Advanced Commercial Pricing Boot Camp for Health Actuaries

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SOA Advanced Pricing Boot Camp

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SOCIETY OF ACTUARIES

Who?

- Mary van der Heijde
- T.J. Gray
- Doug Norris

- Attendees - who are you, where do you work, what do you do, what you seek most from this bootcamp?

Housekeeping

- The boot camp concept
- Stop us to ask questions throughout
- Consider anti-trust and anti-collusion laws in your conversations with one another
- Cell phones = vibrate or off
- There will be breaks, but feel free to step out

Advanced Topics

Who Benefits? ...where are they?
Medicaid expansion interactions
Individual subsidies relation to enrollment
Anti-selection amongst individuals
Anti-selection amongst employers
Grandfathered rules and impacts
Transitional policies
Predictive modeling techniques for new enrollees
Geographic Factors

What is the Benefit?
New product requirements, coverages & design implications, EHBs
Mental Health Parity compliance
Pediatric Dental
Catastrophic plans
Grandfathered rules and impacts
Transitional policies
Actuarial Value / Minimum Value
Where? ...Tiered networks, smaller networks, ACOs

Who Pays For It?
Individual and small employer subsidies
Risk adjustment, reinsurance, and risk corridor

How Much Will It Cost Us?
Predicting the statewide risk pool
Induced demand
Pent up demand

What About Our Price?
Everything on this page (obviously, plus...)
Underwriting rules, minimums loss ratio rules
Administration, Taxes, Assessments,
Profit Margin, Contribution to Reserves
Competition

When?
Deadlines
When will Stability be reached in the market?

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New product requirements, [illegible]
implications, EHBs
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Where? ...Tiered networks,
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What about me?
Keeping current with guidance and research
Code of conduct and ASOPs

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Risk adjustment, reinsurance, and risk corridor

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When?
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Individual Mandate

Guaranteed Issue

Individual Mandate

- Everyone is required to have insurance or pay a penalty
- Supreme court ruling:
  - Unconstitutional under commerce clause
  - However, Congress has power to tax; therefore, it's constitutional
- Penalty:
  - In 2014, either
    - $95 for each adult and $47.50 for each child, capped at $285 per family.
    - 1% of family income
  - In 2015, higher of:
    - $325 for each adult and $162.50 for each child, capped at $975 per family.
    - 2% of family income.
  - In 2016 and 2017, higher of:
    - $695 for each adult and $347.50 for each child, capped at $2,085 per family.
    - 2.5% of family income.
  - Flat dollar amount is indexed to inflation after 2017.
  - Imposed on individual tax returns

Guaranteed Issue

- Insurers must accept every individual and group that applies for coverage
- Enrollment periods
  - Group
    - Employer can purchase any time
    - Denial allowed based on employer contribution and group participation rules
  - Individual (on or off the Exchange)
    - 2014 open enrollment: Oct 1, 2013 to March 31, 2014
    - 2015 open enrollment: Nov 15, 2014 to Feb 15, 2015
    - 2016-2017 open enrollment: Nov 1 to Jan 31
    - 2018+ open enrollment: Nov 1 to Dec 15
  - Qualifying ERISA events still trigger a special enrollment period

Related Provisions and Rules

- Healthcare Benefit Exchanges
- Cost sharing subsidies
- Medicaid Expansion
- Standardized benefit designs (AV and EHBs)
- Rating restrictions and rules
- Risk sharing and limiting techniques

Premium Subsidies

Income Level	Premium as a % of Income (2014)
Up to 133 % FPL	2.00% of income
133 – 150 % FPL	3.00 – 4.00 % of income
150 – 200 % FPL	4.00 - 6.30 % of income
200 – 250 % FPL	6.30 - 8.05 % of income
250 – 300 % FPL	8.05 - 9.50 % of income
300 % – 400 % FPL	9.50 % of income
https://www.irs.gov/irb/2014-50_IRB/ar11.html	

Premium Subsidies - Indexing

Income Level	Premium as a % of Income (2017)
Up to 133 % FPL	2.04% of income
133 – 150 % FPL	3.06 – 4.08 % of income
150 – 200 % FPL	4.08 - 6.43 % of income
200 – 250 % FPL	6.43 - 8.21 % of income
250 – 300 % FPL	8.21 - 9.69 % of income
300 % – 400 % FPL	9.69 % of income
https://www.irs.gov/pub/irs-drop/rp-16-24.pdf	

- Maximum premium "indexed" annually to keep up with medical inflation
  - Extra indexing applies starting in 2019 to limit government costs

Premium Subsidies - Indexing

$$Adjustment\ (Year\ X) = \left[\frac{Premiums\ (X-1)}{Premiums\ 2013} / \frac{Personal\ Income\ (X-1)}{Personal\ Income\ 2013}\right]$$

- Premiums source: Projections of average per-enrollee employer sponsored insurance premiums from National Health Expenditure Accounts (NHEA) calculated by CMS
- Personal Income source: Personal income projections from NHEA data

$$Adjustment\ (2017) = \left[1.1325256291 / \frac{\$49{,}875}{\$44{,}925}\right] = 1.0201245892$$

$$2.00\%\ X\ 1.0201245892 = 2.04\%$$

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$$9.50\%\ X\ 1.0201245892 = 9.69\%$$

Premium Subsidies

- Compute the available subsidy and out of pocket premium payment in the following example:
  - 2 member household
  - $32,480 annual income
  - Cost of second lowest silver plan is $3,600 per year

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,180 for each additional person.	
1	$12,060
2	$16,240
3	$20,420
4	$24,600
5	$28,780
6	$32,960
7	$37,140
8	$41,320

https://aspe.hhs.gov/poverty-guidelines

Premium Subsidies

- Compute the available subsidy and out of pocket premium payment in the following example:
  - 200 % FPL
  - Maximum premium is 6.43 % X $32,480 = $2,088
  - Subsidy is $3,600 - $2,088 = $1,512
- Subsidy is flat, so anything below the cost of the second lowest Silver plan is free
- For higher AV (or higher cost) plans, the enrollee can pay the difference

Medicaid Expansion

Implications for the Medicaid Markets

- Most important result of ruling on Medicaid Expansion
  - Expansion of Medicaid up to 133% is not required, to retain federal funding
- Current Medicaid programs remain unchanged
  - Current programs usually only cover families, pregnant women, children, or disabled
  - Healthy men are usually not covered now

Medicaid Expansion:
Impact on commercial carriers

How does Medicaid expansion affect the commercial market?

1. Changes the mix of purchasers within the exchange

2. Changes the overall average health status of the market, which affects risk adjustment

The < 133% population

What do they look like?

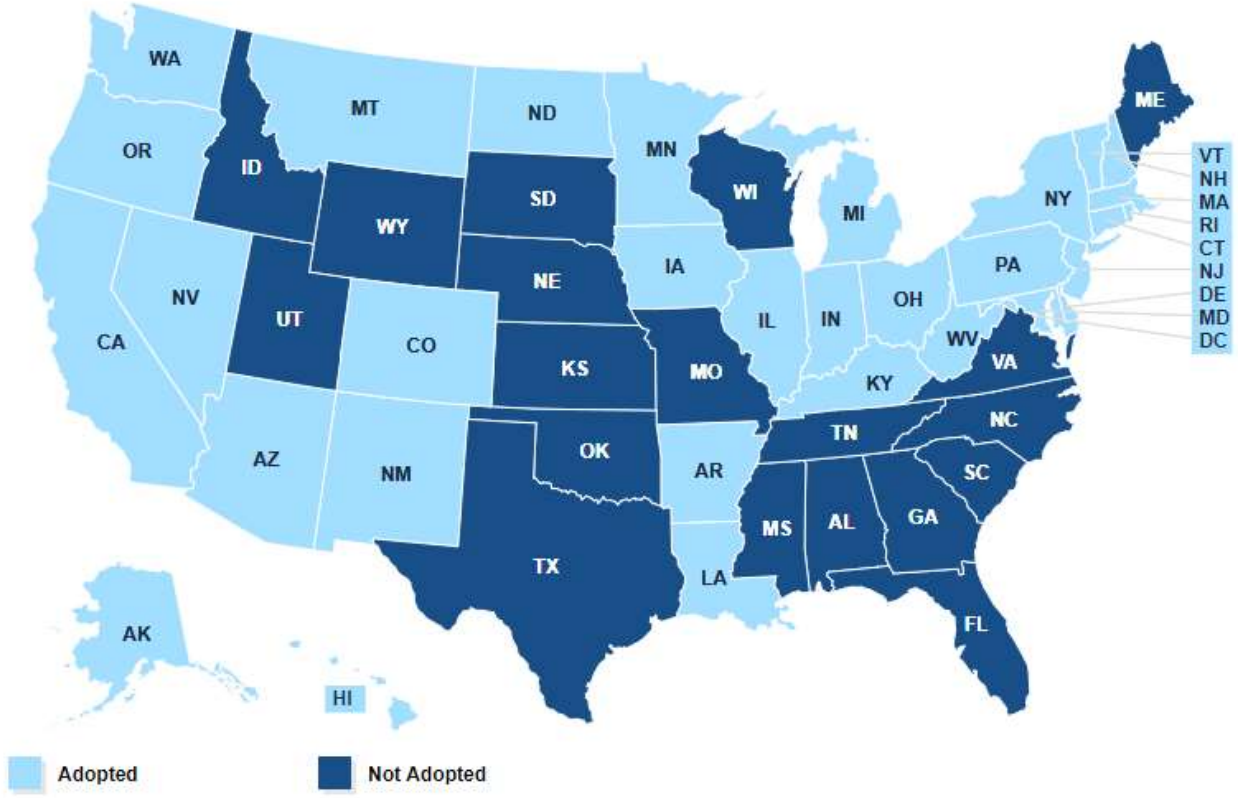
- Many don't file taxes
- If required contribution is greater than 8% of gross household income, this is considered an "affordability exemption" and would result in exception to the penalty requirement.
- Other exceptions may be made for:
    - Certain religious beliefs
    - Incarcerated individuals
    - Undocumented aliens
    - Individuals in a hardship situation
    - Indian tribe members
    - Medicaid/Medicare members
    - Individuals lacking coverage for less than 3 months

- Additionally, PPACA allows for a 90-day grace period (before coverage can be terminated for reason of no premium payments)

What happens to the portion of the population who would have been newly Medicaid eligible?

- As ACA is currently written, they are in a “no man’s land”
- ACA assumed those up to 133% of FPL would have Medicaid, so only discussed and provided subsidies for > 133% FPL in the Commercial market
- ACA includes a table of what the subsidies are by FPL which includes values for “up to 133%”. It would seem that covers this population.
- However, it does not because only “applicable taxpayers” may have a subsidy.

Medicaid Expansion:
Current Status



https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Benefit Design Implications of the Affordable Care Act

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Benefit Design Implications

Maximum Out-of-Pocket tied to HSA limitations in 2014, but different thereafter

- $6,350 single, $12,700 family in 2014
- $6,600 single, $13,200 family in 2015
- $6,850 single, $13,700 family in 2016
- $7,150 single, $14,300 family in 2017
- $7,350 single, $14,700 family in 2018
- Coincidentally very close to the Minimum Value 60% limit on the large group market, as well as the least rich “bronze” plans on the individual and small group markets
- Unexpected implications for all markets
  - Co-pays must accumulate towards the OOP Max, both medical co-pays and pharmacy co-pays – major affect on benefit set up that also affects pricing
  - One-year delay mainly for pharmacy carve-out situations

Benefit Design Implications

Annual Maximums on Essential Health Benefits Eliminated

Lifetime Maximums Eliminated

Retiree-only plans exemption from ACA

also stand-alone dental, LTC, Medigap

Benefit Design Implications

Grandfathered: exist on March 23, 2010 and applied for GF status

Applies to group (ASO and insured) and individual

Requirements to maintain GF status:

- Disclosure requirements to members
- Cannot significantly reduce or cut coverages
- Cannot raise coinsurances on members
- Cannot significantly raise co-pays.. no more than greater of $5 or medical inflation +/- 15%
- Cannot significantly raise deductibles and OOP Maximums (medical inflation +/- 15%)
- Cannot add or tighten annual limits
- Cannot reduce employer subsidization
- Cannot restructure such as in mergers, acquisitions to have people moved into a GF plan
- Cannot force employees into other less valuable, albeit GF plans

Benefit Design Implications

Grandfathered versus Non-grandfathered

- GF plans still must comply with certain ACA rules:
  - Age 26 dependents
  - Lifetime limit elimination
  - Annual limit elimination
  - Prohibition of pre-existing conditions
  - Prohibitions on rescissions of coverage

Benefit Design Implications

100% preventive coverage:

- Services rated A or B by the U.S. Preventive Services Task Force (USPSTF)
- Includes immunizations
- Pay close attention to mammograms and colonoscopies, which are high cost and prevalent, big portion of the preventive bucket
  - Possibility for differences among geographies or through time for coding as “preventive” and following timing guidelines allowed

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

How many Essential Health Benefit categories can you name?

What are Essential Health Benefits?

Which plans must offer EHB?

YES

NO

Benchmark Plan Options

What are Essential Health Benefits?

We propose to provide states with **additional flexibility** in how they select their essential health benefits (EHBs) benchmark plans for benefit years 2019 and beyond, and outline potential future directions for defining EHBs. Specifically, we propose to allow states to **select a new EHB-benchmark plan on an annual basis**, which would allow states to update their EHB-benchmark plan on a schedule that works for the state, rather than one set by HHS. We also propose to provide states with **substantially more options** in what they can select as an EHB-benchmark plan. Instead of being limited to 10 options, states would be allowed to: 1) choose from the 50 EHB-benchmark plans that other states used for the 2017 plan year; 2) replace one or more EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or 3) otherwise select a set of benefits to become its EHB-benchmark plan, provided that the new EHB-benchmark plan does not provide more benefits than a set of comparison plans and is equal to the scope of benefits provided under a typical employer plan, as required by the PPACA.

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Proposed-2019-HHS-Fact-Sheet.pdf

Gaps?

- Pediatric Dental
- Vision
- Habilitative Services

What is a habilitative benefit?

Rules for pediatric dental EHBs

- For those under the age of 19
- Can include “medically necessary” orthodontia
- May be provided in a QHP or in a stand-alone dental plan on the Exchange
  - “When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB”

Rules for pediatric dental EHBs

- For stand alone plans inside the Exchange, separate AV and cost-sharing limits apply:
  - AV must be at either
    - High – 85 %
    - Low – 70 %
    - Still allows de minimis variation of 2 %
    - No AV calculator available from HHS
    - Must be certified by a member of the American Academy of Actuaries
- Cost Sharing must be a "reasonable annual limitation as determined by the Exchange."

2019 Proposed NBPP removes this

Rules for Rx EHBs

- EHB plan must cover at least the greater of:
  - One drug in every category and class, or
  - The same number of drugs in each category and class as the EHB-benchmark plan
- Drugs listed must be chemically distinct

Other Benefit Design / Coverage Items

- Specified preventive visits must have no member cost sharing
- Out of network emergency coverage must be at in network levels (along with prior authorization or coverage limits)
- Existing state mandates (as of 12/31/2011) are retained
  - If additional mandates are added, then the state must fund them
- MHPAEA expansion to the individual and small group markets

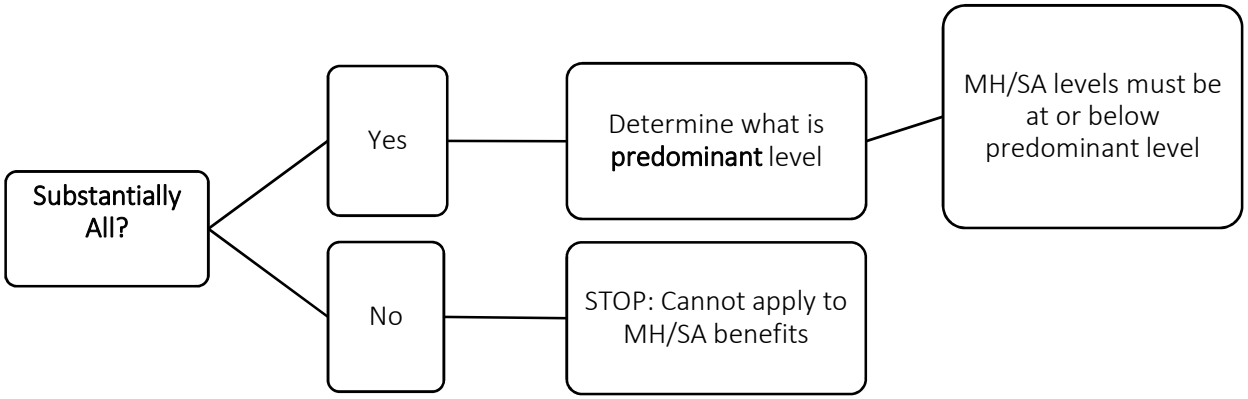
MHPAEA - Parity Must Exist

- Within all combinations of benefit plans
- Within all classifications of benefits
  - Inpatient (in and out-of-network)
  - Outpatient (in and out-of-network)
    - Office visits
    - Non-office visits
  - Emergency Care
  - Prescription Drugs
- Within each coverage unit
  - Employee, employee plus spouse, employee plus family

MHPAEA – What is Allowed?

- Member cost sharing can be applied to MH/SUD benefits only if a particular type (copay, coinsurance, etc..) of cost sharing is applied to 'substantially all' (>= 2/3) of medical/surgical benefits
- If cost sharing is allowed the 'predominant' level of cost sharing applied to medical/surgical benefits (>50%) needs to be determined
- The 'Substantially All' and 'Predominant' tests also apply to non-financial quantitative limits such as visit limits

MHPAEA – What is Allowed?



MHPAEA Cautions

- Effective in 2015, testing by tier is allowed.
  - Since multiple in-network benefit tiers will be tested separately, no longer must apply “best“ tier to all MHPAEA benefits.
- Careful with tobacco cessation coverage (if covered in one benefit category, it must be covered in all)
- Careful with non-quantitative parity
  - Pre-approval limits
  - Pre-authorization procedures
  - Step therapy
  - Behavior modification class enrollment requirements

Question #1

An HMO provides unlimited benefits (with no cost sharing) for treatment of anxiety, alcoholism, and major depression. For bipolar disorder, only inpatient care is covered. No other behavioral condition is covered at all.

What does the plan do to be in compliance?

Answer Choices

a. Nothing – this is compliant
b. Add coverage for all other behavioral conditions
c. Expand bipolar disorder coverage to include outpatient care, emergency care, and prescription drug coverage.
d. Remove coverage for bipolar disorder.

Question #2

A plan is designed such that:

- 30% of the in-network medical/surgical benefits in a class are subject to a $20 copay; in the same class
- 30% are subject a $30 copay,
- 30% are subject to 15% coinsurance, and
- 10% do not have any cost-sharing requirements.

Currently, behavioral services in the class are subject to the $30 copay. What could be done to comply with MHPAEA?

Answer Choices

a. Eliminate the $30 copay for behavioral services
b. Change the $30 copay for behavioral services to 15% coinsurance
c. Change the $30 copay for behavioral services to the $20 copay
d. Use actuarial equivalence to express coinsurance as a copay before testing for substantially all
e. Nothing, this is compliant

Question #3

A plan imposes copays for office visits (behavioral and medical/surgical) and coinsurance for all other outpatient services (behavioral or medical/surgical). Neither copays nor coinsurance would satisfy the Substantially All test in the in-network outpatient classification, since each is 50% of costs.

What should the plan do?

Answer Choices

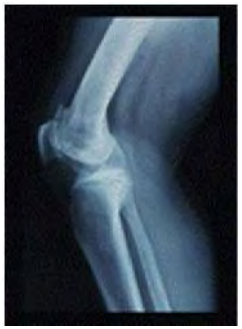
a. Nothing, this is compliant
b. It must remove all cost sharing for in-network outpatient behavioral services
c. It should classify all non-office outpatient services as inpatient, in order to satisfy the Substantially All test
d. It should divide the outpatient classification into two subclasses (office visits and other) and test each subclass separately

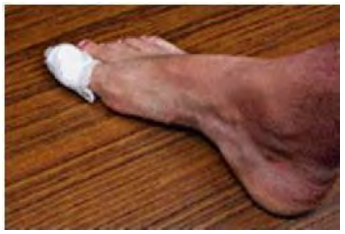
The Outpatient Safe Harbor

Service	Cost Sharing	Total Allowed Dollars
PCP office visits	$20 copay	$100,000
Specialist office visits	$30 copay	$75,000
Lab/X-Ray	20% coinsurance	$25,000
Outpatient surgery/Other	20% coinsurance	$100,000
MH/SA office visits	$20 copay	
MH/SA partial hospital	20% coinsurance	

The Outpatient Safe Harbor

- What are other outpatient behavioral services?





- Why does this matter?
- Are my SPDs specific enough?

FAQ (April 2016)

Measuring medical/surgical benefit costs

- Tests require having dollar weights
- Final rule: “Any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation”

FAQ (April 2016)
Measuring medical/surgical benefit costs

- Question: When performing "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations under MHPAEA, may a plan or issuer base the analysis on an issuer's entire overall book of business for the year?

- DOL answer: No. This “is not a reasonable method.”

FAQ (April 2016)
Measuring medical/surgical benefit costs

- DOL says the following "should" be used:
  - Self-insured: Group-specific data
  - Fully insured large group: Group-specific data
  - Small group and individual: Plan-level data
- What does "any reasonable method" actually mean?

