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The Sustainability of the New American Entitlement: Actuarial Values and the ACA

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We were reminded of the importance of Actuarial Values in the Chairperson's Corner of this publication's January 2013 edition. I am talking about the virtuous kind, not the calculated results from a pesky spreadsheet. Steven Schoonveld clarified our professional obligation to objectively speak to the sustainability of the financing systems that we manage and to recommend necessary changes. Efficient use of funds, aligned incentives, long-term consumer affordability and equity among participants are fundamental concepts that we require for sustainable programs.[1]

The Patient Protection and Affordable Care Act (ACA) has been with us for a few years now. As we are approaching the end of an initial three-year discovery period with temporary risk mitigators,[2] there have been an increasing number of questions raised by some health actuaries regarding the long-term sustainability of the individual market platform. An instructive article from a landmark Health Section publication analyzes the risks (from a health insurer's perspective) of participation in the new ACA markets compared to pre-ACA markets and other major lines of business.[3] Some major carriers have already caused concern by publicly suggesting a potential individual market exit in 2017 (in particular, United Healthcare has exited most ACA markets) due to predictive difficulty, high claim costs and financial losses.[4] Market exits have been accelerated by a significant shortfall in risk corridor funds available[5] due to government decisions to fund only those losses covered by risk corridor gains.

This article discusses the nature of the ACA sustainability challenges and illustrates the uniqueness of the ACA program in the American entitlement system.[6]

ACA BACKGROUND

The ACA, enacted by Congress in 2010, has brought numerous changes to health care markets, but the most notable impact is the transformation of a lower-risk, medically underwritten, individual market to a higher-risk, 2014-and-later, guaranteed-issue market without pre-existing condition exclusions or health status as an allowable rating factor. Federal subsidies of varying amounts are available to some enrollees to offset the high cost of premiums and cost sharing. These subsidies represent the first major health entitlement spending intended to benefit Americans not eligible for the 1960s-era Medicare and Medicaid programs.

Due to the federal subsidies targeted at middle-income[7] individuals and families, the size of the individual market has grown significantly among the middle-income population. In addition to the subsidy benefits, another enrollment incentive is the application of a tax penalty (individual mandate) to individuals without qualified health coverage. Surprisingly at odds with legislative intent to attract young, healthy enrollees and the noted sustainability requirements, the mathematical mechanics of the premium subsidy calculations are designed in such a way that federal provisions are more generous to older enrollees.[8]

The next two sections provide a background of the American entitlement framework and explore the unique elements of the ACA subsidies relative to other government programs.

HISTORY OF AMERICAN ENTITLEMENTS

While not necessarily comprehensive, the table below illustrates a history of major entitlement legislation in the United States. As suggested in the table, American public assistance and social insurance programs have focused on serving vulnerable populations and can be grouped into two broad areas, Financial Security and Health Care.

Entitlement spending has grown each year due to population growth, general inflation, increased health care inflation, longevity increases, the Baby Boom generation, and the addition and expansion of major government programs. Budget pressures are significant at the federal and state levels; significant growth of federal entitlements (50-year average annual growth of 9.5 percent from 1960 to 2010[9]) continues to challenge our fiscal systems, and there are legitimate concerns regarding the long-term viability of current programs. In particular, since 1960, the advent of Medicare, Medicaid, Medicare Part D, Earned Income

Population	Financial Security	Health Care
Elderly	Social Security (1935)	Medicare (1965)**
Low Income	Subsidized Shelter & Food (1930s)*	Medicaid (1965)***
Disabled	Social Security (1956)	Medicare (1965)
Middle Income	Earned Income Tax Credit (1975)	ACA Subsidies (2010)****

* Various programs

** Prescription Drug Benefits (Part D) added in 2006

*** Funding shared with states; eligibility rules vary greatly across states; ACA (2010) provided additional federal funding to Medicaid for a newly eligible population (in states that chose to expand)

**** Only available to individuals who do not have access to "affordable" employer-based coverage, either by themselves or through a family member

Tax Credits, and significant Social Security enhancements in the 1970s, have all contributed to the explosive growth in entitlement spending. It was in this challenging environment in 2010 that a current program (Medicaid) was expanded to cover a previously ineligible population (low income, able-bodied, non-custodial adults) and a new entitlement program was developed to partially subsidize health care premiums and costs in an attempt to make health insurance affordable and an attractive value across the income spectrum.

