the risk adjustment methodology is arguably having a destabilizing impact on the ACA marketplaces. Some health plan executives are so disillusioned by these results that it is difficult to even begin a general conversation about the methodology mechanics. State regulators have also struggled with comprehension, as they have assuaged many new solvency concerns that caught them by surprise. The state of New York released an emergency regulation to reverse stabilize the ACA impact on the small-group market. [11]

The use of a SWAP adds to the predictability challenges and creates a very difficult situation for insurers that do not command a large market share. Due to their size, large insurers strongly influence both the average premium and the risk score. They make a large contribution to both the average risk score and the SWAP, which results in less volatile consequences. Notably, even some large insurers have been surprised by the formula results. The inequities and volatility created by use of a SWAP need to be addressed for the markets to succeed.

Pricing Implications

As mentioned earlier, insurers have historically based rates on their own risk profile. An ideal risk adjustment methodology should allow an insurer to change from pricing a specific risk to an average risk and rely on risk adjustment payments to bridge only that difference. The HHS risk adjustment methodology introduces many other variables and creates unreasonable predictability expectations. Even with an accurate and impartial risk-scoring methodology, insurers would need to be able to project a considerable number of extraneous variables to fully and appropriately consider risk adjustment transfers in pricing formulas. To accurately project actual revenue, the pricing actuary needs to estimate each of the following factors that currently influence risk adjustment transfer payments:

1. Risk profile of eligible enrollees
2. Risk profile of who enrolls in the market versus who does not enroll
3. Insurer's relative risk to the market
4. Premium rates of all other insurers
5. Enrollment by benefit plan and region of all insurers
6. Health status of each insurer
7. Coding efficiency of each insurer

Summary

Successful risk adjustment models foster predictability and eliminate incentives for enrollee selection based on specific health conditions. They equitably adjust premium levels to reflect the health status or actuarial risk of an enrolled population. They provide impartial treatment for all health plans and do not offer advantages based on size, growth patterns, breadth of network, efficiencies, medical management or cost structure. The current risk adjustment results are altered by including multiple variables unrelated to claim cost risks. The current methodology systematically harms cost-effective insurers, and the penalty is magnified for smaller insurers. The methodology effective through 2017 further inflates the damages by including the full amount of administrative expenses in the formula.

As it exists today, the risk adjustment methodology is preferential to existing health plans that enroll high-risk individuals and charge high premiums. The exclusion of prescription drug claims and the lack of recognition for partial-year enrollees

further misestimates the relative actuarial risk between new and existing insurers. These imbalanced assessments penalize the type of insurers and enrollees that the ACA seeks to attract.

Some of the stated concerns with the current risk adjustment methodology are conceptually addressed in the payment notice, which should improve the accuracy and equity of the model. The incorporation of adjustments for partial-year enrollment, prescription drug data, and potentially HCC scoring based on marketplace data are tentatively planned to be phased in over the next several years. HHS has not signaled a change to the statewide average premium methodology, which is a key component in the desire of HHS to maintain budget neutrality with this program. While the relevance of the data and the methodology are expected to improve over time, some of the program dynamics responsible for the volatility and inequity assessments will likely remain without further modifications.

INDIVIDUAL MARKET SUSTAINABILITY

The individual market is more fragile than the small-group market due to the underlying incentives for prospective enrollees that are present in the net premium calculations. This fragility adds to the instability in the individual market and creates an even more challenging and unpredictable risk adjustment environment.

It was recognized from the beginning of the program that adequate participation from young and healthy individuals is required for success, so targeted promotional efforts and outreach have focused on a younger demographic. These efforts continue as young adults are offered the lowest value proposition and remain the eligible demographic with the highest uninsured rates. The dynamics of the rating rules and the premium subsidy allocation are attracting a skewed enrollment mix and creating significant financial challenges for health plans.[12] The underlying mechanics of the subsidy provisions continue to produce results that make the program relatively unattractive to younger enrollees. This is highlighted by the fact that a market-based insurance product—one that has always been available and now includes an easier process to secure coverage (exchange, no medical questions), government subsidies to reduce costs, and a tax penalty for not purchasing coverage—still requires heavy promotion by external entities to obtain sufficient participation.

Risk Adjustment Impact

As discussed, the risk adjustment methodology requires the pricing actuary to predict many things that are outside the scope of traditional pricing mechanics and that are unrelated to the risk profile of the insurer population or the market population. The current individual marketplace is unattractive to insurers and young healthy individuals alike. Accordingly, there is significant turmoil in the market, with insurers leaving the market and individuals staying for only a short time or changing insurers. This market volatility adds to the unpredictability of the risk adjustment calculations and magnifies the existing concerns.

In a budget-neutral environment, the enrollment of varying health risks cannot be solved by the risk adjustment process alone. An application of the current risk adjustment methodology only allows HHS to transfer money between insurers; it does not begin to compensate for a higher-than-average-risk market enrollment. It is important to achieve a stabilized risk pool that allows insurers to understand the ongoing health status of the overall market as well as the relative risks of their own populations.

Potential Short-term Solutions

It is recognized that all of the enrollment challenges related to the underlying enrollee incentives cannot be resolved through federal regulations. From an administrative standpoint, HHS could work proactively with states and interested stakeholders to facilitate state innovation waivers under Section 1332,[13] which allows states to use existing federal funds to create a broader market appeal. This is a more constructive use of time and resources than merely continuing the outreach efforts to introduce the new markets.

GOING FORWARD

The individual market represents less than 6 percent of the population. It is a small market, yet it is a very important one. You may have noticed that it receives a disproportionate share of attention relative to its size. It is often a last resort for those seeking health insurance, and it is the only major medical insurance option available to individuals without coverage through government programs or their employers. It is, therefore, important to develop and maintain it in a way that is attractive to both insurers and consumers.

For all of its faults, the ACA certainly increased awareness of the individual insurance market. As we move forward, we should learn the appropriate lessons from the ACA experience and remain grounded in actuarial principles. It is important that the policies that are enacted strengthen and stabilize markets, and that appropriate incentives attract eligible enrollees across the age/income spectrum. It is also necessary for the marketplace to allow insurers to offer efficient, quality coverage without unnecessary volatility or disadvantages.

During the initial years of the ACA, the majority of comments that reached a general audience were not from objective sources and often diminished public understanding. It is disheartening to see that pattern emerge with other legislative proposals that have been discussed in recent months. I would rather see honest, objective actuarial input considered at the forefront of the discussion.

Within our political framework, cultural and financial limits prohibit some proposals from taking shape. Within these bounds, we have opportunities to offer innovative solutions and ground rules. I will suggest two. Insurance markets do not work without attention to actuarial principles, and for any market to work, it has to make market sense for both buyers and sellers.

As we move forward, we should be encouraged that any proposed ACA market change will be heavily scrutinized. I am hopeful that we can constructively add to that debate. Part II of this series will discuss the latest market transition and include some thoughts and perspectives from health actuaries. I would love to hear your ideas. ■

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ENDNOTES

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