FAQ (April 2016)
Measuring medical/surgical benefit costs

- Likely consequences
  - Increase in cost and complexity of demonstrating compliance
  - A given plan design is compliant for some large or self-insured groups, but not for others
  - A given individual or small group plan design is compliant in some network configurations or areas, but not in others

FAQ (October 2016)
Measuring medical/surgical benefit costs

- Question: If a group health plan or issuer does not have sufficient claims data, what data can they use to conduct the analyses?
- DOL answer
  - If a group health plan has sufficient claims data, such data should be used for these analyses
  - Should not use claims data from an issuer's or TPA's entire book of business in an unreasonable manner.
  - Use appropriate and suffiecient data to comply with ASOPs
    - Self-Funded and LG – consider group health plan-level claims data
    - SG and Individual – consider "plan"-level (as opposed to product-level) data
  - Qualified actuary should determine what's appropriate from a credibility standpoint

Common areas of Non-compliance
Quantitative

- Day/Visit Limits
- Limits on smoking cessation drugs
- Emergency Care

Question #4

County Hospital provides health insurance to its employees, administered by ABC Insurance. County Hospital is an in-network facility for all ABC plans. The normal coinsurance rate for in-network inpatient services is 20%, but the coinsurance rate is only 10% if members choose County Hospital. (This applies to both medical/surgical and behavioral care.)

Most County Hospital employees use County Hospital when they require inpatient care.

What does the plan do to be in compliance?

Answer Choices

a. Nothing – this is compliant
b. Remove the coinsurance for all in-network behavioral care.
c. Reduce the in-network (non-County Hospital) coinsurance rate on behavioral care to 10%.
d. Increase the County Hospital coinsurance rate to 20% for all care (medical/surgical and behavioral).

Non-quantitative Compliance

- Usual, reasonable, customary
- Network admission requirements
- Unequal access to providers of care
- Care management procedures
- Utilization management practices
- Different penalties for failing to get preauthorization

Can Plans Still Manage MH/SUD Benefits?

- Common non-quantitative treatment limits such as utilization management, medical necessity criteria, step therapy, and pre-authorization must be

> "comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification"

Common areas of Non-compliance

Non-quantitative

- Pre-approval limits
- Pre-authorization procedures
- Behavior modification class enrollment requirements
- Step-therapy

The new “warning signs”
Possible NQTL red flags

- Prior authorization
- Fail-first
- Probability of improvement
- Treatment plans
- Other

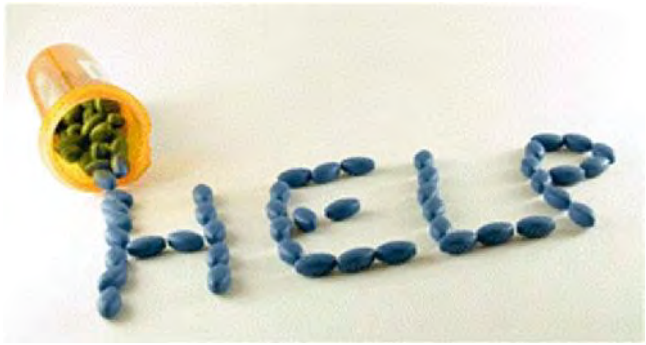
Scope of Services

- Condition coverage
- How much coverage is enough?

Scope of Services Examples

- Plan covers inpatient and outpatient treatment for drug abuse but excludes residential treatment facilities.

- Is it OK to exclude coverage for residential treatment facilities?



Scope of Services – Final Rules

Clarifications regarding requirements for scope of services

The preamble also addresses comments seeking clarification around the scope of services that must be included within each of the six classifications of benefits. In particular, the Departments make it clear that MHPAEA is not intended to create a "benefit mandate," requiring greater MH/SUD benefits than medical/surgical benefits. However, the Departments also clarify that they did not intend that plans and issuers could exclude "intermediate levels of care," such as residential treatment, from parity requirements on the grounds that these services do not clearly fall within one of the six classification levels.

Plans and issuers must assign intermediate MH/SUD benefits to the six benefit classifications in the same way that they assign intermediate medical/surgical benefits. The preamble provides the example that if a plan classifies care in a skilled nursing facility as inpatient care, then it must treat covered care in a residential treatment facility for MH/SUDs as inpatient care. The Departments do not anticipate that this clarification will result in a significant increase in costs due to the small number of enrollees that reportedly utilize intermediate levels of care.

Source: Manatt Phelps & Phillips LLP, "Final mental health parity rules clarify requirements regarding treatment limitations and plan disclosure obligations," 11/13/2013, http://www.lexology.com/library/detail.aspx?g=6e6c1d2c-3eb9-4135-b243-e67383c6d1ef

The ACA Impact

Plans must cover these benefits:

- Alcohol misuse counseling
- Depression screening
- Tobacco use counseling and interventions

The ACA Impact

Does this mean alcoholism, depression, and tobacco addiction need to be covered in full?

Cautionary tales in non-compliance

- Can’t create benefit classifications – often a concern for ambulance use
- What seems “fair” is not necessarily compliant
- Matching PCP cost sharing does not guarantee compliance
- Matching the state benchmark plan does not guarantee compliance
- Receiving DOI approval does not guarantee compliance

Market Segmentation

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Population Segments

- Different segments of the population are eligible for different benefits
- Eligibility depends on what plans and subsidies they are eligible for
  - Use premium subsidy levels as a guide

Income Level	Premium as a % of Income (2017)
Up to 133 % FPL	2.04% of income
133 – 150 % FPL	3.06 – 4.08 % of income
150 – 200 % FPL	4.08 - 6.43 % of income
200 – 250 % FPL	6.43 - 8.21 % of income
250 – 300 % FPL	8.21 - 9.69 % of income
300 % – 400 % FPL	9.69 % of income
https://www.irs.gov/pub/irs-drop/rp-16-24.pdf	

Population Segments
<100% FPL

- If state expands Medicaid:
  - Individual is eligible for Medicaid
  - Individual may not seek commercial coverage on Exchange
- If state does not expand Medicaid:
  - Regulation lists that only “applicable taxpayers” may be eligible for subsidies
  - Below 100% FPL is not an “applicable taxpayer”
  - In “no man’s land” regarding subsidies
  - Likely still eligible for 94% CSR Plan

Population Segments
100%-133% FPL

- If state expands Medicaid:
  - Individual is eligible for Medicaid
  - Individual may not seek commercial coverage on Exchange
- If state does not expand Medicaid:
  - Member eligible for premium subsidies covering almost all premiums
  - Eligible for 94% CSR Silver plan
  - Individual would benefit from selecting CSR Silver plan

Population Segments
133%-150% FPL

- Member eligible for premium subsidies covering almost all premiums
- Eligible for 94% CSR Silver plan
- Individual would benefit from selecting CSR Silver plan

Population Segments
150%-200% FPL

- Member eligible for premium subsidies covering significant portion of premiums
- Eligible for 87% CSR Silver plan
- Individual would benefit from selecting CSR Silver plan

Population Segments
200%-250% FPL

- Member eligible for premium subsidies covering significant portion of premiums
- Eligible for 73% CSR Silver plan
- Since CSR plan is not much richer than standard silver and subsidies tied to second-lowest cost silver, benefit of selection CSR not as strong

Population Segments
250%-400% FPL

- Member eligible for premium subsidies covering portion of premiums
- Not eligible for any CSR plans

Population Segments
>400% FPL

- Not eligible for premium subsidies or CSR plans
- Not a financial incentive to purchase on the exchange (since they do not receive subsidies)

Population Segments

Likely Options

Income Level	Medicaid Expansion?	Premium Subsidies	CSR Plan Eligibility	Likely Selection
Up to 100 %	Yes	Maybe none	94%	Medicaid or 94% CSR Silver
100 – 133 %	Yes	Most of cost	94%	Medicaid or 94% CSR Silver
133 – 150 %	No	Most of cost	94%	94% CSR Silver
150 – 200 %	No	Significant	87%	87% CSR Silver
200 – 250 %	No	Significant	73%	73% CSR Silver or Bronze
250 – 400 %	No	Some	None	Silver or Bronze, but all metallics are good options
400%+	No	None	None	All metallics are good options

Other Population Segments

- Native Americans
  - Eligible for Native American CSR plans
    - Zero cost sharing for those <300% FPL
    - For others, free coverage at Indian Health Services facilities
  - Most will select these CSR plans
- Young and healthy
  - If under 30, and if available and priced favorably, can select catastrophic coverage
  - Group most likely to forego coverage and pay penalty
  - If under 26, can still be on parents' plan
- Grandfathered Plan Members
  - Those benefitting from old rating rules tended to stay, older and less healthy will move to new ACA compliant plans

Small Group Segments

- Fewer than 25 FTEs, less than $50,000 average salary
  - SHOP Exchange = tax credits
  - Credits up to a maximum of 50% of employer-paid premiums
- Other small groups
  - SHOP Exchange = employee choice
  - Massachusetts Exchange: low small group exchange take-up
  - Organizations with more paternal environment will want to choose plan, will seek coverage off Exchange
- Small didn't have coverage mandate in 2014; many didn't offer coverage
- Mandate for 2015 applies to groups with 100+ FTEs
- Mandate for 2016+ applies to groups with 50+ FTEs
  - Individual states may substitute with 100+

Large Group

SOCIETY OF ACTUARIES

Large Employer Requirements

EHB and Benchmark Plans

The EHB benchmark plan defines the essential health benefits that must be covered by plans in the state

All large group

- Not required to cover EHB
- If they do, may not apply annual or lifetime dollar limits
- Non-dollar (duration) limits are still allowed
- Employers may remove benefit if they do not want to waive dollar limits

Fully Insured

- Plans will follow the benchmark for their situs state
- Many carriers will remove dollar limits from all EHBs starting in the first plan year on or after Jan. 1, 2014

Self-funded

- Self-funded employers must choose a benchmark option to determine which of the benefits they cover are considered EHB
- Can choose any state or federal plan as their benchmark plan

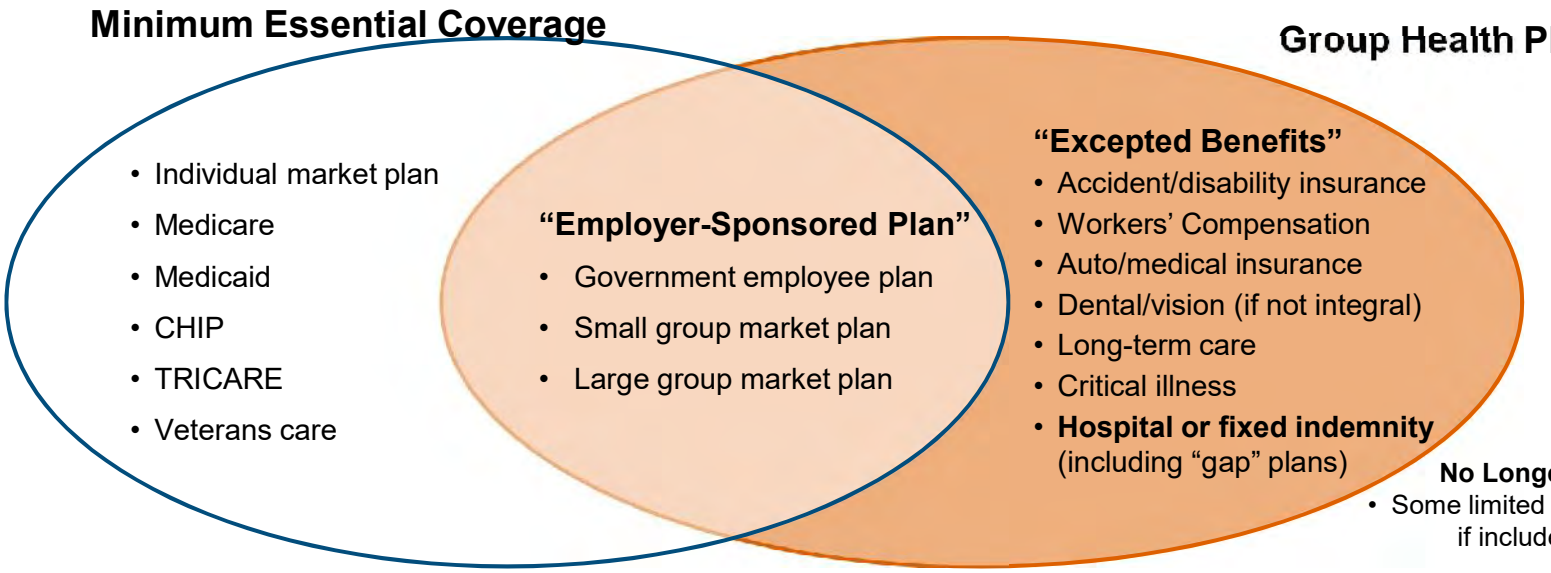
EHB Final Rule, 2/20/13

HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS **(including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories)** [and intends] to work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.

Elimination of any benefit coverage including EHB will result in plan losing grandfathered status

What counts as Minimum Essential Coverage (MEC?)

What's still legal?



No Longer Permitted
- Some limited benefit plans if include dollar limits
- Very high deductible/OOPM plans

	Employer-Sponsored Plans –60% MV or greater	Employer-Sponsored Plans – Less than 60% MV	Excepted Benefits
Employer Mandate	• If employer offers and it is affordable, satisfies mandate	• By itself, does NOT help employer satisfy mandate	• Does NOT help employer satisfy mandate
Individual Mandate	• If employee is enrolled in an employer-sponsored plan that provides MEC, then the employee satisfies the mandate		• Does NOT help employee satisfy individual mandate
Applicable Rules	All rules for small group and/or large group markets, including: • OOPM ceiling • Prohibition on lifetime/annual dollar limits		• Do NOT need to follow health reform plan design rules

Employer Obligations – Play or Pay

Employer mandate to applies to all employers

- Mandate applies to **employers with 50+ FTEs** (for calendar year 2015; 100+FTEs for 2016) (based on avg. count full/part-time in prior calendar year)
- Uses **IRS aggregation rules** to determine if subsidiaries and jointly owned companies treated as one
- Applies to **both fully insured and self-funded** groups and to **grandfathered** groups
- Must offer coverage to dependents up to 26, but NOT to spouses

Minimum Essential Coverage

- Must **provide "minimum essential coverage"**
  - NOT a limited benefit or mini-med plan, disability, accident, critical illness, indemnity plan
- **Offer must include 95% of full-time employees, and be available to dependents**

Penalty Assessment A

If employer not offering MEC → $2,000 penalty per full-time employee per year (minus 30-employee buffer).

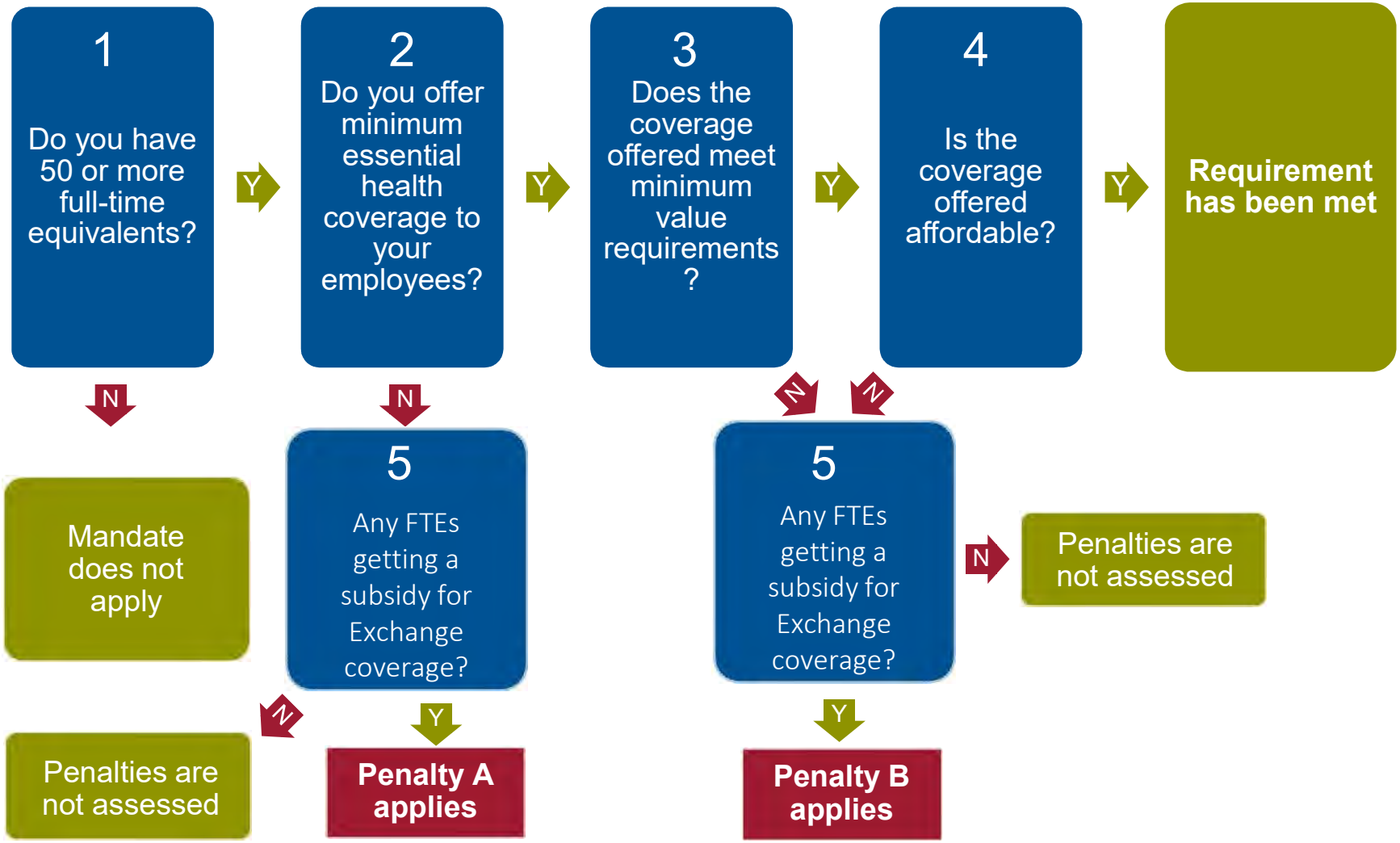
Minimum Value & Affordable

- Must be **affordable**
  - Single employee contribution for lowest cost plan must not exceed 9.5% of household income (in 2014, indexed thereafter (9.69% in 2017))
  - 3 safe harbors to use as proxies for household income:
    - W2 income, Box 1
    - 130 times hourly wage monthly
    - Poverty level
- Must provide **minimum value**
  - Plan pays 60% or more of medical costs across a typical population

Penalty Assessment B

If coverage fails these tests → Penalty is $3,000 per employee per year receiving subsidy in Exchange.

Five Key Employer Questions



Small Group:
Self-Funded and Level Premium Comparison

Funding mechanism	Description of funding and costs to sponsor
Fully-Insured	Premium paid to insurer, who covers claims
Minimum Premium/Level-Funded	Level monthly amount paid to insurer to fund: - expected claims; - additional charges for administrative costs; - premium for "stop-loss" coverage for unfavorable claims. Plus annual settlement for favorable/unfavorable claims.
Self-Funded (ASO)	Plan sponsor purchases administrative services from insurer, and funds claims as they are adjudicated.

Small Group:
Self-Funded and Level Premium Comparison

Funding mechanism	Risk to Plan Sponsor	Overall Cost to Plan Sponsor
Fully-Insured	Least: Plan sponsor does not retain any risk of unfavorable claims.	Highest: Plan sponsor is required to play premium taxes on full amount of coverage. Risk margins highest on fully-insured coverage where insurer takes full risk.
Minimum Premium/Level Funded	Some: Plan sponsor may retain some risk of unfavorable claims (but will hedge catastrophic risk with stop-loss insurance).	Some: Premium taxes are often required on the unfavorable claims insurance only. Lower risk margins since insurer is taking less risk.
Self-Funded	Most: Plan sponsor retains full risk of unfavorable claims.	Least: In many states, the portion of the monthly outflow used to fund claims and administrative expenses is not considered premium, so the plan sponsor does not owe premium taxes on that portion of the funding.