In spite of the significant cost challenges, the recognition that access to affordable health insurance is good for society, coupled with the number of uninsured Americans and the high cost of health insurance, 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.

THE ACA ENTITLEMENT

The new entitlement program, offering premium and cost-sharing subsidies to middle income Americans, is a 21st century American experiment unlike any financing mechanism that has been tried before. All prior entitlement legislation has mostly offered cash assistance or benefits that were of inconsequential direct cost to beneficiaries. There have been some notable participation fees, Medicare Part B premiums, for example, but they have generally paled in comparison to the expected benefits. The ACA subsidies formula does not follow this pattern. Due to a contentious debate on the legislation and a political requirement for deficit neutrality (as scored by the Congressional Budget Office, before dynamic scoring was in play), available federal funds to provide the desired assistance were limited. Congress decided to provide partial premium assistance to individuals and families with incomes up to 400 percent of the Federal Policy Level (FPL). Material cost sharing assistance was also provided up to 200 percent of the FPL.[10]

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The premium assistance formula is complicated and certainly unusual, relative to traditional government and employer provisions for health benefits. Rather than provide a fixed dollar amount (defined contribution or premium support), contribute a percentage of the premium (an employer-subsidized example) or simply fund the cost of benefits (traditional fee-for-service), government outlays are determined by an indirect calculation that requires a collection of market rates and personal income as inputs. The methodology works like this: health plans participating in a given market submit benefit options (falling into four value tiers, though health plans are not required to offer benefits in each tier) and rates for state review. The state reviews the filings and rates and either approves rates as proposed, rejects the filing, or approves the filing at another rate level (usually lower).

The approved rates for all health plans are then aggregated and the second-lowest-priced plan in the second-lowest value tier is determined to be the benchmark plan. Affordable coverage for each enrollee is determined based on a sliding scale percentage of income. An enrollee can purchase the benchmark plan with an enrollee contribution equal to the calculated "affordable" percentage of his/her income. The remaining premium (benchmark plan premium rate minus enrollee contribution) is the federal subsidy. Enrollees can carry the dollar amount of this subsidy to other plans, either within the same value tier or not, and purchase less expensive or more expensive coverage.

A brief illustrative example of the subsidy calculation methodology is demonstrated below; more extensive calculations can be found in the May 2014 edition of *Health Watch* and the December 2015/January 2016 edition of *The Actuary*.

Figure 1 illustrates the gross monthly premiums for two sample companies, A and B, offering plans in the two lowest-value tiers to sample individuals. Bronze is the lowest tier; Silver is the second-lowest tier.

Figure 2 illustrates the subsidy calculation for a particular income level and age. This is determined by calculating the maximum monthly contribution that an enrollee pays for the benchmark plan (the second-lowest-cost silver tier plan, or 'B Silver'). Assuming the maximum contribution percentage of 7.50 percent for an individual with an income of $48,000 (reasonable approximation but not representative of any year), the maximum monthly contribution for that individual is $300 [$48,000 * 7.50% / 12]. The calculated subsidy is the gross monthly pre-

Figure 1

Age	Gross Monthly Premium			
	A Bronze	A Silver	B Bronze	B Silver
24	270	315	300	350
64	810	945	900	1050

Figure 2

Age	Subsidy Calculation			
	Income	Maximum Contribution Percentage	Maximum Contribution	Subsidy
24	48,000	7.50%	300	50
64	48,000	7.50%	300	750

Figure 3

Age	Net Monthly Premium			
	A Bronze	A Silver	B Bronze	B Silver
24	220	265	250	300
64	60	195	150	300

mium of the benchmark plan minus the $300 maximum contribution from the enrollee.

