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MANAGING COST SHARING

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Over the last 30 years, health insurers have had to adapt to the changing health insurance landscape. They have moved from managing benefits (indemnity vs. fee-for-service) to managing care (PPOs and HMOs) to managing revenue (risk scores) and will now be faced with managing cost sharing. The Patient Protection and Affordable Care Act (ACA) introduces richer benefits for lower income members in 2014. Health insurers participating on the exchange are being challenged to design the new benefits, identify and educate eligible members and providers, measure the benefit improvement, and coordinate the financing of the richer benefit with the federal government.

The richer benefits come in the form of reduced cost-sharing provisions (i.e., deductibles, coinsurance, copays, maximum out-of-pockets, etc.). Eligible members must enroll in an individual silver plan (defined as a 70 percent actuarial value with +/-2 percent allowed variance), sold on the exchange in their own states and must have a household income between 100 percent and 400 percent of the federal poverty level (FPL). In 2013, 100 percent of the FPL is $11,490 for a household with only one member.[1] The FPL threshold naturally increases with the number of household members.

Eligible members will receive reduced cost-sharing provisions based on the percentage of their household income relative to the FPL threshold. The reduced maximum out-of-pocket (MOOP) and actuarial value are based on the table shown in Figure 1.

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Figure 1: Household Income, MOOP Reduction, and Required Actuarial Value[2]

Household Income (% of FPL)	MOOP Reduction	Required Actuarial Value*
100% to 150%	67%	94%
150% to 200%	67%	87%
200% to 250%	50%	73%
250% to 300%	50%	70%
300% to 400%	33%	70%

*Actuarial value equals health insurer portion of the benefits or paid claims/allowed claims.

All other cost-sharing provisions will apply as filed with the silver plan unless the minimum required actuarial value (within +/-1 percent allowed variation) cannot be achieved with the MOOP reduction.

There is also the provision in Section 1402(c)(1)(B) of the ACA that allows further adjustment to the MOOP if the actuarial value were to exceed the required minimum shown in Figure 1. A reduced MOOP without any other changes increases the actuarial value. MOOP reductions for household incomes between 250 percent and 400 percent of FPL (shaded in Figure 1) would result in actuarial values above 70 percent. Therefore, the U.S. Department of Health and Human Services (HHS) does not expect health insurers to reduce the MOOP for these households.

In addition, depending upon household income, the member may also be eligible for premium subsidies. The premiums ultimately collected by the health insurer are unchanged in the case of premium subsidies. The insurer will either collect (1) the full premium from the member at the time of enrollment (and the member receives a tax credit) or (2) partial payment from the member and a deferred payment from HHS.

As with many provisions of the ACA, the practical applications are similar to Medicare Part D.[3] The payment methodology in Section 1402(c)(3) of the ACA will be similar to how the Centers for Medicare and Medicaid Services (CMS) reimburses Part D carriers for low-income cost sharing (LICS) and federal reinsurance. Health insurers will be paid a monthly prospective amount reflective of the difference in actuarial value between the silver plan (68 percent to 72 percent actuarial value) and the cost-sharing reduction (CSR) plan, plus an allowance for induced utilization.

The table in Figure 2 shows a simple calculation for developing the monthly prospective amounts.

Figure 2: Calculating the Monthly Prospective Amount

Plan	Index Rate*	Change in Actuarial Value**	Induced Utilization[3]	Prospective Payment
Silver 70%	$400			
Silver CSR 94%	$400	24%	1.12	$107.52
Silver CSR 87%	$400	17%	1.12	$76.16
Silver CSR 73%	$400	3%	1.00	$12.00

* From Unified Rate Review Template filed with HHS.
** From Plan and Benefits Template filed with HHS.

For every member that is eligible for the CSR 94 percent plan, HHS would pay the health insurer $107.52 for each month the member is enrolled.

About six months after the contract year, the monthly prospective payment will be compared to actual cost-sharing reduction payments made by the health insurer and trued up. That is, the health insurers are not at risk for the cost-sharing reduction payments. The table in Figure 3 shows an illustrative reconciliation with HHS.

Figure 3: Illustrative Reconciliation with HHS

Plan	Prospective Payment	Illustrative Actual Payment	(To)/From HHS
Silver CSR 94%	$107.52	$125.52	$18.00
Silver CSR 87%	$76.16	$70.00	($6.16)
Silver CSR 73%	$12.00	$12.50	$0.50

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The risk adjustment program is a "zero-sum game": by definition the expected payout will equal the expected receipts.

The difference between the prospective and illustrative actual payment would be calculated for each member for the entire year and then aggregated to determine the total amount owed to or due from HHS.

FINANCING THE NEW PROVISIONS

A concern for many is the ability of our country to finance the new provisions. The ACA is a dramatic change to the health insurance landscape. The risk adjustment and transitional reinsurance programs under ACA were intended to be self-supporting. The risk adjustment program is a "zero-sum game"; by definition the expected payouts will equal the expected receipts. HHS has estimated the per capita cost for the benefits of the transitional reinsurance program in the individual market. Health insurers and third-party administrators (TPAs) are charging all covered insureds, individuals as well as fully and self-insured groups, a reinsurance fee to cover these large claims emerging in the individual market.