Small Group: Product Overview

- Fully-Insured: Plan sponsor pays premium to the insurer to cover all claims, administrative expenses, and risk margins

- Self-Funded: Claims funded directly by plan sponsor, who also pays an "administrative services only" (ASO) fee to the insurer to administer claims

- Minimum Premium / Level Funded: Plan sponsor accepts some risk of claims variance, along with potential rewards in favorable claims situations, while also insuring a portion or all of the catastrophic downside risk
  - Hybrid between fully-insured and self-funded

Small Group: Risks

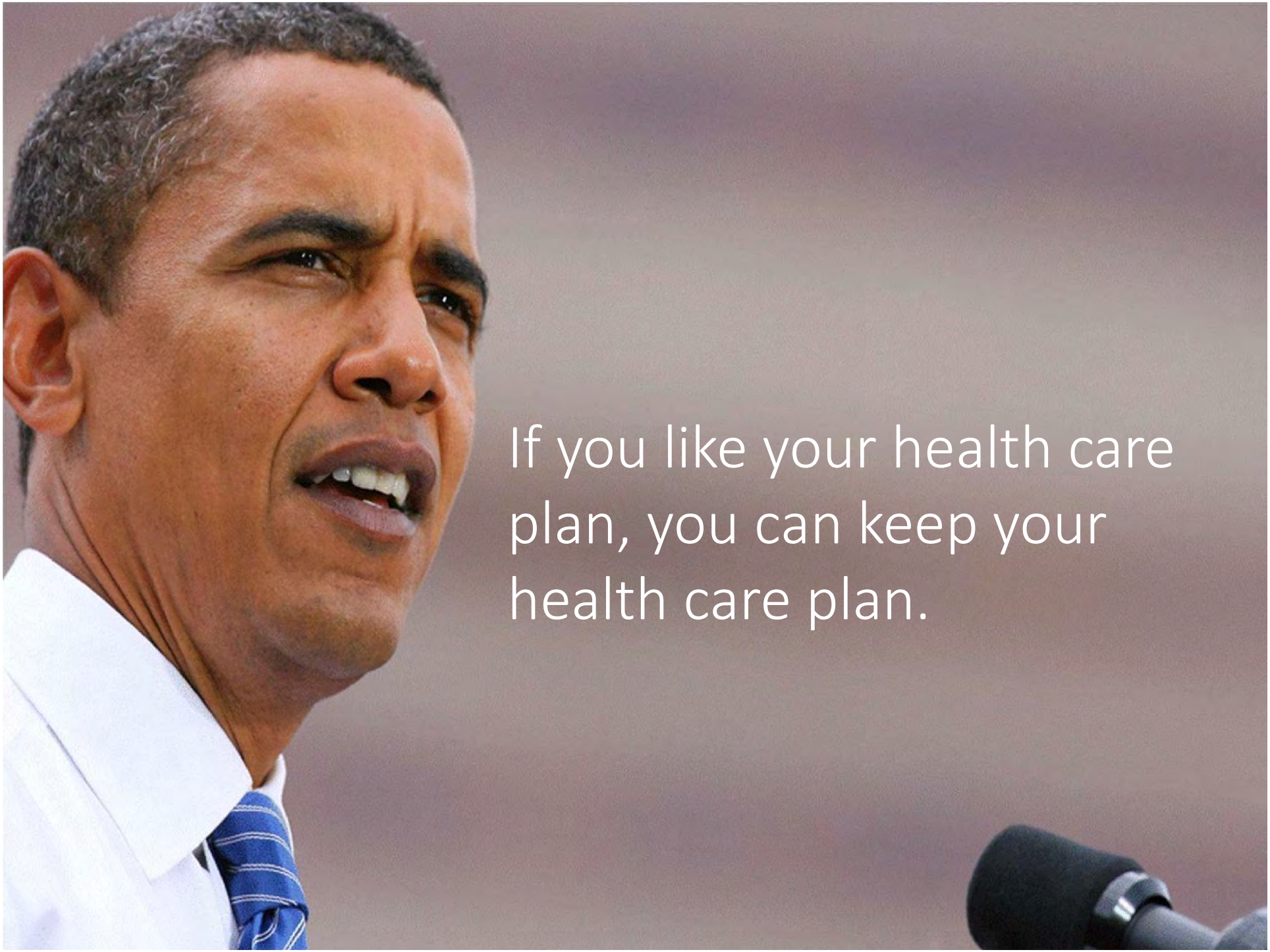
- Fully-Insured: Plan sponsor bears no risk
- Self-Funded: Plan sponsor bears all risk
- Minimum Premium / Level Funded: Plan sponsor bears some risk, but uses stop-loss insurance to protect against catastrophic downside risk
- Other considerations:
  - Groups that consider themselves "better risks" tend to choose self-funded or minimum premium plans
  - If all else is equal, a smaller group is at a greater risk of hitting the unfavorable claims threshold due to higher variance of claims

Small Group: Costs

- Fully-Insured: Plan sponsor pays premium and tax for insurance on full amount of coverages
- Self-Funded: Funded "as you go," dependent on the amount of claims incurred
  - Some claim amounts could be insured using stop-loss insurance
- Minimum Premium / Level Funded: Fund claims at same rate every month without regard to actual level of claims with a retrospective settlement at the end of the year
  - Rate = expected amount of claims each month
  - To insure against paying extra to fund higher than expected claims, plan sponsor will seek aggregate stop-loss insurance
  - Typically do not owe premium taxes on portion of funding used for claims and administrative expenses

Small Group:
Self-Funded and Level Premium Comparison

Consideration	Level Premium	Self-Funded
Costs to plan sponsor	Level payment for expected claims, administrative services, stop-loss insurance End of year settlement	Administrative services Fund claims as adjudicated
Risk to plan sponsor	Some	High
Overall cost to plan sponsor	Some	Low
Month-to-month variance	None, until the end	High
Administrative complexity	Low	High
Characteristics of groups choosing this option	Smaller groups (250 employees or fewer) Some risk appetite Perceive themselves to be lower cost	Larger groups (500 employees or more) More risk appetite Can handle extra administrative burden
Insurance against catastrophic claims	Aggregate	Specific (per claimant)


If you like your health care plan, you can keep your health care plan.

Grandfathered Plans

- Allows carriers to retain previously existing healthcare plans that are not subject to some of the ACA requirements.
  - Exempt from EHBs
  - Exempt from 100% coverage of preventive benefits
  - Exempt from AV level requirement
- Still must comply with the following:
  - Removal of annual and lifetime limits
  - Pre-existing condition provisions
  - Dependents to age 26
- Does not require carriers to maintain these plans

Grandfathered Plans - Membership

- Who stayed in grandfathered plans?
  - People who benefit from pre-ACA rules
  - Decision based on premiums and plan designs
- Premiums
  - Those benefitting from old rating rules tended to stay in GF plans
    - Healthy members
    - Younger members
  - Unhealthy or older members tended to move to take advantage of age rating restrictions and no health rating
- Plan designs: Those who prefer their plans without the necessary changes to become ACA compliant remain in these plans

Transitional Policy Coverage

- “Grandmothered” plans
- February 2017– Extended Transitional Policy for any active coverage (on or before Jan 1, 2014) through December 2018
- Still allowed by 35 states (although 4 of them don’t have any left in the market)

Individual and Small Group Pricing

- Single Risk Pools
- Rating Categories
- Trends
- Induced Utilization
- Required Fees
- Individual Market Considerations
- Small Group Market Considerations

Individual and Small Group Pricing
Single Risk Pools

- February 2012 – HHS issued final rule effective on plan years beginning Jan. 1, 2014 or later.
- Prevents insurers from segmenting enrollees into separate rating pools in order to increase premiums at a faster rate for higher-risk individuals.
- Index Rates
- Product-specific rates determined through:
  - Actuarial value and cost sharing design
  - Provider network, delivery system and utilization management
  - Benefits in addition to the EHBs
  - Expected impacts of eligibility categories for catastrophic plans

Allowable Rating Factors

Individual and Small Group Pricing
Area Factors

- Different rating factors for individual and small group markets
  - Based on expected differences in costs between areas
- Must apply uniformly within each market
- Cannot vary by product
- Areas based on divisions by county
- Number of areas equals the number of MSAs plus one non-MSA area, unless there was formal request at the state level, and approval from CMS
- Factors can be set based on unit cost and provider practice pattern differences, but not based on morbidity by region

Individual and Small Group Pricing

Age Rating

- ACA allows for variation up to 3:1 for similar individuals over 21
- e.g. 64-year-old's premium cannot exceed 3 times a 21-year-old's, for the same product and area
- Age defined as that at time of effective/renewal date of policy
- Age curve may vary by state, but is uniform within each state (most states use standard curve determined by CMS)

CMS Standard Age Curve (2018+)

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-14	0.765	31	1.159	48	1.635
15	0.833	32	1.183	49	1.706
16	0.859	33	1.198	50	1.786
17	0.885	34	1.214	51	1.865
18	0.913	35	1.222	52	1.952
19	0.941	36	1.230	53	2.040
20	0.970	37	1.238	54	2.135
21	1.000	38	1.246	55	2.230
22	1.000	39	1.262	56	2.333
23	1.000	40	1.278	57	2.437
24	1.000	41	1.302	58	2.548
25	1.004	42	1.325	59	2.603
26	1.024	43	1.357	60	2.714
27	1.048	44	1.397	61	2.810
28	1.087	45	1.444	62	2.873
29	1.119	46	1.500	63	2.952
30	1.135	47	1.563	64+	3.000

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf

Individual and Small Group Pricing
Tobacco Rating

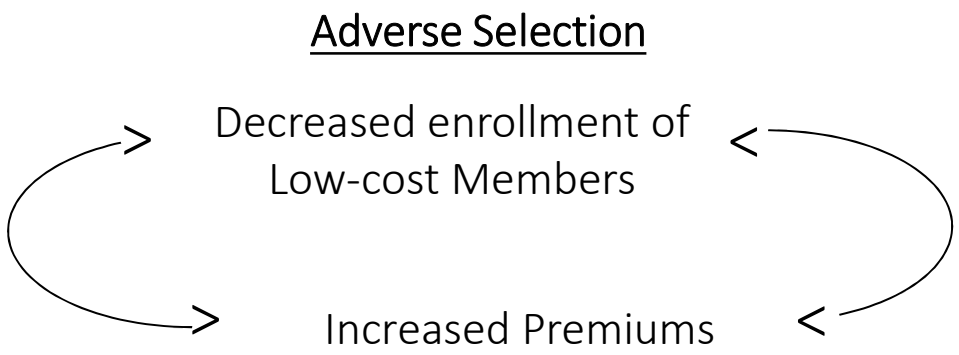
- ACA allows for up to 50% smoker load
  - Smoker load can differ by age
    - e.g., A 64 year old smoker can be charged a total of 4.5 times a 21 year old smoker (3x for age and 1.5x for smoking)
  - Some states have stricter limitations on smoker load – which overrule the 1.5:1 federal allowance
  - 2014 HHS Rates Template didn't allow for this
  - Was fixed for 2015 filings

Individual and Small Group Pricing
Family Rating and Child Loads

- Rate based on individual or family enrollment
  - i.e., Individual + Spouse, Individual + Dependents, etc..
- Three child cap
- How to prepare for unexpected costs?
  - Child load
  - Spread expected cost of additional children over family

Individual and Small Group Pricing
Pricing for Selection

- Prohibited pricing based on expected plan selection of enrollees
  - Can rate by age category
- Mitigates ongoing adverse selection



Individual and Small Group Pricing

- Must include EHBs
- Must consider plan AV
  - AV calculator values should not be used for pricing

Individual Pricing: Marketplace Changes

- Increased costs due to individual mandate and plan design requirements
  - Morbidity in the Newly Insured
  - Pent-Up Demand
  - Induced Utilization
- Critical pricing consideration for both individual and small group:
  - Pricing must be at your carrier's cost structure, but price at the market average risk. Must not price for carrier average risk.
- Must also consider change in impact between years, especially as the market population changes over time.
  - Penalties go up over time
- Will cover the "Three Rs" in more detail tomorrow morning, quick overview here first.

Individual Pricing: Transitional Reinsurance

- Only insurers in individual market receive payments; all contribute (including small group, large group, self-insured group plans)
  - Existed from 2014 to 2016 – no longer exists for 2017+
- Value depends on the expected members with high claims
  - Attachment point:
    - 2014: $45,000
    - 2015: $70,000 originally; lowered to $45,000
    - 2016: $90,000
  - Cap:
    - $250,000 (each year)
  - Coinsurance rate:
    - 2014: 80% (paid out at 100%)
    - 2015 and 2016: 50% (paid at 55.1% for 2015, 52.9% for 2016?)
- Removal in 2017 contributed to rate increases

Individual Pricing: Risk Adjustment

- How does the carrier's risk score in the market compare to the statewide market as a whole?
  - New insurers
  - Existing carriers
  - Actual risk versus measured risk
- What is the carrier's market share?
  - Small issuers have more variation in risk scores
  - As an issuer gains market share, their risk profile approaches the same level as the market, so risk adjustment receipts and payments trend toward $0.
- A risk score of 1.00 does not mean no payment. Risk scores are compared to the market wide (state, and individual or small group) risk score, which can be something other than 1.00.

Individual Pricing: Risk Corridors

- How were risk corridors considered?
  - The Risk Corridors program incorporate the results of Transitional Reinsurance and Risk Adjustment programs, so projecting Risk Corridor receipts is at least as difficult as projecting those programs
  - What are your allowable administrative costs?
  - If there is a non-zero amount built into pricing, it can imply that expected costs are different than what you priced for and the pool is 'priced incorrectly'
- CMS announced on October 1st, 2015 that 12.6% of payments requested in 2014 will be paid in 2015, with charges for the 2015 and 2016 plan year filling in the rest
  - November 2016 announcement – about another 1% for 2014.
  - November 2017 announcement - ???

Small Group Pricing: Early Renewals

- Existing small group carriers have an established membership pool
- Some groups were better off under current plan design and rating rules
- Many insurers decided to offer early renewal on 12/1/2013 for these groups to keep their current coverage longer
  - The insurer gets to keep the group for an extra 11 months prior to extra competition on Exchanges
  - The small group gets to keep their current plan priced under the current rating rules for another 11 months

Small Group Pricing: Early Renewals

- Who was a candidate for early renewal?
  - Healthy groups: to avoid rating rules that don't allow health status as a risk factor
  - Less expensive industries: to avoid the removal of industry as a rating factor
  - Groups that enjoy their current plan not compliant with ACA
  - Will be more prevalent in states with less strict current rating rules
- What is the implication?
  - Fewer healthy groups entering the Exchange
  - For insurers newly entering the market, fewer potential groups
- A similar process is happening in many states for the 51-100 group size

Small Group Pricing: 3 Rs

- Transitional Reinsurance receipts do not apply to the small group market
- Risk Adjustment receipts should be smaller (closer to zero) than for individual market
  - Less market shifting than in the individual market
  - Fewer newly insured members in the small group market
  - Small insurers still need to worry about large swings
  - Exact amount will still be difficult to project because you still have to compare your risk score to the statewide market
- Since there is less market shifting, risk corridors might be relatively easier to project in the small group market than in the individual market

Small Group Pricing: Open Enrollment

- Open enrollment for small groups is year-round, with one exception
- Issuers may impose a minimum contribution or minimum participation requirement
  - Groups not meeting this requirement must be allowed to purchase during a specified open enrollment period
  - Outside of this open enrollment period, groups may be denied
  - The open enrollment period lasts from Nov. 15 to Dec. 15
- Small groups purchasing coverage on the SHOP Exchange must contribute at least 50% of a single employee's monthly premium to qualify for tax credits

Statewide Pool Information

- Publicly posted rate filings can assist in developing rates
- Publicly available information varies by state
- New ACA filing requirements can provide useful information
- Sources include:
  - Actuarial Memorandum
  - Unified Rate Review Template (URRT)
  - Shadow Pricing

Actuarial Memorandum

- A new ACA requirement, the Part III Memorandum is publicly available
  - Intended to accompany URRT
- Useful information includes:
  - Trend rates
  - Projected loss ratios
  - Process for projection of 3 Rs (now just risk adjustment)
  - Load for increased morbidity in individual market
- A state required actuarial memorandum may also be available, and could include additional information

Unified Rate Review Template (URRT)

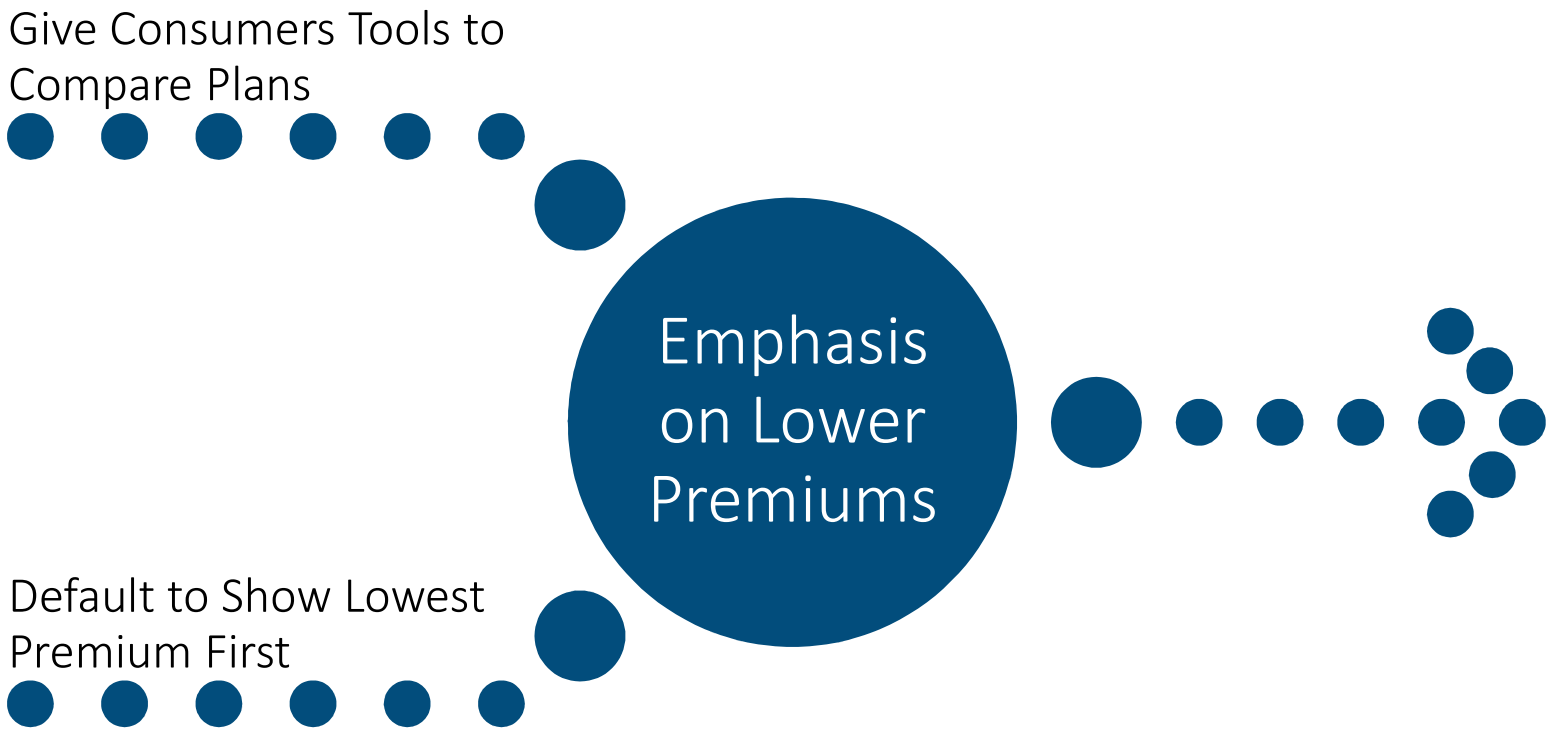
- A new ACA requirement, URRTs are made public
- Wealth of useful information, including:
  - Projected benefit richness
  - Projected transitional reinsurance
  - Projected risk adjustment
  - Enrollment take-up assumptions
  - Enrollment distribution by product and metal level
  - Retention components (split by profit, taxes & fees, and other)
  - Projected CSR receipts

“Shadow” Pricing Review

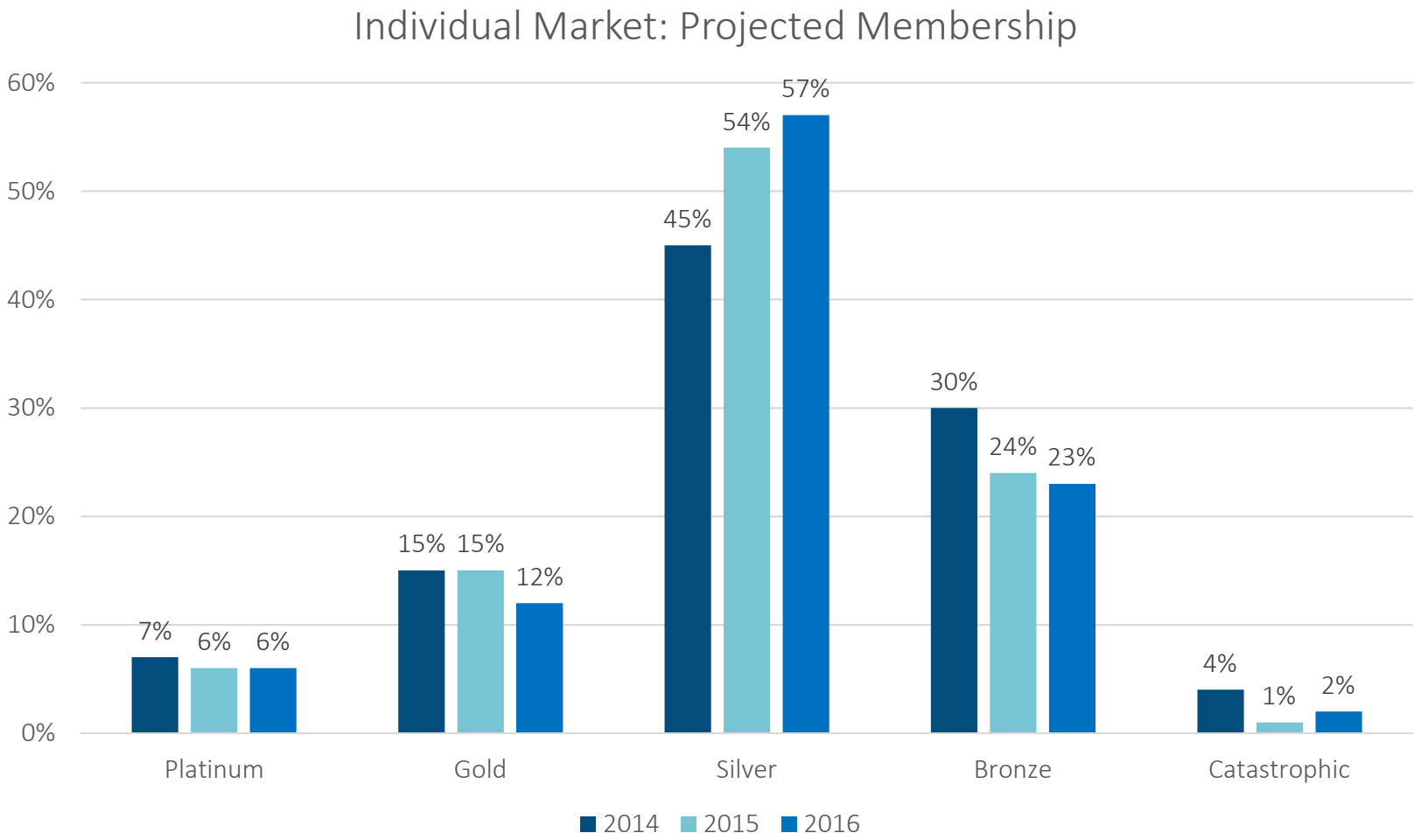
- In some instances, states make filed rates immediately available
  - Issuers filing later can use filed rates and factors as competitive information
  - There is no bonus for filing early!
- In some instances, rates and filings were released by DOIs and issuers were allowed to resubmit rates
  - Competition among rates
  - Ability to review competitor assumptions to revise your own assumptions