Figure 3 illustrates the net monthly premiums that enrollees pay for each plan in the market after subtracting the subsidy from the gross monthly premiums.

ACA IMPLICATIONS FOR BENEFICIARIES AND HEALTH PLANS

The result of all of this is different subsidy levels, which vary primarily by age, income, and geographic area, for all enrollees. Significant leveraging of the premium subsidy produces unintended results, where older enrollees pay less for certain benefit plans (those with lower gross premium than the benchmark plan) than younger enrollees at the same income level.[11] Consequently, the varying relationships between the subsidy amounts and the full premium create enrollment incentives for some and disincentives for others.[12]

The high cost of health insurance for enrollees who are not heavily subsidized has undoubtedly contributed to the lower than expected enrollment.[13] These disincentives trouble policymakers and insurance companies alike. In addition to premium levels, consumer complaints have also been focused on high cost sharing and inadequate networks, both of which have exacerbated enrollment concerns. Erosion of enrollment, especially among younger and healthier people, could complicate risk pool and pricing assumptions. Health plans need to be concerned with not only their own plan enrollment, but also the overall market enrollment for the state, due to the inter-company risk adjustment transfer process.

It has been suggested by health actuaries and other commentators that 2017 may be the telling year to evaluate the market conditions based on carrier participation, as health plans evaluate two years of transitional experience before committing to participate in a riskier market without the temporary risk mitigators. A conclusive understanding may take longer to develop as markets do not change instantaneously. Health plan participation in this high profile market is more involved than an isolated business decision based on a financial forecast. There have been external pressures for health plans to participate in the ACA marketplace since program inception, but the potential of major players to exit may trigger more forceful coercion.[14]

From a beneficiary perspective, the significant contributions (premiums and cost sharing) required of many enrollees to receive entitlement benefits is a new phenomenon. Reliance on market prices and consumer behavior to determine inputs to government outlay formulas is new as well. Unlike other entitlement programs, proposed solutions to ACA concerns do not fall in line with traditional thinking of Congressional spending or program adjustments. Since the passage of the ACA, the focus from Washington has been promotion of the program (sometimes targeted at younger ages) rather than increased spending to shore up perceived gaps in the program.[15] This is unusual relative to other programs; the government has not launched an advertising campaign and the President has not solicited contributions to convince people to sign up for Social Security or Medicare (low enrollment is not considered a potential threat), but the budget challenges are frequently discussed.[16] Government actuaries opine every year on the financial outlook of these programs, but the major sustainability inputs are macroeconomic in nature. Suggested changes almost always fall in the realm of adjusting spending formulas or benefits.

In many respects, the uniqueness of the ACA subsidies as an entitlement is the reliance on market forces rather than legislative commitments to meet demographic expectations and economic realities. It is important to understand the current data, but more important to understand the various incentives in effect that will continue to shape the size and nature of the individual market. In my opinion, this unprecedented experiment will require an informed, ongoing actuarial viewpoint (or, preferably, multiple viewpoints) focused on sustainability to preserve the individual health market and the reputation of our profession.

SUSTAINABILITY MEASURES

As discussed in the opening paragraph, our work requires adherence to certain values. Reflecting on these values and our obligations to stakeholders and the public, what are some of the potential concerns with each value in our response to the ACA? Let us revisit each point:

1. Efficient use of funds: Federal funds are allotted with the intention of making health care affordable. The mechanics of the ACA subsidy calculations create greater benefits for some enrollees and little or no benefits for others. Could the funds be reallocated in such a way as to be more "efficient"? That is an interesting question, and one that individual states may consider if they choose to take advantage of a new waiver opportunity that will allow distribution of federal funds in a more desirable way.[17]

2. Aligned incentives: There are incentives that promote coverage for some segments of the population. These incentives vary by age, and may promote an older individual market and a younger group market as employees have a new incentive to retire early and younger individuals may be motivated (due to higher cost of guaranteed issue market, restricted age bands, and subsidy mechanics) to seek opportunities for employer-sponsored coverage.[18] Unfortunately, there are also incentives for individuals to reduce work due to "subsidy cliffs" when earning additional income could significantly reduce the subsidies available. The Congressional Budget Office anticipates that employer and employee incentives embedded in the ACA will reduce work hours by 1.5 to 2.0 percent from 2017 to 2024.[19]

3. Consumer affordability: For some individuals, enrollee premium contributions are very low or even zero in extreme cases. Due to the "family glitch" and the affordability measure, "affordable coverage" may be available to the employee but not to the family members of an employee who has affordable employer-sponsored coverage.