Unlike the risk adjustment and federal reinsurance programs, the cost-sharing subsidy programs are not self-supporting. The Congressional Budget Office[4] (CBO) estimates that the cost-sharing subsidies will increase the federal deficit by $4 billion in 2014, $8 billion in 2015, and $13 billion in 2016. Over the next 10 years, the cost-sharing subsidies are estimated to cost $149 billion.

POTENTIAL HEALTH INSURER CASH FLOW ISSUES

The timing of the financing arrangement can also create issues for an insurer, especially for start-up organizations or health insurers with significant numbers of members eligible for cost-sharing reductions. This cash flow mismatch can put strain on a health insurer's financial position in two ways, if not managed appropriately. First, there is a mismatch between the timing of the prospective payment and the actual cost-sharing reduction. The prospective payment represents an average over all these eligible members over all months within the calendar year. If the MOOP is the primary cost-sharing reduction, then it would be expected that the actual cost-sharing reduction would be lower than the prospective payment in the early part of the year and increase as the year progresses and more members' cost sharing reaches the lower MOOP.

Second, there is estimation risk that could impact an insurer's short-term cash position. If the actual cost-sharing reductions are greater than the prospective amounts paid from CMS, then the health insurer will not be made whole until approximately six months after the contract year. Medicare Part D plans have seen the LICS receivables that are due to this mismatch equal as much as 20 percent of premium.

CALCULATION OF COST-SHARING SUBSIDIES

HHS recognizes the administrative burden of adjudicating claims twice, so they are allowing the use of a "simplified method" in 2014.[5] Unlike Medicare Part D, where the Prescription Drug Event (PDE) files were designed to capture both the standard benefit and the reduced cost-sharing benefit, claim systems currently used by health insurers were not designed with this in mind. Most health insurers will likely opt for the simplified method in 2014 while working toward operational changes in their claim systems to accommodate both cost-sharing levels.

In practice, the member eligible for a cost-sharing reduction will see the reduction at the point of service in a medical service encounter (i.e., the provider will not ask them to pay any more than their reduced cost sharing). As such, claim records will reflect the lower cost sharing. Therefore, the carriers must estimate the cost sharing they would have paid.

The simplified method uses data from members who are not eligible for cost-sharing reductions to estimate what eligible members would have paid for the silver plan. HHS has identified four steps to estimate the cost-sharing reduction:

1. Calculate the average deductible;
2. Calculate the effective coinsurance for members with allowed costs below the deductible;
3. Calculate the effective coinsurance for members with allowed costs between the deductible and the MOOP trigger (i.e., total costs where cost sharing exceeds MOOP);
4. Calculate the cost sharing for members with allowed costs above the MOOP trigger.

Health insurers will use the statistics identified above to stratify the cost-sharing reduction members' allowed costs, potentially for "self" versus "other than self" coverage as well as medical versus prescription drugs, depending on the structure of the benefits. Figure 4 shows a simple example for three members with the following illustrative assumptions:

- Average deductible is $1,500.
- Effective pre-deductible (<$1,500) rate is 50 percent.
- MOOP Trigger is $33,833 (($6,350 - $1,500) / 15% + $1,500).
- Effective post-deductible ($1,500 to $33,833) coinsurance rate is 15 percent.

If the data is not credible, then the health insurer uses the standard plan's actuarial value and the total allowed costs to determine the cost sharing. Either way, the estimated cost sharing for each member is compared with the actual cost sharing based on the reduced cost sharing reflected in the claim system to determine the impact of the cost-sharing reduction. This calculation is done for each member and aggregated for each CSR plan and in total for the health insurer. The aggregate impact of the cost-sharing reduction is then compared to the aggregate prospective payments from HHS to determine whether the health insurer makes payments to or receives payments from HHS.

Figure 4: Simplified Method Example

Member Cost Range	Allowed Amount	Cost Sharing**
$0 to $1,500*	$1,000	$500
$1,500 to $33,833***	$20,000	$4,275
Above $33,833***	$40,000	$6,350

*All not subject to the deductible.
**Effective deductible and effective coinsurance based on non-cost-sharing reduction members.
***All cost subject to the deductible.

The simplified method of estimating the value of the cost-sharing reduction is intended to reduce the administrative burden in the first year of the ACA. However, health insurers should assess the accuracy of the method and the risk of using these estimates.

SUMMARY

The new cost-sharing reductions introduced by the ACA create a new set of operational needs for health insurers, including the following:

- Designing benefit plans that meet the reduced cost-sharing requirements,
- Collecting and reconciling prospective payments from HHS,
- Reconciling internal member eligibility with HHS information,
- Educating members and providers on the cost-sharing reductions,
- Managing cash flows,
- Monitoring and measuring the actual cost-sharing reductions, and

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- Preparing claim systems to handle cost-sharing reductions in 2015.

This is just one aspect of the ACA facing health insurers. Given the magnitude and required effort of these operational and financial changes, health insurers should start early to understand potential issues and provide feedback to HHS.

END NOTES

1 Federal Register (Jan. 24, 2013).

2 U.S. Department of Health and Human Services (Feb. 24, 2012). Actuarial Value and Cost-Sharing Reductions Bulletin.

3 Leida, H. (August 2013). Learning from Medicare Advantage and Part D: Lessons for the individual insurance market under ACA.

4 CBO (May 2013). Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage.

5 Federal Register (Oct. 24, 2013).