Plan Design Strategies In the ACA Marketplace

Hypothesis



Plan Design Strategies
In the ACA Marketplace



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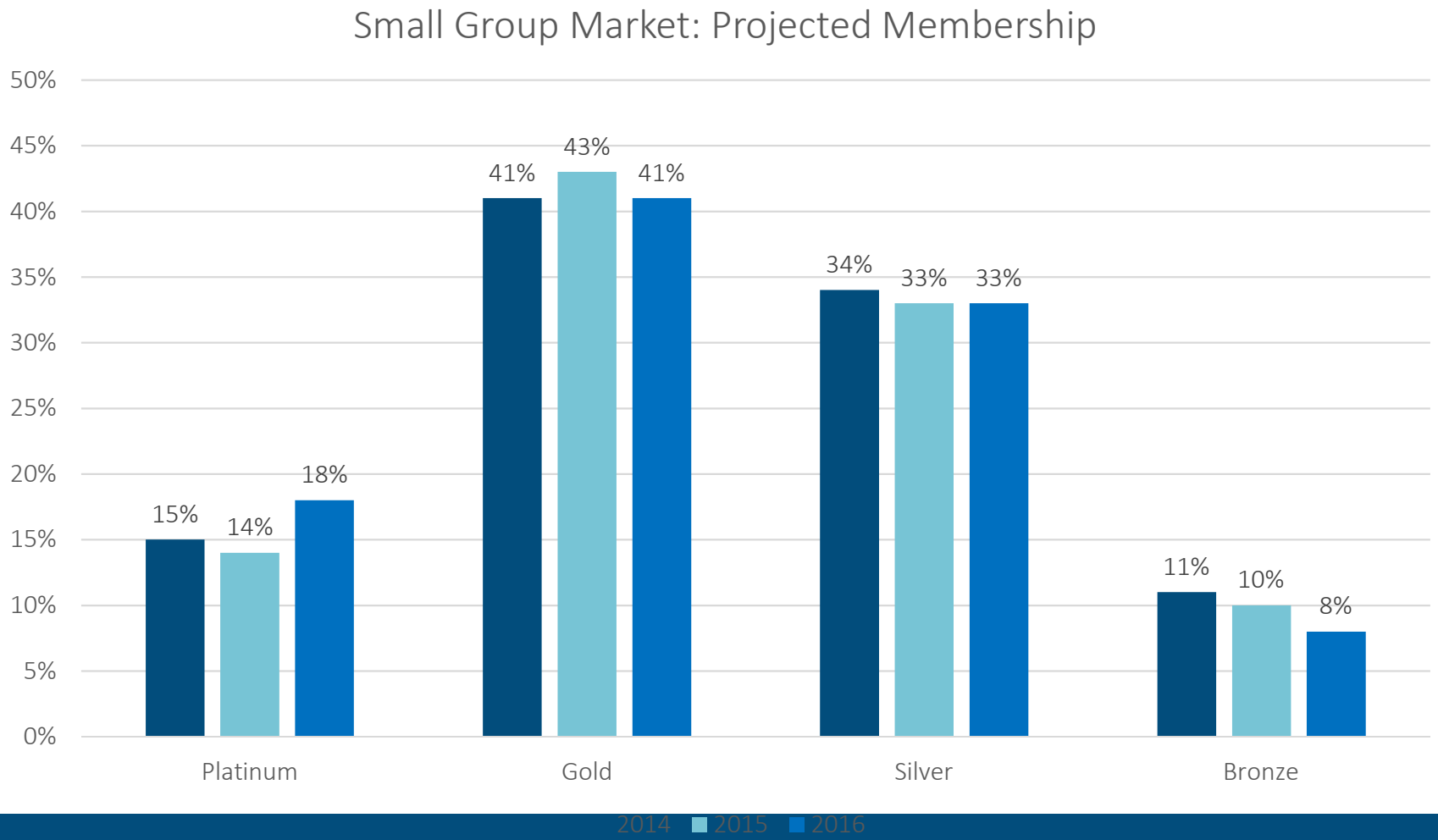

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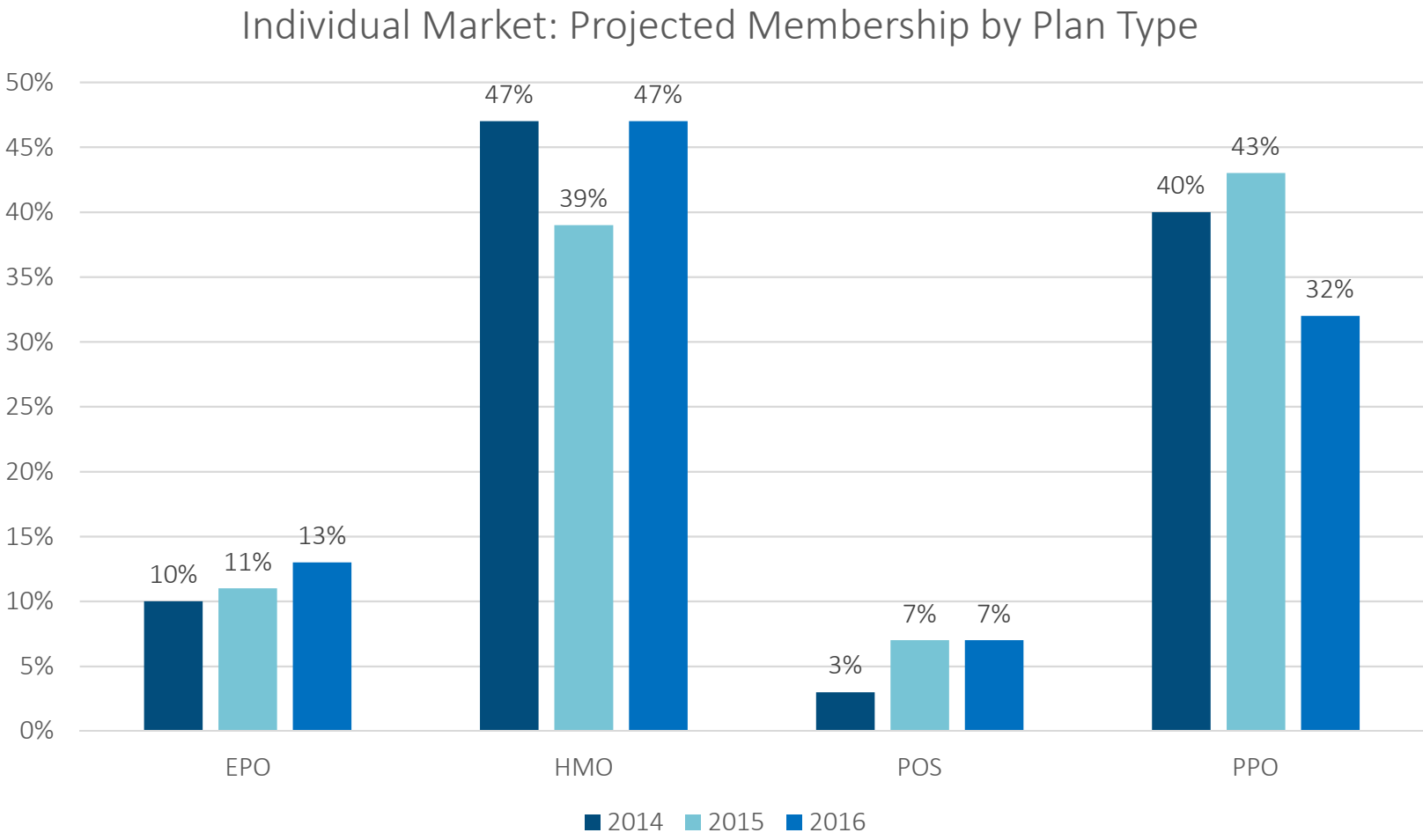

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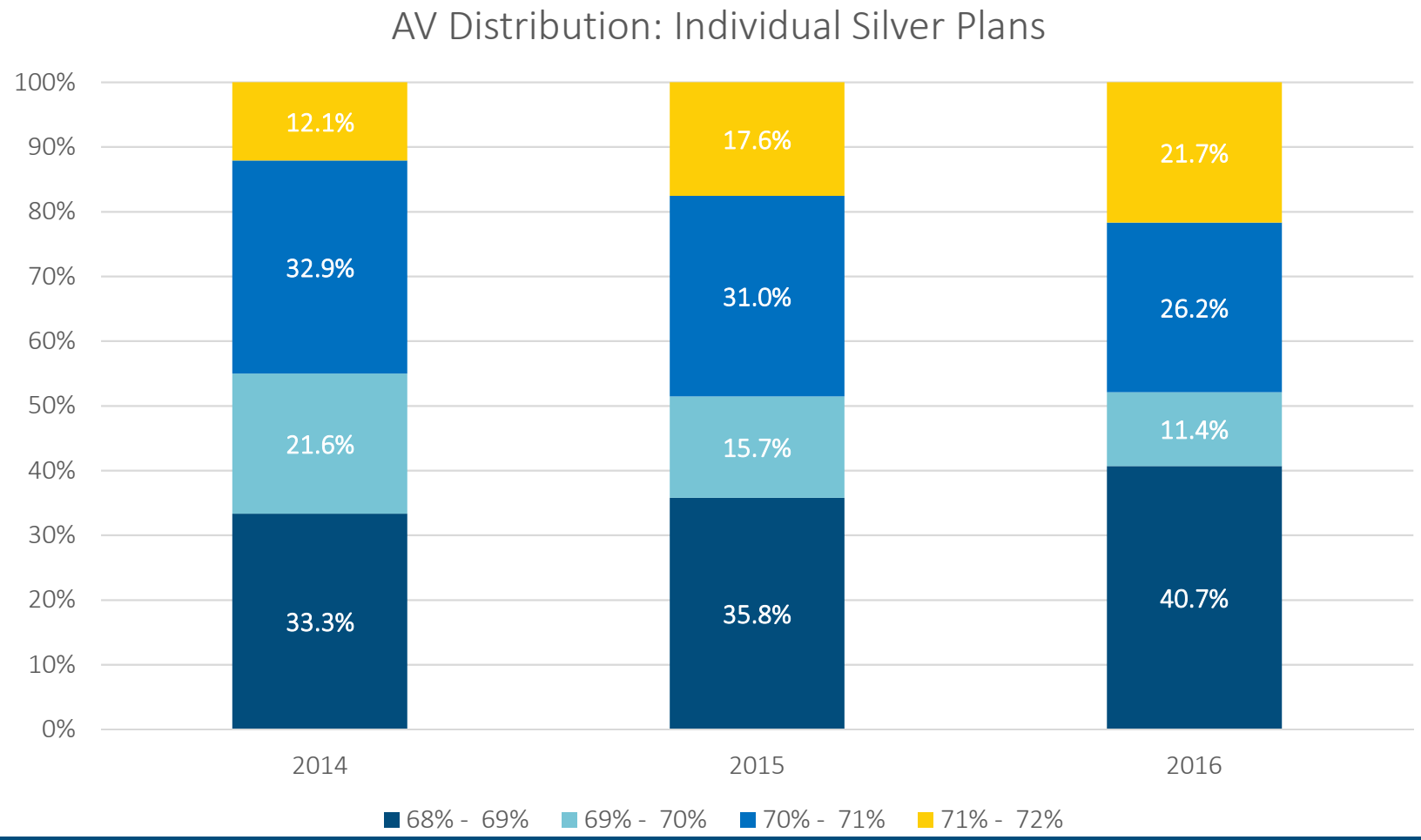

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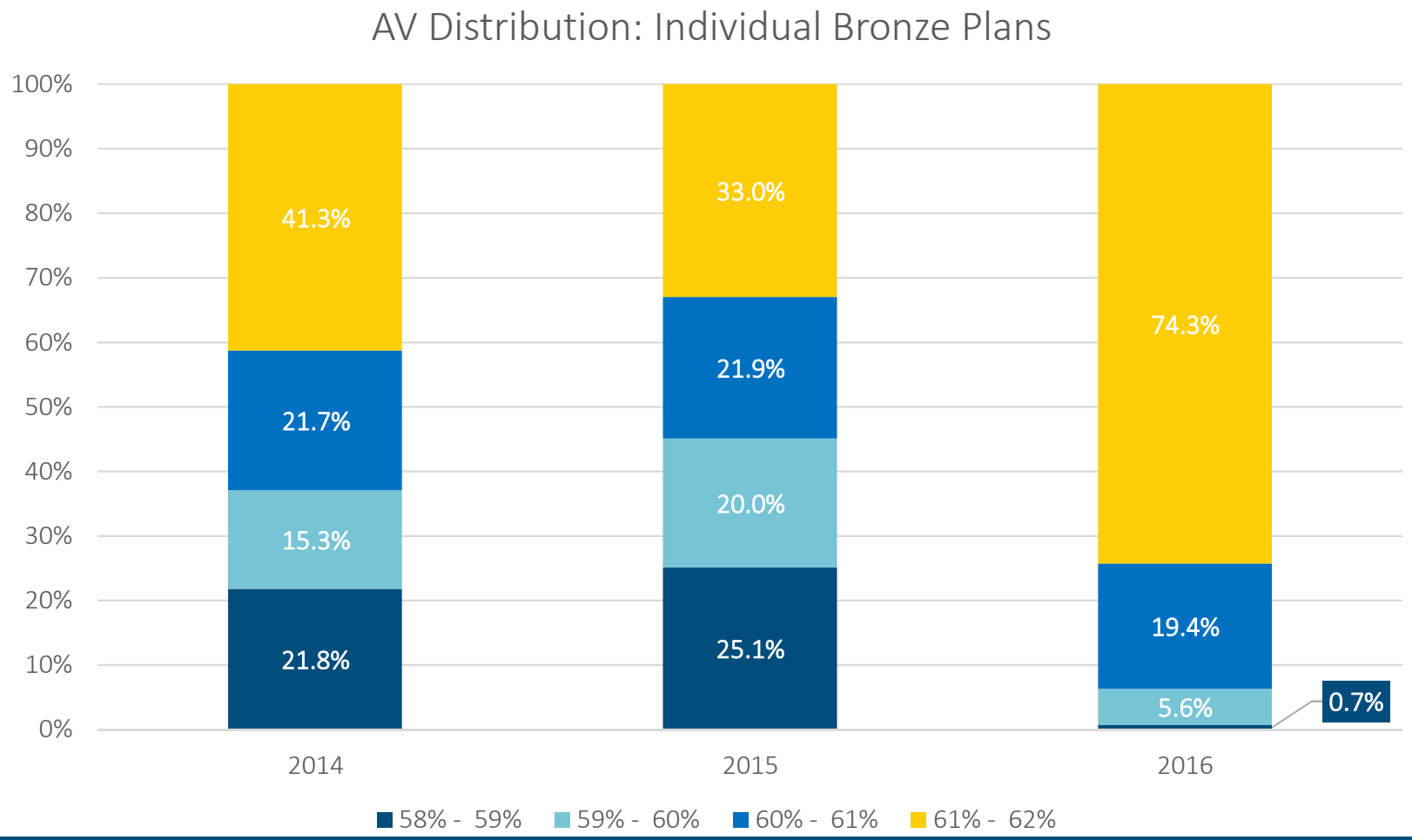

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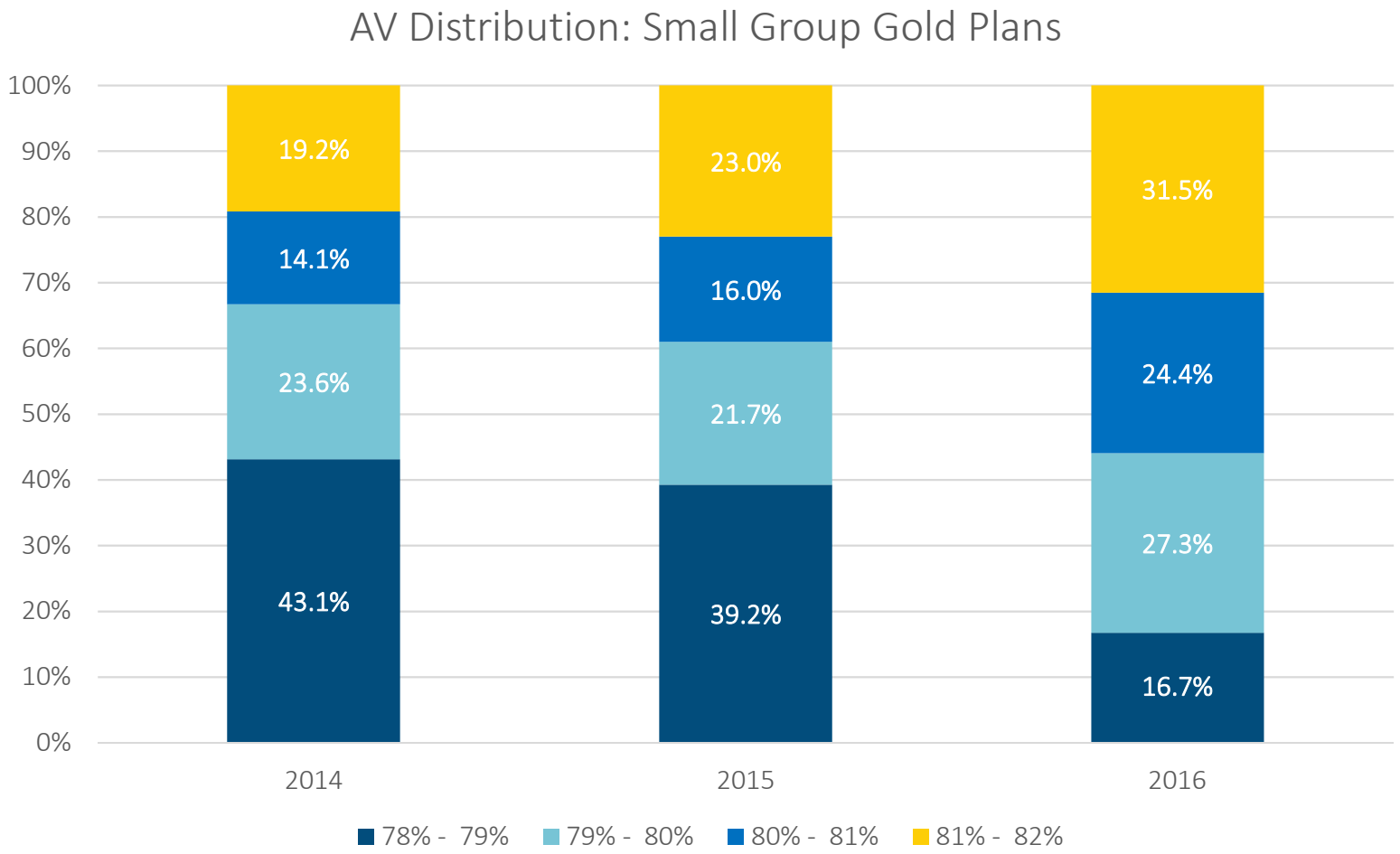