4. Equity among participants: The nature of the subsidy calculations results in greater subsidies and stronger coverage incentives for older individuals. The resulting net premiums fall short of the principle that "differences in rates reflect material differences in expected cost for risk characteristics." [20] As mentioned above as an "efficient use," federal funds could be distributed more equitably through a state waiver.

The most challenging period for the ACA is still ahead of us, with a riskier market for all participating health plans, waning enthusiasm as the initial promotional value wears off, and a new president who is not personally identifiable with the program.

The three-year discovery period allowed health plans to test the new program with some risk protections that will soon expire. This provided an incentive to be more aggressive in a price sensitive market. Clearly, health plans will assume more risk in the future. There are also non-financial aspects to consider. It is my (non-actuarial) opinion that enrollment results have benefited from heavy promotion (partially offset due to operational struggles and some negative commentary), general awareness, and excitement related to a new program that has received tremendous attention.

The most challenging period for the ACA is still ahead of us, with a riskier market for all participating health plans, waning enthusiasm as the initial promotional value wears off, and a new president who is not personally identifiable with the program. In my opinion, a long-term sustainability viewpoint will recognize the financial implications and inherent incentives, acknowledge the need of positive outcomes for both health plans and consumers, and appropriately discount the early emotional activity associated with this new marketplace.

ACTUARIAL CHALLENGES

I do not believe it is an overstatement to suggest that the new challenges the ACA creates for health actuaries present greater professional risk than any previous developments in the health care market. Many of these challenges, including developing pricing assumptions for an unknown population in a new market environment with an unknown revenue component,[21] have been primary topics in health actuarial forums since the ACA regulations were developed.

A different type of challenge is the subjective scrutiny of actuarial practice and attempted coercion to breach our objective professional obligations to justify a particular policy or point of view. If you have followed the career of actuary Richard Foster, you recognize that this is not an entirely new occurrence.[22] Pressure from outside of our profession is not limited to policy-related issues. A 2012 survey of American Academy of Actuaries members indicated that the overwhelming ethical concern from a list of 18 choices was "responding to pressure from principals and/or management to select inappropriate assumptions used

in pricing or reserving."[23] This result was strikingly consistent across all practice areas and employment types.

As health actuarial work has become more public and more connected to policy, the criticism has heightened. The partisan nature of the legislative development and the tendency of people on both sides of the debate to misrepresent (perhaps unintentionally) the law's impact and twist every data point to their liking has complicated the public's understanding of the legislation. By and large, the actuarial response has been more measured and actuaries have refrained from drawing premature conclusions.

The politically charged nature of the law has complicated our practice since inception, and the attention and subjective viewpoints have not dampened. Criticism of a 2013 Society of Actuaries-sponsored study on expected claim costs cited actuaries as biased by virtue of being primarily employed by insurance companies and, therefore, aligned with the insurance lobby. The rate review process has brought more oversight and attention to actuarial work and perhaps has made us better—or at least more diligent—at our craft. Even state regulators, who have historically been viewed as the reviewers of actuarial rate development, but not reviewees themselves, are now under a watchful eye as "what used to be a purely analytical exercise is now peppered with political overtones."[24]

I believe that this new reality is not a temporary environment that will settle as the ACA market matures and stabilizes.[25] Future legislation and regulations will demand our opinions and analyses with the same degree of attention. It is interesting to note that few voices proclaim the ACA to be a solution or a final destination. It is either "a step in the right direction" or bad legislation that should be "repealed and replaced." As we have seen with financial markets, government intervention drives marketplace changes, which, in turn, creates a recurring need for more government intervention. The ACA is a major change in federal health legislation; market reactions will necessitate legislative adjustments, and actuaries will be asked to understand the implications, measure the impact, and go about their daily duties with a high-intensity, post-ACA-level, spotlight on their work. The challenge of being asked to do more analysis with less information, while under a more intense and subjective oversight microscope, is our present and will be our future.

CONCLUSION

20th century entitlement programs now comprise more than two-thirds of the unified federal budget. As expressed by some commentators, the growth of entitlements could potentially impact other budgetary items and ultimately harm national security and the overall economy.[26] The sustainability of these programs is consistently measured in a traditional way, projecting benefit costs and allocating spending. If necessary, Congress will make adjustments, sometimes crowding out other important items in the federal budget.

As sustainability is threatened by market forces rather than federal budget limitations, the need for Actuarial Values is more acute.

The ACA subsidies need to be evaluated through a different framework. As sustainability is threatened by market forces rather than federal budget limitations, the need for Actuarial Values is more acute. We must appreciate the various incentives for buyers and sellers in the market to understand the long-term sustainability equation. It is important to note that these incentives reach beyond the individual health care market; they impact the labor market and the overall economy. Employers now have new considerations when hiring workers, setting work hours or providing health benefits, and employees have new incentives to seek more work or different work, reduce their work hours, or retire earlier. The high level of health care costs and the disparate subsidies available through the ACA create various incentives that may have long-term implications on the demographics of the labor market,[27] which, consequently, will impact the demographics and, potentially, the sustainability of the individual health market.

Actuaries have a strong history of identifying unsustainable models and offering their honest assessments. We do not have to look far for a classic example; a part of the ACA known as the Community Living Assistance Service and Supports Act created a voluntary long-term care program. Due to potential adverse selection and little government support, the actuarial community quickly deemed the program unworkable; it was repealed in 2013. The initial ACA impact to the individual health market has been more nuanced, although that did little to deter early strong conclusions.

We are now at a critical juncture on the ACA timeline, developing pricing assumptions (at the time this article was written) from transitional experience for the 2017 rating period, the year after which two of the initial risk buffers sunset. There is much at stake, and it is imperative for actuaries to boldly offer our objective approach. Our technical skills, experience, and deep knowledge of the regulatory details equip us to submit expert opinions.[28]

The implications of this law are complicated and require a comprehensive appreciation of incentives for health plans, employers, employees and individuals. The majority of comments that have reached a general audience are not from objective

sources and have obfuscated public understanding; in fact, it was the repeated misperceptions of the legislative impact that initially piqued my interest in writing about the program details. More than other entitlement programs, measuring the sustainability of the ACA is within the actuarial domain. I will continue to advocate for the objective voices of health actuaries to be recognized as trusted experts. I hope you will join me in this endeavor. ■

Author's Note: The views expressed herein are those of the author alone and reflect current information as of May 2016. They do not represent the views of the Society of Actuaries, Axene Health Partners, LLC or its consultants, or any other body.

A thorough examination of the technical components discussed in this article, along with some suggestions on how actuaries can contribute to the public good by correcting simplified explanations and common misconceptions, was published in the May 2014 edition of Health Watch.[29]

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ENDNOTES

1 *"Actuarial Values"* – https://www.soa.org/Library/Newsletters/In-Public-Interest/2013/january/ipi-2013-iss7.pdf January 2013.

2 "Temporary Risk Corridors" provide a symmetric sharing of gains and losses from 2014 to 2016. "Transitional Reinsurance" provides specific stop-loss protection against high claims in the individual market from 2014 to 2016. Each of these programs were intended to encourage carrier participation and stabilize premiums in the early years of the new market.