Plan Design Strategies
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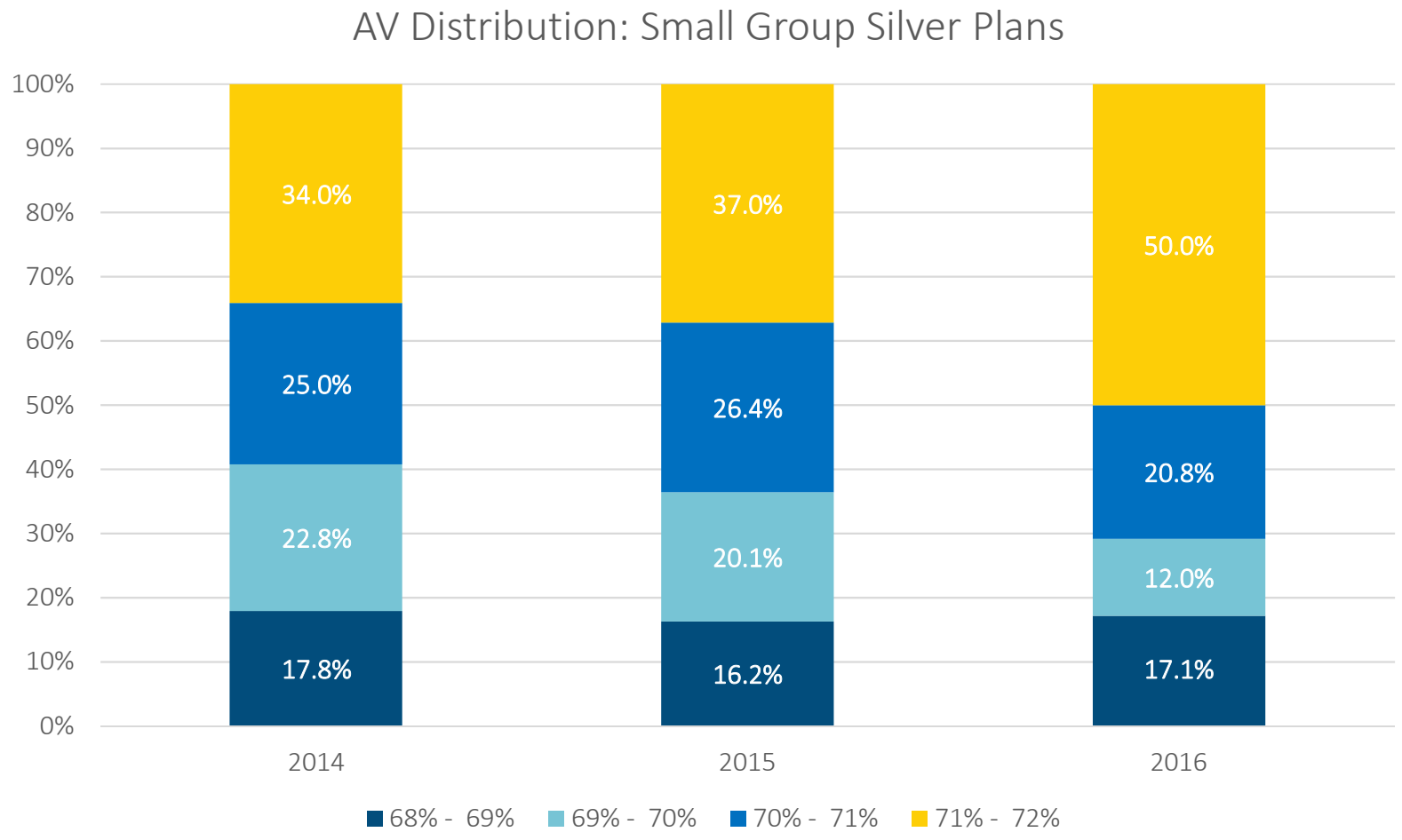


Plan Design Strategies In the ACA Marketplace

- Market membership projections exhibited a preference for
  - Individual
    - Lower-cost plans
    - Health maintenance organization (HMO) plans
    - Plans at the lower-end of the allowable actuarial value range
  - Small Group
    - Higher AV ranges within metallic levels

Modeling utilization

- Do people use more services, or do the services that they use cost more?
- Sources:
  - Your carrier's ACA data
  - Adjusted non-ACA data
  - Outside data

Section 1332 Waivers

- State flexibility.
- Available beginning with 2017 plan year.
- Bigger, faster, stronger!
- Some options:
  - Attachment point reinsurance pools
  - Condition based reinsurance pools
  - Modifications to ACA rating and exchange rules
    - Age curve, single risk pool, metallic levels
  - Modifications to subsidies
    - CSR payments, APTC adjustments

Value Based Designs: Tiered Networks of Providers

- Contracts with select high performing hospitals and provider groups:
  - Centers of excellence
  - Narrow network products
  - Offered in a limited geographic area
  - Brand name recognition (could be tied to provider)
- Consider plan license type (HMO, PPO)
- Closed network: specialists and PCPs, possibly with gain sharing
- Price differential is needed to drive enrollment
- Caution! Link between quality and cost

VBID Benefit Design Features

- Discourage utilization of high cost, low value services

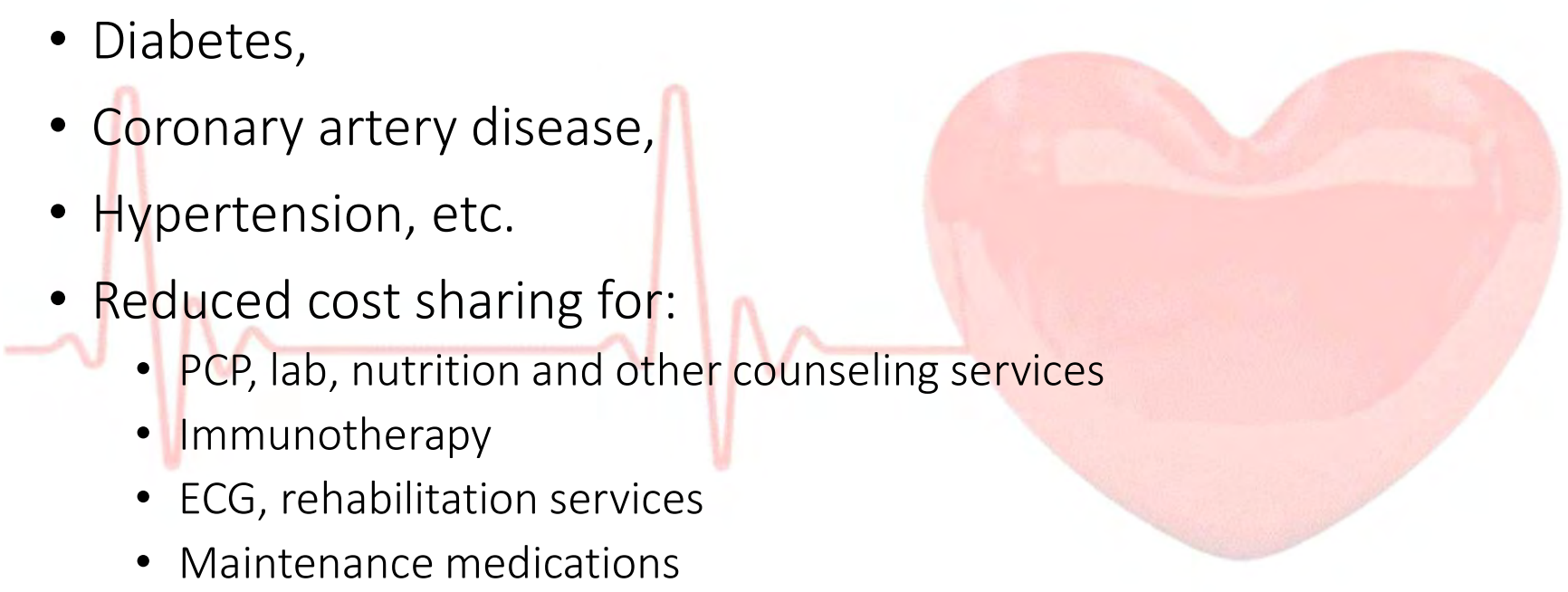
- Encourage utilization of low cost, high value services
- Remove barriers to valuable services

VBID Benefit Design Features: Carrots

- Impact on utilization from member cost sharing
- Reduced or waived cost sharing for specific medications
  - Maintenance medications for chronic conditions
  - Generic vs. brand drugs
  - 7-tier drug formulary
  - Increase adherence through mail order
- Waiving cost sharing for preventive services, routine supplies, maintenance specialist visits
- Telehealth
- Steering to center of excellence:
  - Differential cost sharing between tiers of providers
- Encouraging urgent care utilization vs. ER

Focus on Chronic Conditions

- Asthma and COPD,
- Diabetes,
- Coronary artery disease,
- Hypertension, etc.
- Reduced cost sharing for:
  - PCP, lab, nutrition and other counseling services
  - Immunotherapy
  - ECG, rehabilitation services
  - Maintenance medications
  - Wellness visits



VBID Benefit Design Features: Sticks

- Evidence based
  - Higher cost sharing for high cost/low value services
  - Additional costs for overused procedures such as an MRI or knee surgery
  - Prior authorization
  - Step therapy for drugs
  - Coinsurance for high-cost services like specialty Rx and MRI/CT/PET
  - Prioritize treatment options (e.g., X-ray before MRI)

Wellness Programs

- Reward health engagement
- 24/7 access to health advice
- Web-based support
- Encourage healthy lifestyle
  - Free weight-management, smoking cessation programs
  - Nutrition coaching

MedInsight Health Waste Calculator

- Milliman and VBID Health collaborative tool to identify and reduce wasteful healthcare spending
- Algorithms process data to identify wasteful services, such as:

Service Category	Example
Common treatments	Antibiotics for pink eye
Disease approach	Neuroimaging for simple febrile seizure in child
Diagnostic testing	Emergency room CT scans for dizziness
Monitoring	Annual stress testing after coronary artery revascularization
Screening tests	Pap smears on women under 21

- Provides Milliman benchmark reports
- Defines services with a degree of appropriateness for care

Other Considerations

- Quality improvement but no savings? (Health Affairs, July 2013)
- AV rules still apply – have to comply with AV calculator
- Reflect VBID in product pricing
- How to incorporate VBID into policy forms?
- Claim adjudication
- Cost sharing administration in real time

Basic Health Plans

SOCIETY OF ACTUARIES

Basic Health Plans

- States may offer 1 or more standard health plans to eligible individuals in lieu of coverage through an Exchange
- Only MN and NY have done so
- Requirements:
  - Monthly premium cannot exceed amount required by enrollees in second-lowest cost Silver plan on the individual exchange
  - Cost sharing follows the rules for Silver CSR plans on the Exchange
  - Benefits must cover at least EHBs

Basic Health Plans

- Who is eligible?
  - Income 133 – 200 % FPL
  - Not eligible for Medicaid
  - Not eligible for minimum essential coverage
  - Eligible for ESI that is not providing affordable coverage
  - Under 65 years of age at beginning of plan year

Catastrophic Plans

SOCIETY OF ACTUARIES

Catastrophic Plans

- Intended to give young, healthy potential members an attractive and affordable option
  - Very low take-up
- Also provides an option for lower-income, older members
- What is covered?
  - Deductible equal to maximum allowed OOP Max ($6,350 in 2014/ $6,600 in 2015/ $6,850 in 2016/ $7,150 in 2017 / $73,50 in 2018)
  - No coverage before deductible except for:
    - 3 primary care visits per year
    - Preventive services covered at 100%
  - 100% coverage after deductible
  - Must meet all other requirements for QHPs

Catastrophic Plans

- Who is eligible?
  - Under 30 years of age

    OR
  - Qualify for hardship exemption
- Types of hardship exemptions
  - Affordability Exemption: Lowest bronze plan > 8% of household income (net of subsidies)
  - Examples of Other Hardship Exemptions: Homeless, eviction, victim of domestic violence, death of close family member, bankruptcy, etc..

Group Level Pricing

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Rating and Market Rule Changes

RULES APPLYING TO LARGE SELF-FUNDED EMPLOYERS

Removal of pre-existing conditions

- Applies to individuals of all ages
- Applies to all sized employers, all funding types
- Applies to grandfathered plans

Summary by Employer Size and Funding Type: New Benefit and Coverage Rules

	Employer Impacts	Description	Small Group Fully Insured	Large Group Fully Insured	Self-Funded
1	Essential Health Benefits (EHB)	• Health plans must provide Essential Health Benefits for individual and small group only • If large group fully insured or self –funded provides an essential health benefit all annual and lifetime dollar limits must be removed • Large fully insured plans use situs state as benchmark plan • Self-funded employers may choose a benchmark plan	Yes*	No Lifetime and dollar limits removed for any EHB offered	No Lifetime and dollar limits removed for any EHB offered
2	Out-of-Pocket Maximum (OOPM)	• OOP limits must comply with OOP limits for HSA plans • All cost sharing (including copayments) for EHB services must count toward OOPM	Yes*	Yes*	Yes*
3	Clinical Trials*	• Cover certain routine patients costs incurred in approved clinical trials	Yes*	Yes*	Yes*

* Not required for grandfathered plans

Summary by Employer Size and Funding Type: Benefit and Coverage Rules

Employer Impacts	Description	Small Group Fully Insured	Large Group Fully Insured	Self-Funded
Max 90-day waiting period	• Waiting period before coverage is in place cannot exceed 90 days	Yes	Yes	Yes
FSA Limits	• Employee contributions to health FSAs limited to $2,500 per year (beginning in 2013), with indexed increases allowed in future years to adjust for inflation	Yes	Yes	Yes
Expanded Women's Preventive Services	• Beginning August 2012, women's preventive benefits expanded to include additional screening, prenatal office visits, breast-feeding support and some contraceptives. • Impact Range ~.32% or $1 pmpm	Yes*	Yes*	Yes*

* Not required for grandfathered plans

Summary by Employer Size and Funding Type: Employer Mandate, MEC and Market Changes

Employer Impacts	Description	Small Group Fully Insured	Large Group Fully Insured	Self-Funded
Employer Mandate And Minimum Essential Coverage	• Penalty delayed until 2015 • Employers 50+ (average # of employees definition) must provide full-time employees (and dependents) with minimum essential coverage to avoid paying a shared responsibility payment (i.e., tax penalty) • Individual states by substitute with 100+ • Minimum essential coverage must: – Be affordable (employee contribution must not exceed 9.69% household income – Provide minimum value (employer pays more than 60% of covered plan expenses)	50+ only in 2015; 100+ 2016 (pending political challenges and state)	Yes	Yes
Pre-existing Condition Exclusion (All Ages)	• Beginning in 2014, pre-existing condition exclusions must be removed for all members, not just those under age 19	Yes	Yes	Yes
Guaranteed issue	• Insurers must offer coverage to and accept every employer or individual who applies for coverage - certain exceptions • May restrict enrollment in coverage to special enrollment period 11/5 to 12/15 and to individuals in network area	Yes	Yes	No
Guaranteed renewability	• Insurers must renew at the option of the plan sponsor or the individual - limited exceptions • Exceptions include failure to meet minimum participation or contribution standards	Yes	Yes	No

Taxes and Fees Overview

	Description	Effective Date	Timing / Duration	Payment Cycle	Segment Impact	Basis of Assessment
PCORI Research Fee	• Help fund Patient-Centered Outcomes Research Institute • Will assist patients, clinicians, purchasers and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings	10/1/12	Begins 2012 Phases out 2019	July 31 (calendar year following end of plan year)	FI and ASO (ASO paid and remitted by customer) Groups and Individuals	$2.08 pmpy in 2015 $2.17 pmpy in 2016
Insurer Fee	• Annual fee on health insurance sector, allocated by market share, to fund health insurance exchange subsidies • Fees assessed on net written health insurance premiums, with certain exclusions.	1/1/14	Permanent	No later than September 30 of calendar year	FI Only Groups and Individuals	Industry wide targets $8B – 2014 $11.3B – 2015 $11.3B – 2016 $13.9B – 2017 $14.3B – 2018 ~ 2.5% of premium.
Transitional Reinsurance Fee	• Transitional fees to stabilize individual market; assessed on a per capita basis for both fully insured and ASO members • Fee funds reinsurance for high claimants in non-grandfathered individual market plans, on and off Exchange	1/1/14	3 Years (2014-2016)	Annual basis for state and federal ASO paid & remitted by customer	FI and ASO Groups and Individuals	Industry-wide federal targets, to which states may add: $12B – 2014 ($5.25 PMPM) $8B – 2015 ($3.67 PMPM) $5B – 2016 ($2.25 PMPM)

Taxes and Fees Overview

	Description	Effective Date	Timing / Duration	Payment Cycle	Segment Impact	Basis of Assessment
Risk Adjustment Fee	• Administrative expenses for the risk adjustment program will be supported by a user fee, estimated to be no more than $1.00 per enrollee per year • This user fee will be collected from issuers of risk adjusted plans in June of the year following the benefit year	1/1/14	Permanent	June (calendar year following end of plan year)	Individual and small group plans in and out of Exchange	Zero sum redistribution of premiums from plans with healthier populations to plans with unhealthier populations Administrative costs is ~$1 pmpy in year 1
Excise Tax on High Cost Coverage (Cadillac Tax)	• Imposes an excise tax on insurers and employers who offer rich benefit coverage. • Some guidance released on types of coverage counted	1/1/20	Permanent	TBD	All small groups and large groups, both fully insured and self-insured	40% of value of employer-sponsored coverage exceeding $10,200 individual/$27,500 family; indexed by cost of living

Cadillac Tax Overview

- Tax on high cost coverage through employers beginning in 2020
- Proposed for 2018: 40% tax on costs above $10,200 for single coverage and $27,500 for non-single coverage
  - Indexed to CPI + 1% in subsequent years
  - Higher thresholds for “high risk” occupations (law enforcement, paramedics, etc.)
- Plan cost includes HSA, FSA, etc.

Cadillac Tax Considerations

- Uses cost as proxy for richness
  - Doesn't differentiate if high cost is due to rich benefits or high underlying costs (except high risk professions)
  - Industry groups have proposed changes on these grounds
- Could limit or alter frequency of HSA contributions
- If medical trend exceeds CPI, minimum value and Cadillac tax levels eventually converge

Minimum Values
Actuarial Values

SOCIETY OF ACTUARIES

MV / AV
Objective: Designing Plans

- Minimum Value Calculator: greater than 60% in large group and ASO market
  - Safe harbor provided
- Actuarial Value Calculator: Small group and individual Non-grandfathered products must meet actuarial value corridors of the four metal levels (the targets are 90%, 80%, 70% and 60% but +2 /- 4% wiggle room):
  - Platinum (86-92%)
  - Gold (76-82%)
  - Silver (66-72%)
  - Bronze (56-65%)
  - Cost sharing reductions products in individual market must meet +/-1% corridor around target
  - AV calculator corridor constraints do not apply to catastrophic designs, but...

MV / AV
Objective: Designing Plans

What the tool can account for (debatably)

- Induced demand differences between metal levels (tools' focus is plan share)
- HRA and HSA contributions from employer
- Tiered networks
- Up to four tier pharmacy designs
- "X-visits-for-free" designs
- Primary care versus specialist co-pay
- Out-of-network design features (by not handling for materiality reasons, or through tiering ability of material)

MV / AV
Key Warnings

- Not a pricing tool: Doesn't account for carrier-specific utilization or unit cost metrics
- Always use most recent tool, past tools had numerous bugs
- Calculator can only do one plan at a time
- Plans that meet requirements one year might not the next, due to updated data and fixed cost sharing leveraging

Let’s Use The Calculators...

unless you are already comfortable enough as a group

MV / AV Practice Note

Final Practice Note on Minimum Value and Actuarial Value Determinations Under the Affordable Care Act:
http://www.actuary.org/files/MVPN_042314.pdf

(Academy of Actuaries)

- Provides Certification Language to include
- Provides discussion on Qualifications requirements
- Provides Two Illustrative Examples
- Material Effect Clause...
- Data Hierarchy
- What to Include in Report

Determining Minimum Value and Actuarial Value under the Affordable Care Act:
http://www.actuarialstandardsboard.org/wp-content/uploads/2015/10/asop050_181.pdf

(Actuarial Standards Board)

- Provides definitions of key terms (Actuarial Value, Essential Health Benefits, etc.)
- Analysis of issues and recommended practices
- Guidance on communications and disclosures

MV / AV
Embedded versus Non-embedded

- Benefit designs on exchange that seem equivalent when viewed as single coverage may be materially different when compared from the perspective of family coverage
- Embedded structure: there is a lower deductible for one individual within the family to meet, with no requirement for that one person to absorb the entire family deductible
- For AV/MV, wide berth on creating the family plan design's multiplier.
    - The family multiplier is something that is material enough to be included in insurer's pricing tools but HHS did not have the data it needed to value the family multiplier design element
- A solution may have been family multiplier standardization
- May create a competitive scenario for a given plan that changes when viewing single versus family contracts
        - Design attractiveness
        - Pricing
        - Risk adjustment

MV / AV
Embedded versus Non-embedded

- Alternative guidance for valuing “non-embedded” structures
  - Very common in plans compatible with HSAs
- Under guidance from HHS, actuaries are not allowed to simply rely on the single metal level valuation with non-embedded structure
  - Special actuarial adjustments are needed
- Wide range of legitimate data sources, methods, assumptions
  - Resulting in wide range of family designs at each metal level

MV / AV
Embedded versus Non-embedded

- Because *embedded* structures could use any family multiplier, only need "non-embedded versus embedded" adjustment?
  - Work to value family multiplier skipped
  - Visible through higher deductibles than competition

MV / AV
Embedded vs. Non-embedded

- In valuing the family multiplier for non-embedded plans, did the actuary build a family continuance table based upon HHS' AV and MV tools' source data?
  - Members, or hypothetical adults/children?
  - Distribution of family sizes and compositions? Or, expected "member-to-contract ratio"
  - Was experiential data or existing pricing tool adjustments used? If so , was calibration performed?