3 *"The Individual Market and ACA Products: Starting from First Actuarial Principles"* – https://soa.org/news-and-publications/newsletters/health/pub-health-section-newsletters-details.aspx The ACA@5 – August 2015

4 http://money.cnn.com/2016/03/30/news/economy/obamacare-patients-blue-cross-blue-shield/index.html

5 http://www.modernhealthcare.com/article/20151001/NEWS/151009996

6 In federal budget discussions, spending on public assistance and social insurance programs is collectively referred to as entitlement spending, or entitlements. An entitlement benefit suggests a legislated or established right. Entitlement benefits are, in a sense, legally predetermined and outside of the annual Congressional appropriation process, which is often called discretionary spending.

7 For purposes of this article, "middle-income" is loosely defined as above the Federal Poverty Level, not eligible for Medicaid, and below 400% of the Federal Poverty Level.

8 *"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 May 2014

9 http://www.usnews.com/opinion/articles/2012/12/19/the-shocking-truth-on-entitlements

10 The US House of Representatives has filed suit against the Obama administrating alleging that payment of the cost sharing assistance was not authorized. A federal judge ruled in favor of the House but stayed the ruling. As of May 2016, the cost sharing subsidies continue to be paid pending appeal. http://www.politico.com/story/2016/05/house-gop-wins-obamacare-lawsuit-223121

11 *"The True Cost of Coverage"* – http://theactuarymagazine.org/the-true-cost-of-coverage/

12 *"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 May 2014

13 2016 enrollment is roughly half of initial expectations. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf

14 http://www.courant.com/business/connecticut-insurance/hc-blumenthal-united-health-affordable-care-act-1216-20151215-story.html

15 Entitlement legislation is not necessarily an easy process, but getting lawmakers to spend taxpayer money is easier than getting taxpayers to spend their own, particularly if they don't view the product as a good value. There is unanimous recognition that individual market sustainability requires continuous enrollment of young and healthy beneficiaries; hence, the strong promotion and frequent analysis of the market demographics.

16 There is still value in communicating benefit options to all eligible beneficiaries. Medicaid actuaries will point out the 'woodwork' effect; some populations are difficult to reach, and not everyone signs up automatically for benefits even if costs are minimal.

17 *"Section 1332 Waivers. Coming Soon to a State Near You?"* https://soa.org/news-and-publications/newsletters/health/pub-health-section-newsletters-details.aspx May 2016

18 https://soa.org/Professional-Development/Event-Calendar/Podcasts/Health-Section.aspx#ep24 – Episode 14

19 http://www.aei.org/publication/the-aca-and-its-employment-effects/

20 Actuarial Standard of Practice 12, 3.2.1 http://actuarialstandardsboard.org/wp-content/uploads/2014/07/asop012_101.pdf

21 Revenue includes the positive or negative adjustment from the risk adjustment process which is a premium redistribution among health plans. The transfer payment amount depends on the demographic and health status makeup of the market is not known until the middle of the next year. For example, health plans develop 2017 rates in early 2016 based on 2015 experience with knowledge of the 2014 risk adjustment settlements.

22 http://www.forbes.com/sites/merrillmatthews/2014/09/30/medicares-former-chief-actuary-speaks-out-about-its-challenges/#40d795a4507f

23 http://actuary.org/files/Key_Ethical_Concerns_Facing_the_Actuarial_Profession.pdf

24 *"A Regulatory Perspective on Rate Review Before and After the Affordable Care Act"* – https://soa.org/news-and-publications/newsletters/health/pub-health-section-newsletters-details.aspx The ACA@5 – August 2015

25 As discussed throughout this article, long-term market stabilization is not a guarantee. An optimistic viewpoint is that pricing an unknown market in 2014 was difficult, but that a few years of experience to review and price corrections will lead us to a stable marketplace. A less optimistic viewpoint is that legislative or regulatory corrections will be required to facilitate long-term stability in this market.

26 http://www.usnews.com/opinion/articles/2012/12/19/the-shocking-truth-on-entitlements

27 https://soa.org/Professional-Development/Event-Calendar/Podcasts/Health-Section.aspx#ep24 – Episode 14

28 *"The Truth-Seeking Debate"* – https://soa.org/Library/Newsletters/The-Actuary-Magazine/2015/june/act-2015-vol12-iss3-tofc.aspx

29 *"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 May 2014