MV / AV
Embedded vs. Non-embedded

- Express family level and non-embedded as one aggregate adjustment factor?
  - If not, consistency between data sources, methods, and assumptions?
- Monte Carlo simulation to more easily model the difference between embedded versus non-embedded structures
  - Consistent with HHS' average member costs?
  - Distributions of family sizes and compositions?
  - Members, or adults and children?
- Reviewing previous designs' outcomes
  - Difficult since a myriad of embedded and non-embedded design parameter combinations exist.

MV / AV
Embedded vs. Non-embedded

- Should single and family each meet the +/-2% corridor, or in aggregate?
- Weighting between single versus family
  - Past experience in the specific product
  - Past experience of the entire risk pool
  - Predicted compositions
  - Hypothetical estimate of HHS' data source

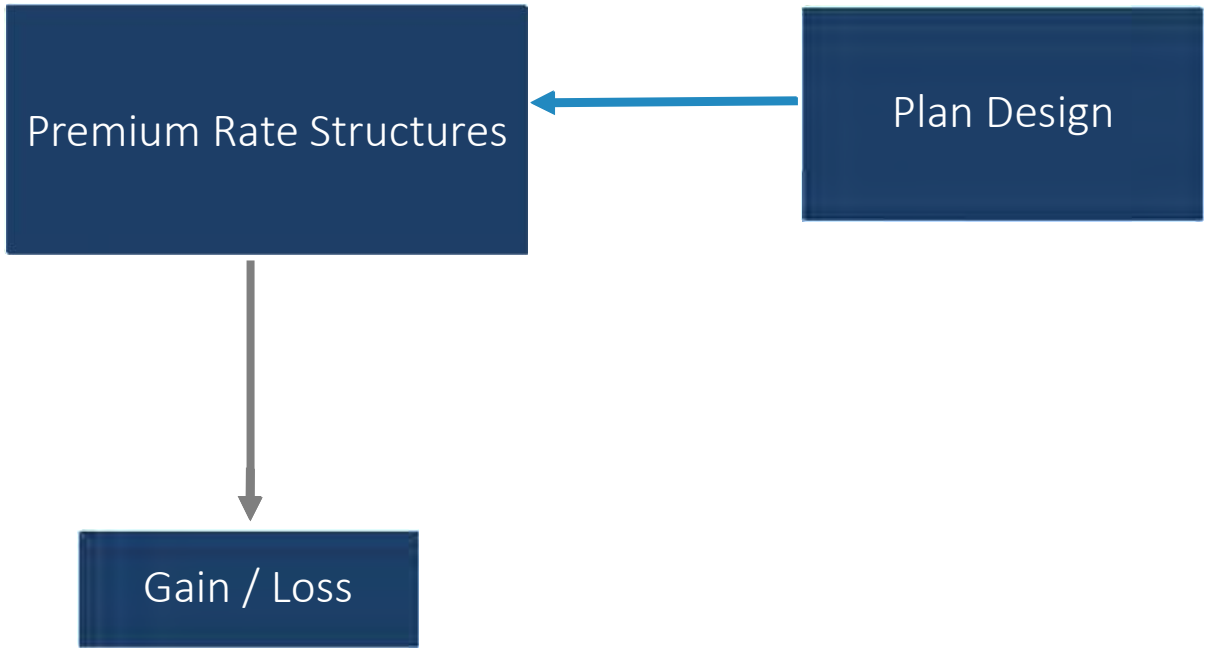
3 Rs – Overview

einsurance

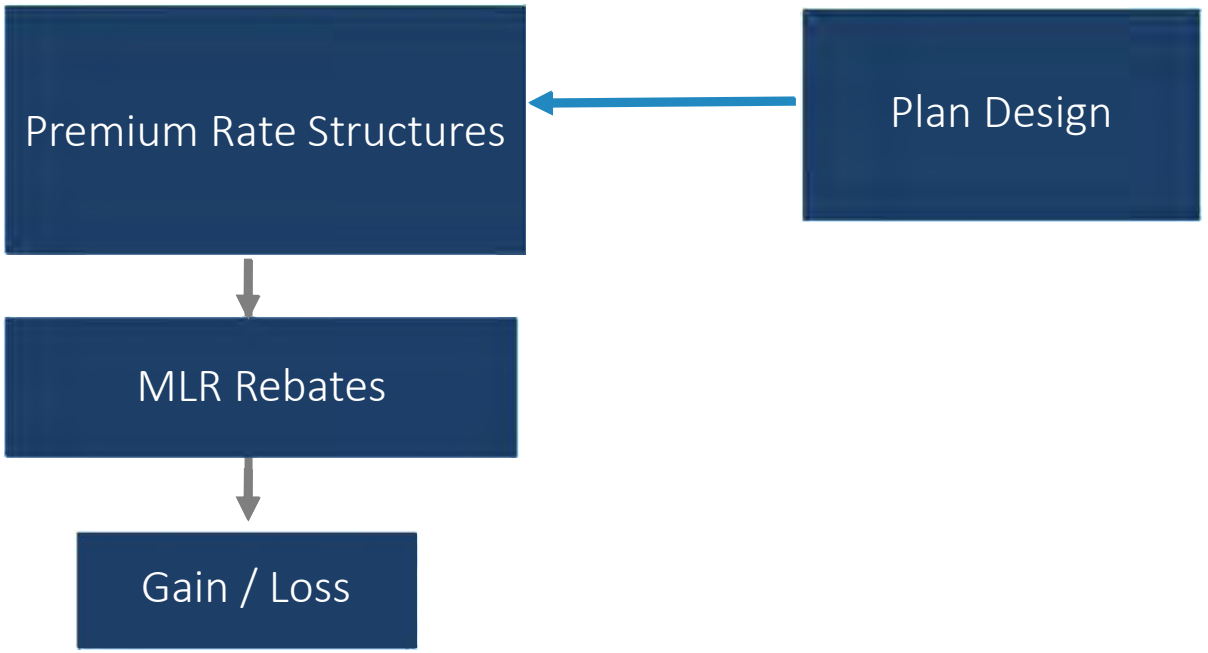
isk Corridors

isk Adjustment

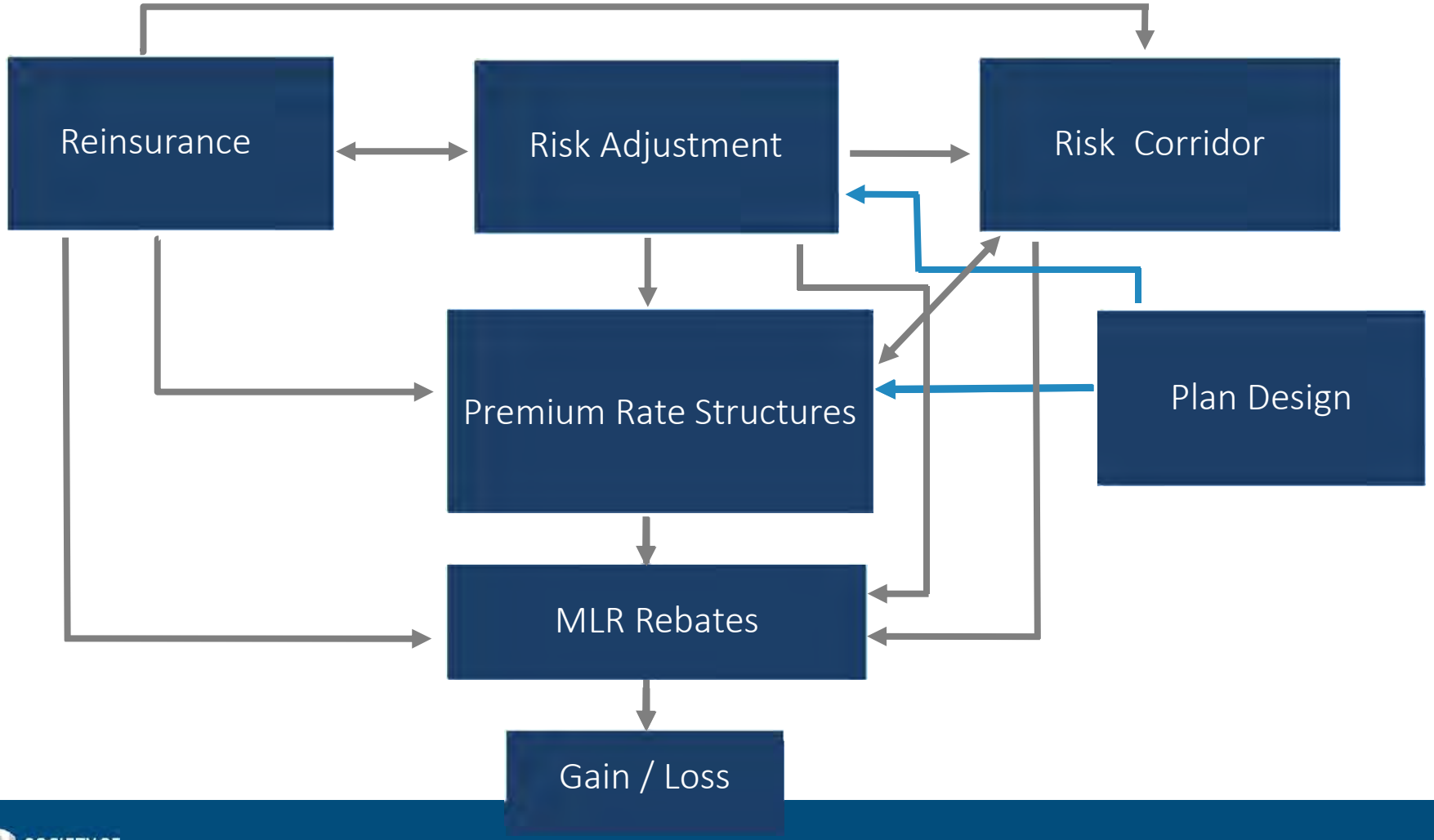
Evolution of ACA Provisions
Pre-ACA



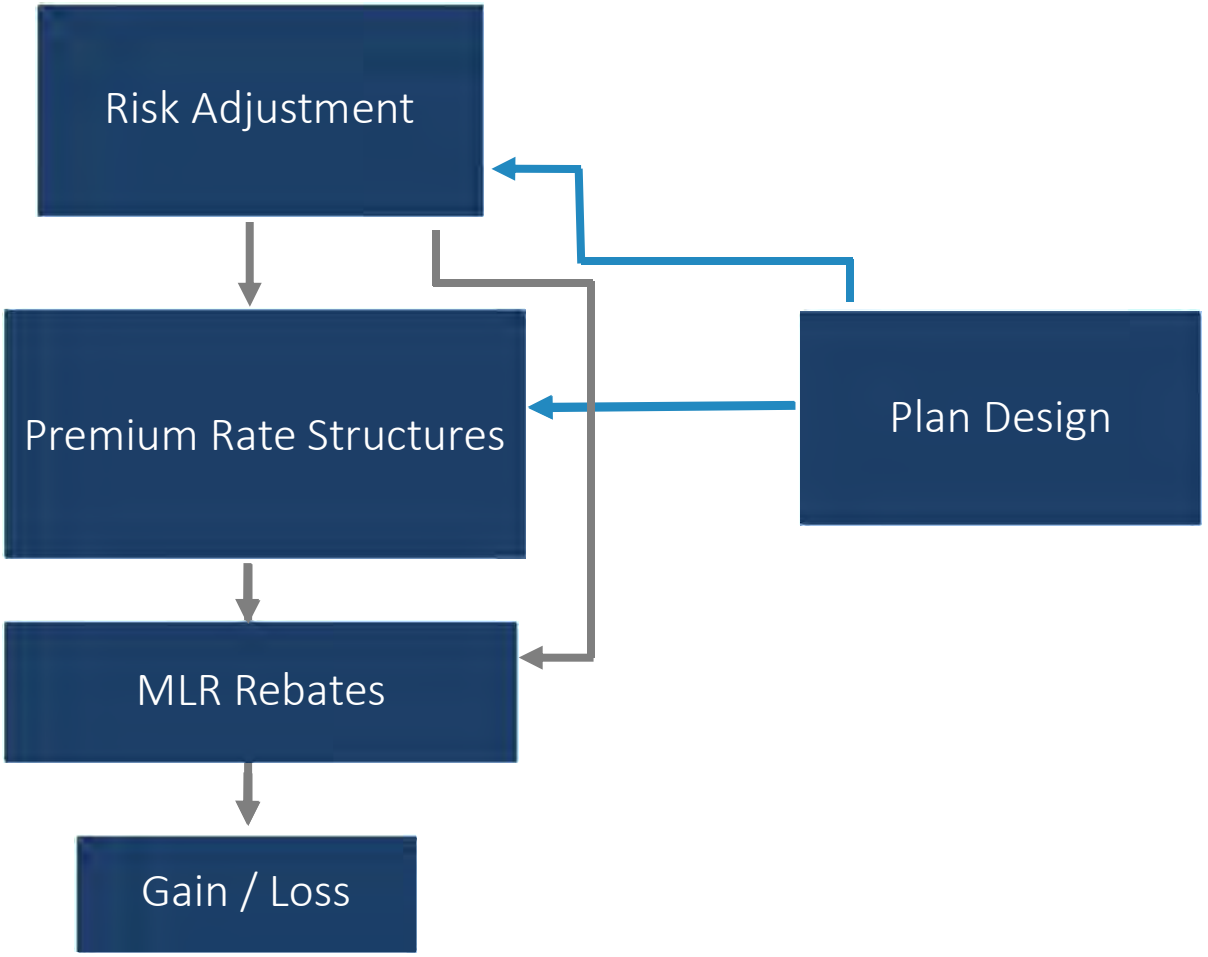
Evolution of ACA Provisions 2012-2013



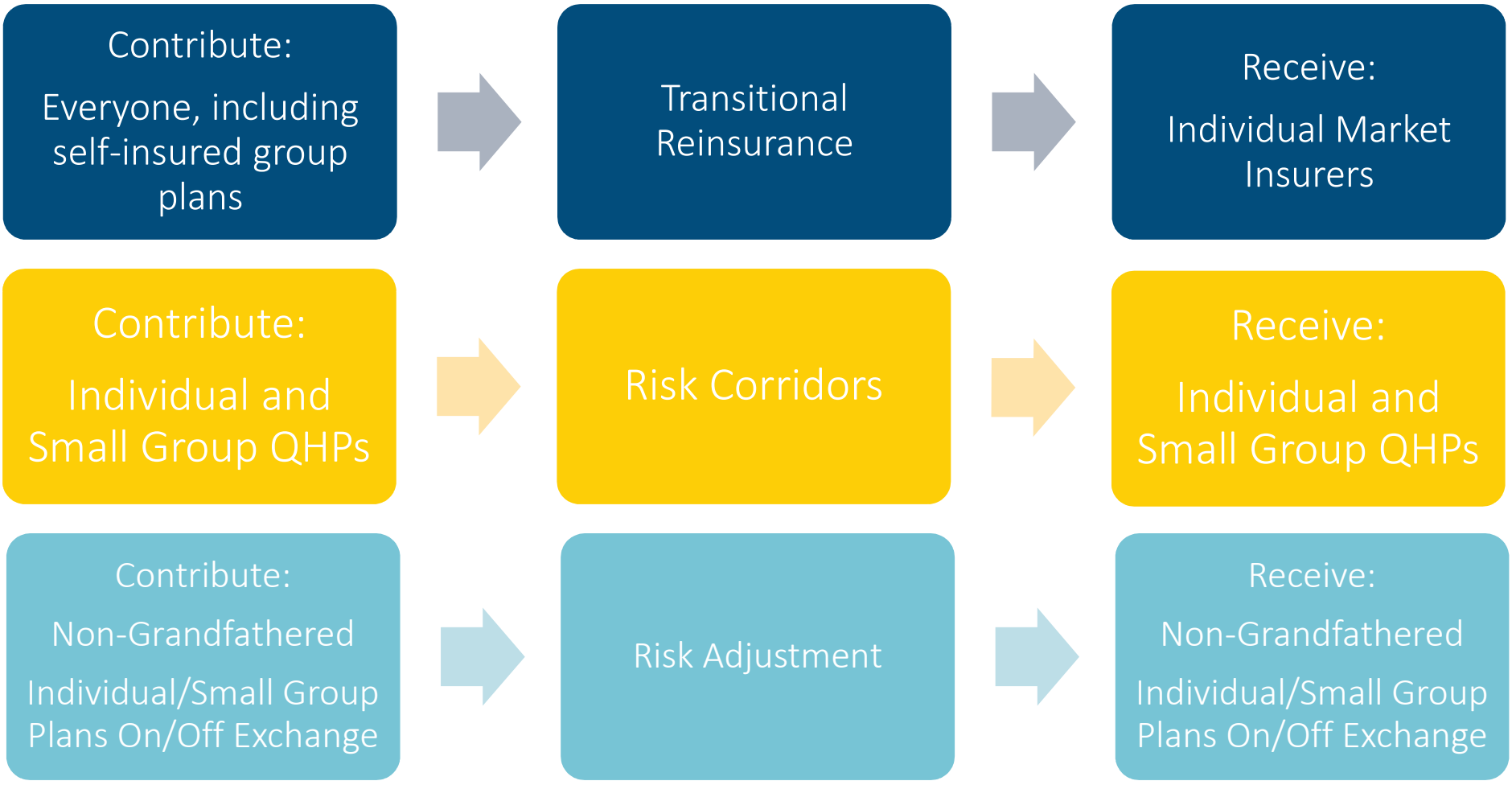
Evolution of ACA Provisions 2014-2016



Evolution of ACA Provisions 2017+



3Rs – Who does each "R" apply to?



3 Rs – Transitional Reinsurance: Implications of the Phase Out

- Recall:
  - Plans have less responsibility for claims in the $45k-250k threshold in 2014, $45K-250k in 2015, and $90-250k in 2016
  - Under current law, transitional reinsurance program ends after 2016 benefit year. Payments for 2016 will be made in 2017.

Individual Market Issuers

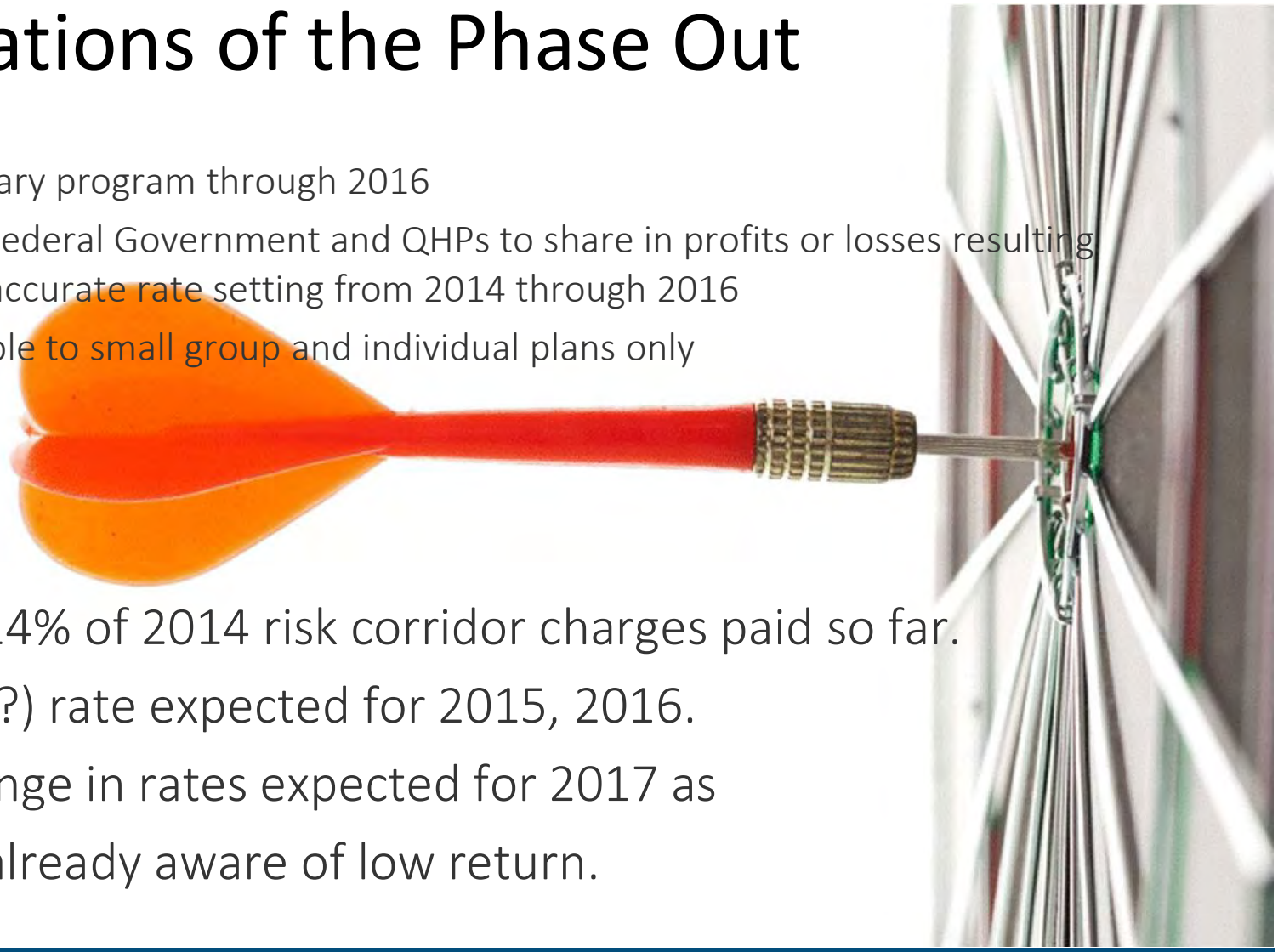
- Reinsurance recovery payments so far have been increased and accelerated
- For 2017 benefit year, however, additional commercial reinsurance will create upward pressure on rates

Small and Large Group Market Issuers

- These issuers have helped fund the program.
- Starting in 2017, no longer making reinsurance contributions. This could results in some downward pressure on rates

3 Rs – Risk Corridors: Implications of the Phase Out

- Recall:
  - Temporary program through 2016
  - Allows Federal Government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 through 2016
  - Applicable to small group and individual plans only



- Only 13-14% of 2014 risk corridor charges paid so far. Low (zero?) rate expected for 2015, 2016.
- Little change in rates expected for 2017 as insurers already aware of low return.

3 Rs – Risk Adjustment: Overview

- Goal: Normalize the impact of differences in health status among carriers within a market
  - Transfers funds from plans with lower risk members to plans with higher risk members
  - Unlike the other programs, Risk Adjustment is permanent
- Affects all non-grandfathered individual and small group products, on and off the exchange

3 Rs – Risk Adjustment: Formula

Premium Factor with Risk Adjustment:		Premium Factor without Risk Adjustment:		Factor for Transfer Payment
RS x IDF x GCF / Market Average of Above	−	AV x ARF x IDF x GCF / Market Average of Above	=	

ARF: Allowable Rating Factor

HHS factors for variation by age

AV: Actuarial Value

Benefit richness adjustment

RS: Risk Score

Includes age, gender, and health status

IDF: Induced Demand Factor

HHS factor to adjust for increased utilization from more rich benefits

GCF: Geographical Cost Factor

Factor to adjust for cost of care variations between regions within a market

3 Rs – Risk Adjustment: Overview

- Risk scores developed from carrier claims data will be compared to market average risk scores to determine payments
- What risk adjuster model will be used?
  - Most states: Federal HCC risk adjuster
  - Model has been released in detail
  - Concurrent Model
- Risk scores are based on demographics, diagnoses, and other data such as CPT codes – but NOT prescription drugs.

3 Rs – Risk Adjustment

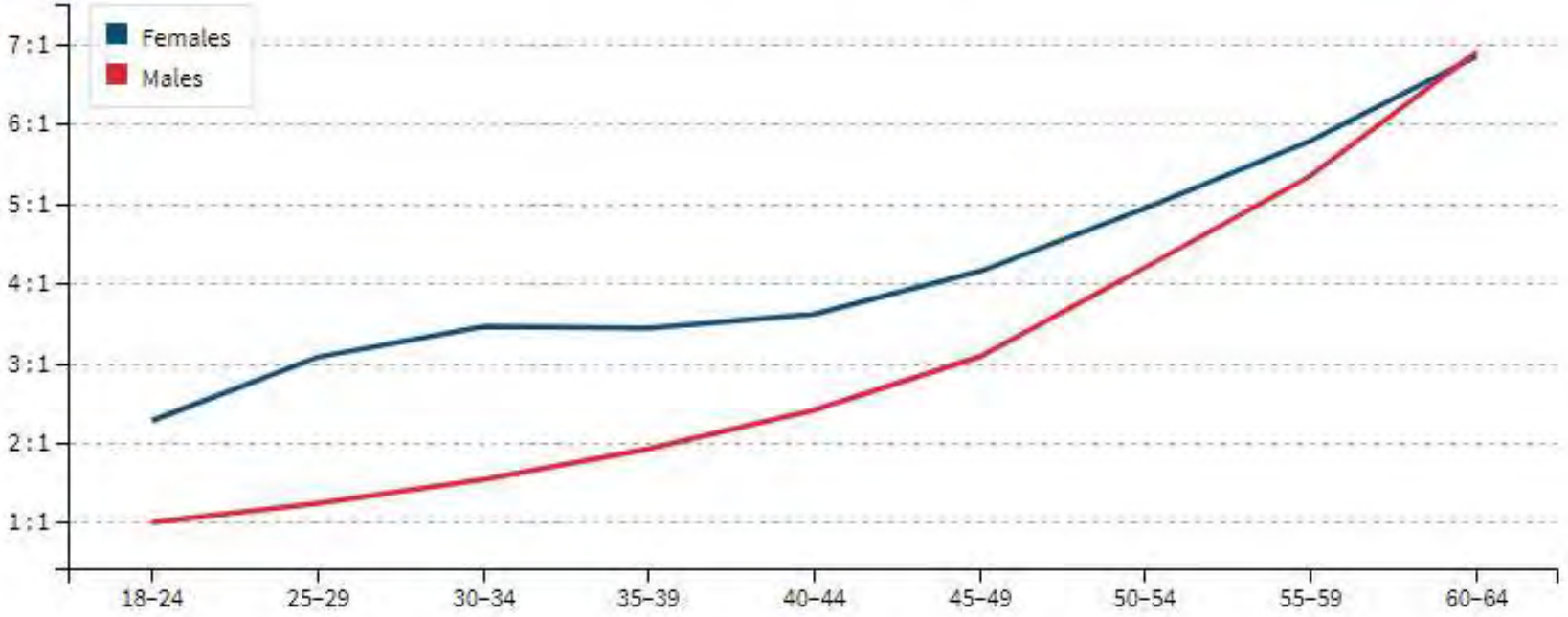
19 %

9 %

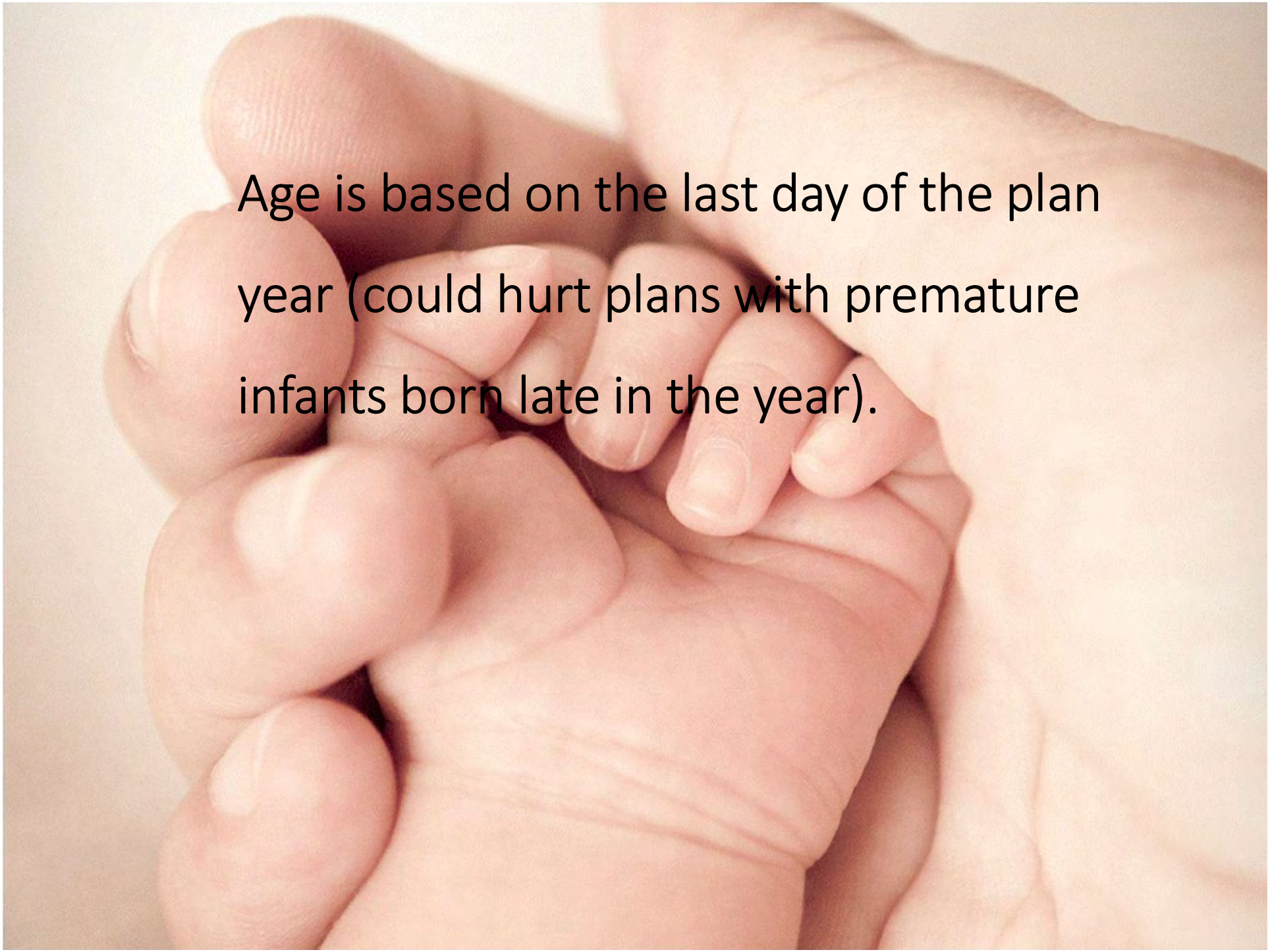
45 %

Age/gender: actual vs. allowed

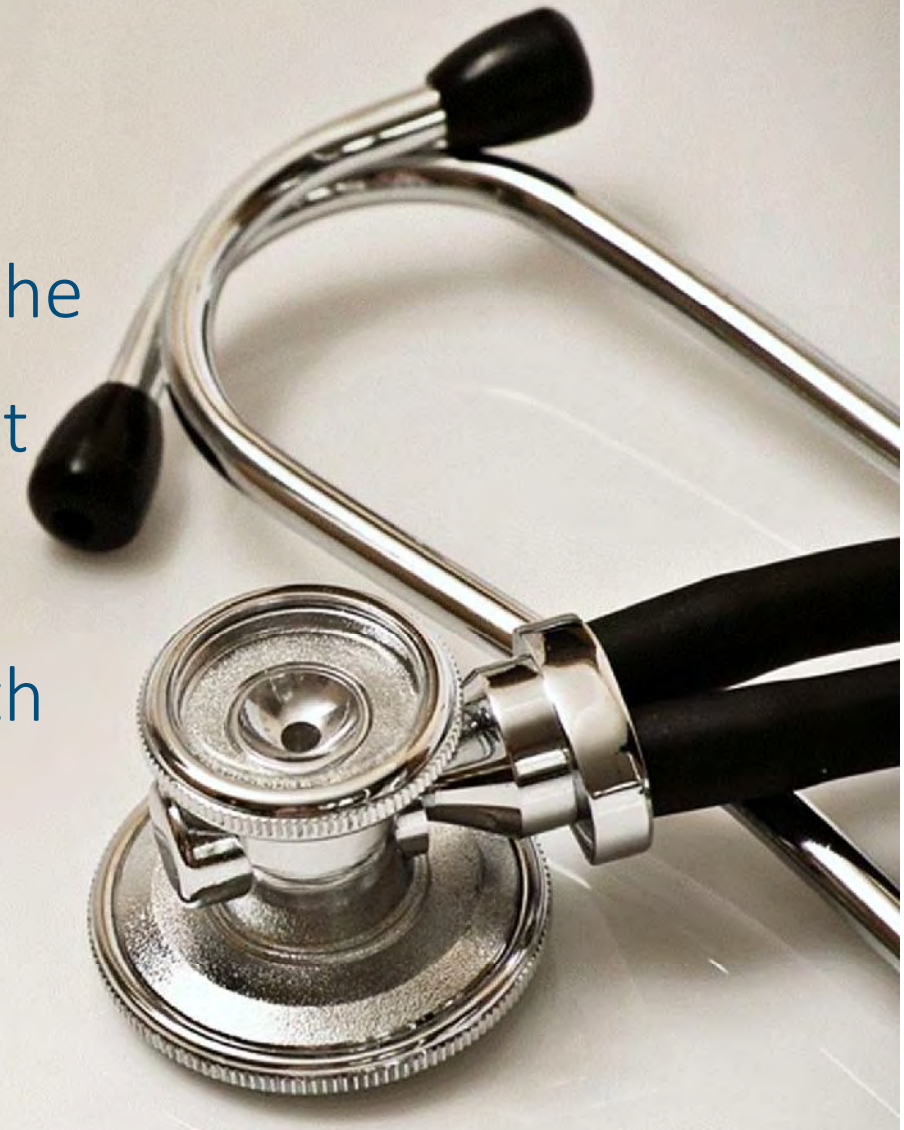
Figure 2: Allowed Claim Cost Relativities by Age/Gender, Commercially Insured Adults



Source: Milliman 2017 Health Cost Guidelines—Commercial


Age is based on the last day of the plan year (could hurt plans with premature infants born late in the year).

For some chronic conditions, the score of the condition (without complications) is the same as the score of the condition (with complications).



No conditions related to injuries (wounds, fractures, sprains, trauma) even though the RA is concurrent and these conditions can be costly.

Smoking is not considered at all

Incomplete data are a major problem

You do not get the payment transfers for up to 18 months after the claim occurs

Risk Adjustment: Profitability and Financial Reporting

- Profitable members were once low-cost members, now may be risky members incurring claims
- Reserving for risk adjustment payments
  - May have significant impact on MLR and profitability
  - Must know carrier risk score as well as market risk score
  - Risk scores may be volatile from year-to-year for the carrier and the market
- Risk Adjustment is not settled until June of the following year, payments in August
  - Well after Supplemental Exhibit and annual statement are due
  - May wait over 18 months after paying claims for a high risk member

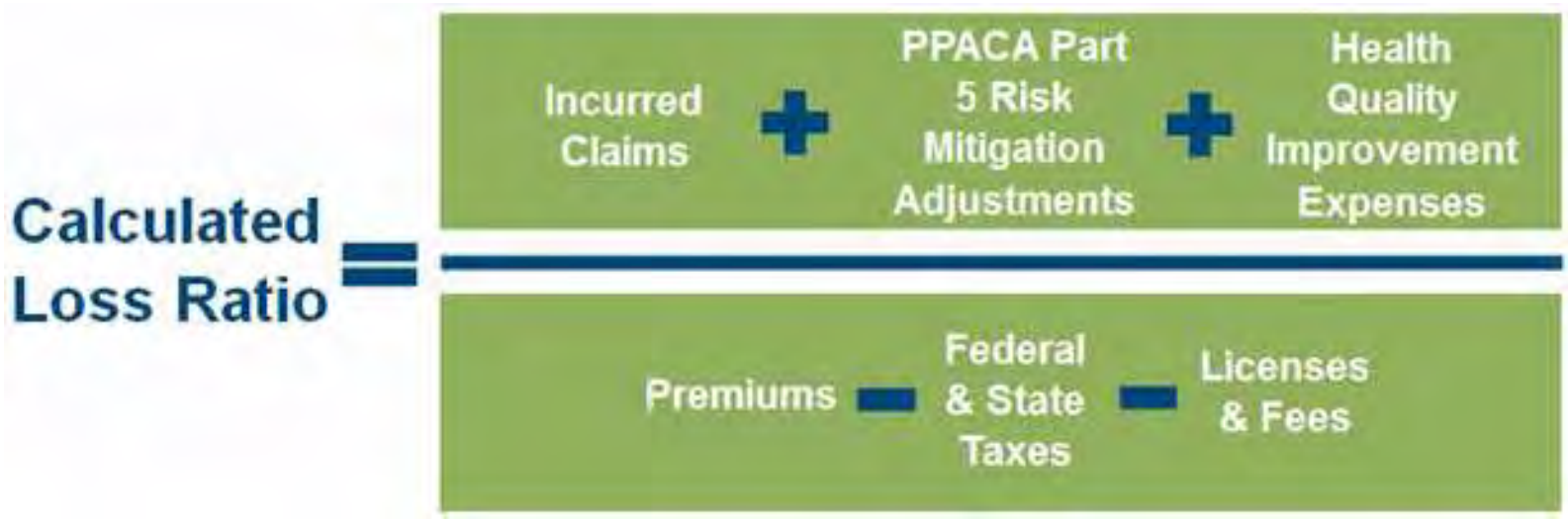
Risk Adjustment: Optimizing Risk Scores

- Effort to trigger as many conditions as possible
  - Many conditions are underdiagnosed
  - Important to reach out to members which may have conditions
    - This strategy is already prevalent with Medicare risk adjustment
    - Past claims history can be used to determine patterns in claims that may trigger risk adjuster conditions
- Follow-up/checkup procedures could trigger conditions in multiple years
- Urge accurate coding by physicians

Risk Adjustment: Ch-ch-ch-changes

- 2017 plan year:
  - Partial year enrollment
- 2018 plan year:
  - (Some) prescription drug utilization
  - High-cost risk pool (60% of costs beyond $1 million)
  - 14% administrative adjustment to statewide premium
- 2019 plan year:
  - EDGE data calibration

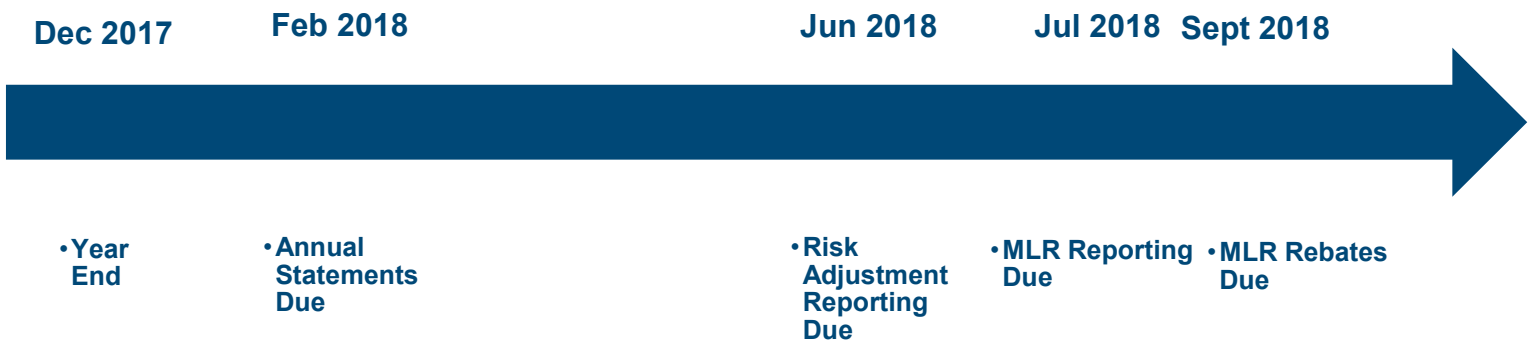
MLR: Overview



- Large group: 85% requirement
- Small group and individual: 80% requirement

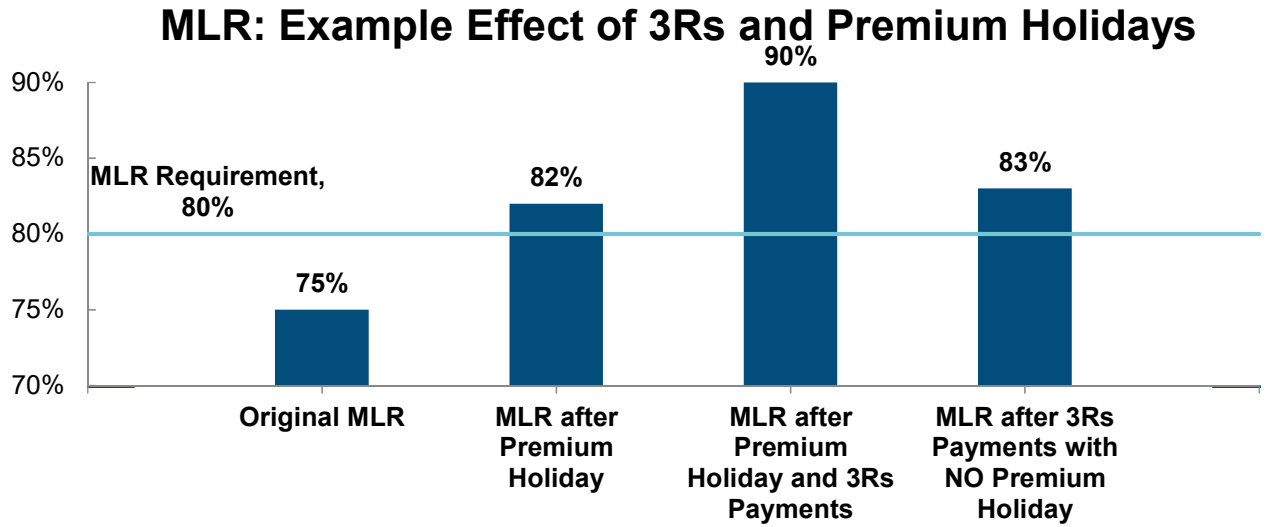
MLR: Timing of 3 Rs

- 3 Rs payments won't be settled until after the year ends
- Risk adjustment reporting due June of the following year
- Insurers had to file MLR reports to the Secretary by July 31st beginning with the 2014 MLR reporting year
- The new MLR rebate due date of September 30th
- In practice, many of these deadlines were delayed in year one



MLR: Avoiding MLR Rebates

- Past strategy: Premium holidays
  - Avoids rebates by not charging premium
  - Unwise to implement without knowing Risk Adjustment scores



- Increasing allowable expenses to maximize Risk Corridor payments increases risk of paying rebates

Risk Adjustment: Example 1

- Factor: 1.24 – 1.33 = -0.09
- Market Average Premium: $4,200 *per year*
- Transfer: -$378 *per member per year*
  - Carrier must pay $378 per member per year into the risk adjustment pool

Risk Adjustment: Example 2

- Consider the following example:

Measure	Factor
Risk Score	0.93
Induced Demand Factor	1.05
Geographic Cost Factor	1.02
Actuarial Value Adjustment	0.70
Allowable Rating Factor Adj.	1.30
Mkt. Avg. Premium Adj.	1.00
Mkt. Avg. Premium w/o Adj.	1.02
Market Average Premium	$350 PMPM
Issuer membership	250,000 member months

- What is the expected risk adjustment payment or receipt?

Risk Adjustment: Example 2

Premium Factor with Risk Adjustment:

$$\frac{(RS \times IDF \times GCF)}{\text{Market Average}}$$

$$\frac{0.93 * 1.05 * 1.02}{1.00}$$

=

Premium Factor without Risk Adjustment:

$$\frac{(AV \times ARF \times IDF \times GCF)}{\text{Market Average}}$$

$$\frac{0.70 * 1.30 * 1.05 * 1.02}{1.02}$$

=

Relative Adjustment Factor

0.99603 – 0.95550 = 0.04053

Risk Adjustment: Example 2

- Factor: 0.99603 – 0.95550 = 0.04053
- Market Avg Premium: $350 PMPM
- Transfer PMPM: 0.04053 * $350 = $14.19 PMPM
  - *Carrier receives **$14.19 PMPM** from risk adjustment pool*
- Total Payment: $14.19 PMPM * 250,000 = $3.5 M

3 Rs and MLR Rebates: Example

- Example:
  - Individual Market
  - Raw Loss Ratio (Claims / Premiums): 88%
  - Transitional Reinsurance: Receipts of 12% of premiums
  - Risk Adjustment: Payment of 5% of premiums
  - Risk Corridors: Receipt of 3% of premiums
- What is the MLR Rebate, if any?

3 Rs and MLR Rebates

- At each step, the 3 Rs affect the Loss Ratio and MLR Rebate

Financial Gain/(Loss) of Actual 3R Results Relative to Accrued Amounts

as of December 31, 2014 (millions)

3R Program	Accrued Amounts	Actual Results	Gain/(Loss)
Risk Adjustment	$230.2	$0	($230.2)
Reinsurance	$6,873.0	$7,886.0	$1,013.0
Risk Corridors	$1,038.6	$0	($1,038.6)
Aggregate	**$8,141.9**	**$7,886.0**	**($255.9)**

Financial Gain/(Loss) of Actual to Accrued 3R Results

as of December 31, 2014 (millions)

3R Program	Total Dollars	PMPM	% of Premium
Risk Adjustment	($230.2)	($1.53)	(0.4%)
Reinsurance	$1,013.0	$6.73	1.8%
Risk Corridors	($1,038.6)	($6.90)	(1.8%)
Aggregate	**($255.9)**	**($1.70)**	**(0.4%)**

Number of ACA Health Plan Issuers With Potential RBC Event Triggered By Actual-to-Accrued Variation

as of December 31, 2014 (millions)

RBC Event	RBC Range	Number of Plans
Company Action Level	150% - 200%	3
Regulatory Action Level	100% - 150%	0
Authorized Control Level	70% - 100%	0
Mandatory Control Level	0% - 70%	4
Accounting Insolvency	< 0%	5

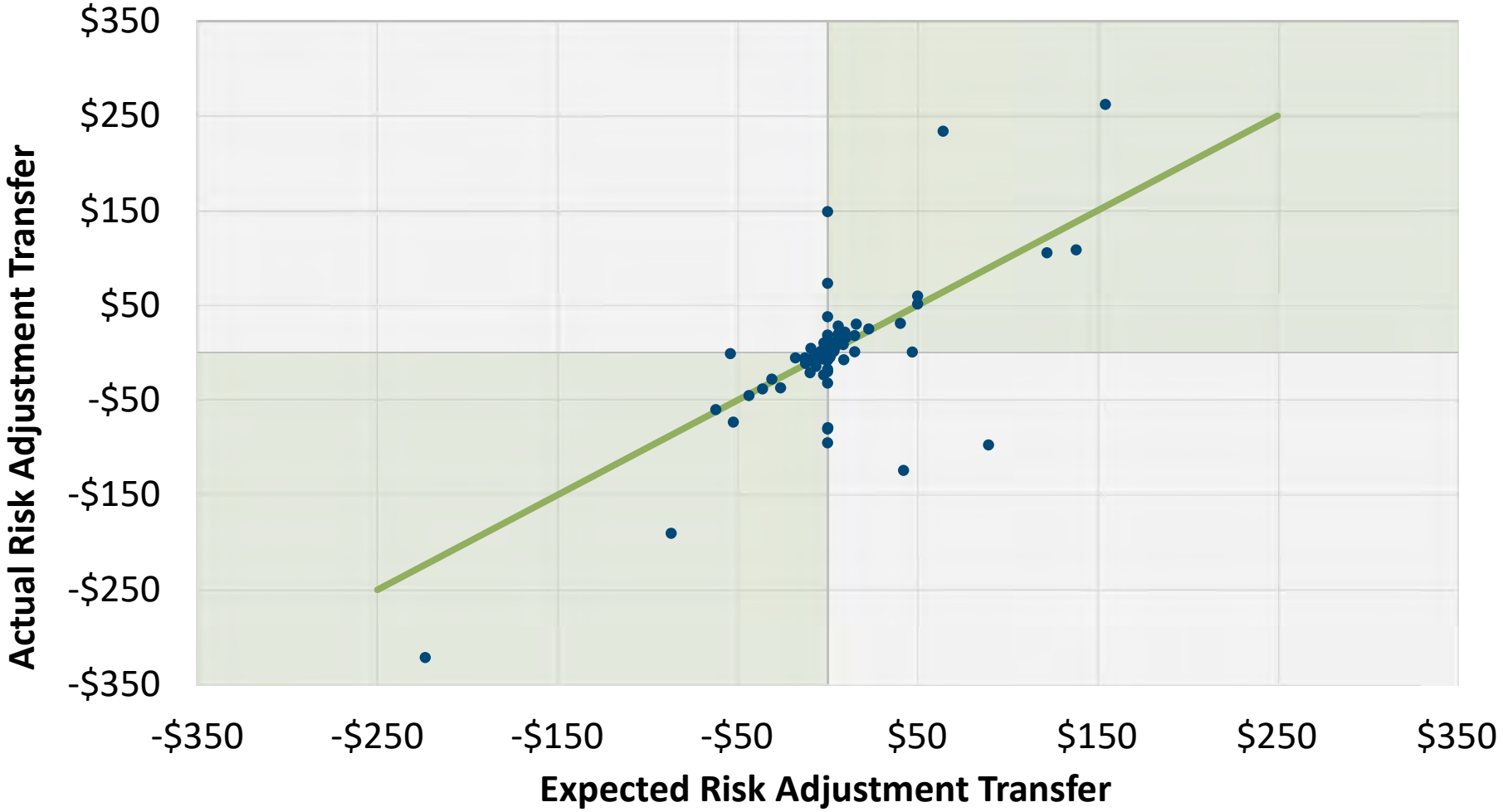
Financial Gain/(Loss) of Actual to Accrued 3R Results

as of December 31, 2014 (millions)

	Actual Receipts	Actual Payments	No Actual Receipts	Actual Total
Accrued Receipts	21%	5%	0%	26%
Accrued Payments	3%	20%	0%	23%
Accrued No Transfer	23%	28%	0%	51%
Accrued Total	**47%**	**53%**	**0%**	**100%**

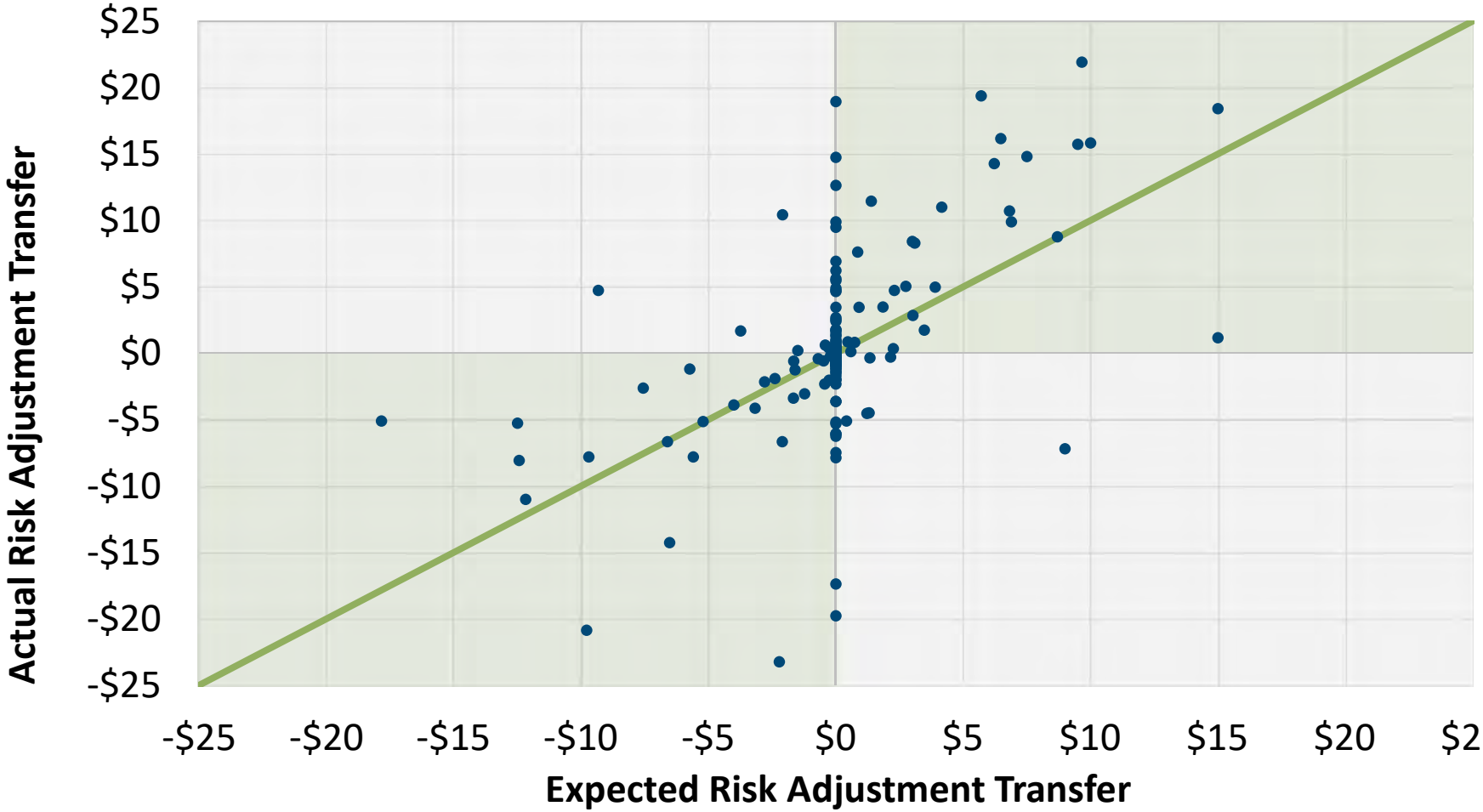
Actual-to-Expected ACA Health Plan Risk Adjustment Transfers

as of December 31, 2014 (millions)



Actual-to-Expected ACA Health Plan Risk Adjustment Transfers

as of December 31, 2014 (millions)



Transitional Reinsurance Estimate Attribution

as of December 31, 2014 (millions)

Item	Amount
Amount Accrued by ACA Plan Issuers	$6,873.0
Coinsurance Variation	$1,718.3
Other Variation	($705.3)
Actual Reinsurance Amount	**$7,886.0**

Summary of 2015 Risk Adjustment

- Direction of risk adjustment accruals, 2014 vs. 2015

		2015 Accruals				
		Accrued receivable	Accrued payable	Accrued zero	No 2015 statement	Total
2014	Accrued receivable	18%	5%	2%	0%	**25%**
	Accrued payable	3%	18%	1%	1%	**21%**
	Accrued zero	14%	18%	12%	5%	**48%**
	New in 2015	0%	2%	4%	0%	**6%**
	Total	**34%**	**42%**	**18%**	**6%**	**100%**

- 48% of issuers accrued in the same direction as 2014
- A significantly smaller number of issuers accrued zero

Summary of 2015 Risk Adjustment

- Reaction to 2014 actual results

		2015 Accruals				
		Accrued receivable	Accrued payable	Accrued zero	No 2015 statement	Total
2014	Actual receivable	29%	10%	6%	0%	45%
	Actual payable	5%	30%	8%	6%	49%
	New in 2015	0%	2%	4%	0%	6%
	Total	34%	42%	18%	6%	100%

		2015			
		Accrued receivable	Accrued payable	Accrued zero	Total
2014	Actual receivable	33%	12%	7%	51%
	Actual payable	6%	34%	9%	49%
	Total	38%	46%	16%	100%

  - Setting aside non-filers, two-thirds accrued the same direction they actually experienced in 2014

Summary of 2015 Risk Adjustment

- Change in magnitude of accrual

		2015 Accruals					
		Increase in magnitude	Decrease in magnitude	Different direction	Accrued zero	No 2015 statement	Total
2014	Overshot	7%	2%	3%	1%	0%	14%
	Undershot	18%	5%	2%	1%	1%	25%
	Accrued zero	0%	0%	31%	12%	5%	48%
	Direction incorrect	3%	1%	3%	1%	0%	7%
	New in 2015	6%					6%
	Total	28%	8%	39%	14%	6%	100%

- Much more common to increase magnitude than decrease it

Summary of 2015 Risk Adjustment Accruals

- Comparisons to 2014
  - Significantly smaller “optimism gap”
  - Greater impact from missing data (non-filers)
  - 2014 actuals seem to have influenced 2015 accruals

- Aggregate plausibility vs. individual company results

2015 Risk Adjustment Actual Results

- Released by CMS on June 30, 2016
- Transfer amounts available by company, state, market
- Can compare to both 2014 results and 2015 accruals

2015 Risk Adjustment Actual Results

- Most transfers were in the same direction as 2014
- More money changed hands in aggregate
- Companies newly accruing a transfer accrued correct direction most of the time
- Still frequent underestimates of magnitudes
- Missing data mattered a lot

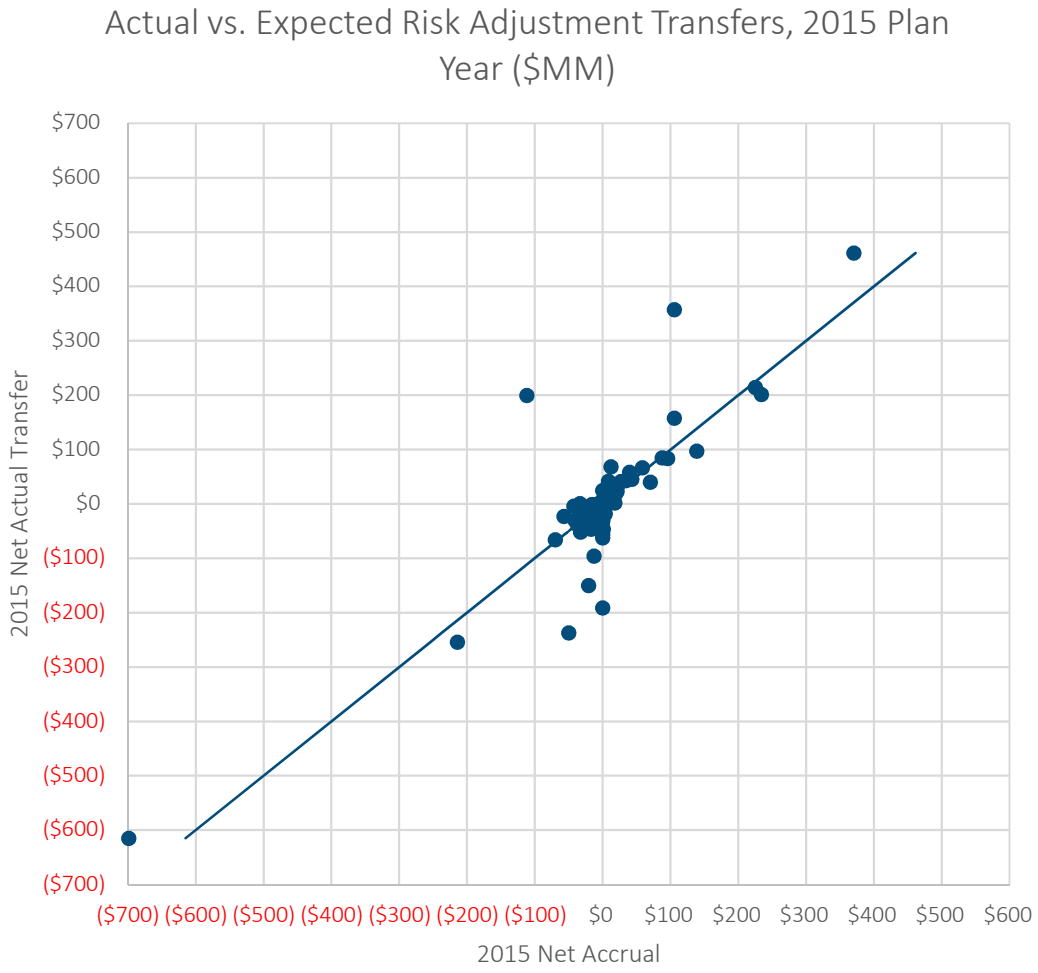
2015 Risk Adjustment: Actual vs. Accrued

- Similar directional results as 2014

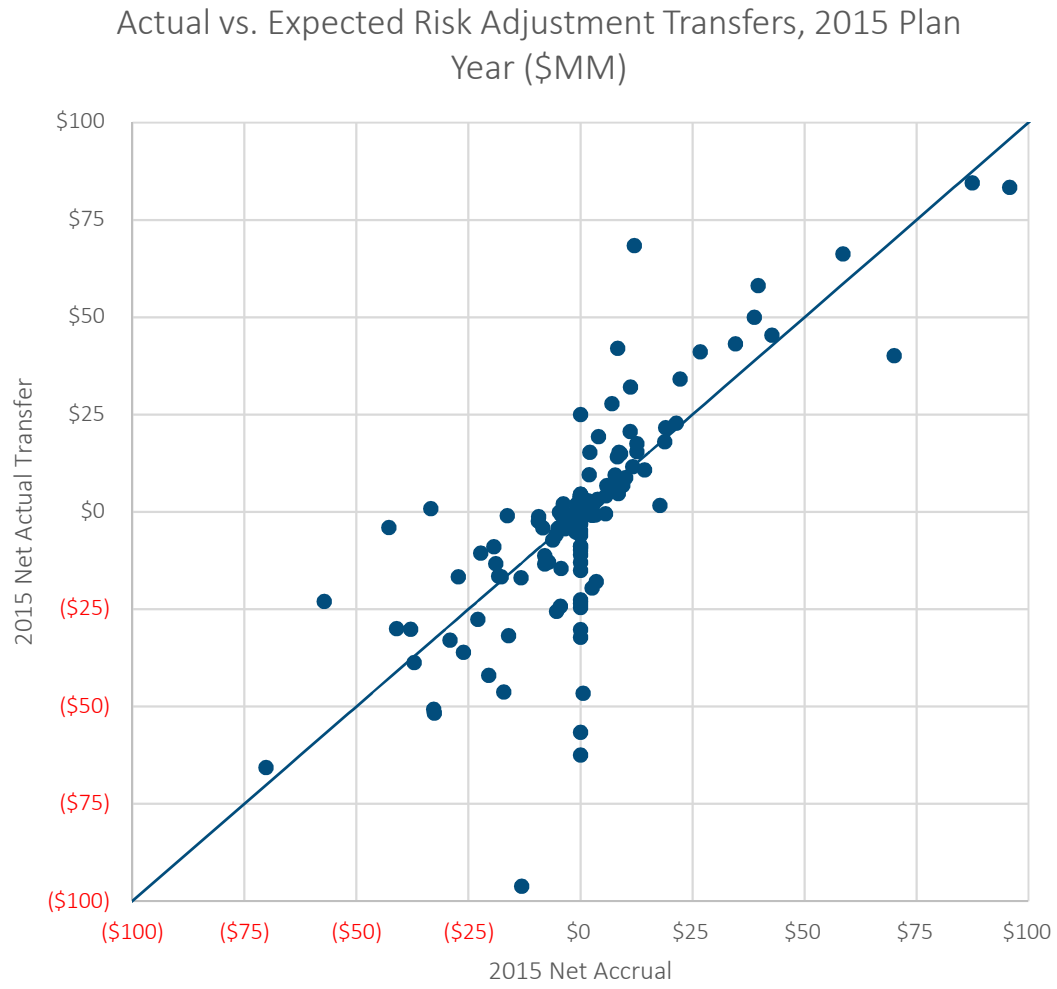
		2015 Actual			
		Actual receivable	Actual payable	No transfer for 2015	Total
2015 Accrual	Accrued receivable	29%	4%	1%	34%
	Accrued payable	4%	38%	1%	42%
	Accrued zero	5%	11%	2%	18%
	No 2015 statement	1%	5%	0%	6%
	Total	39%	58%	3%	100%

- As with 2014, companies accruing zero were more likely to be payers

2015 Risk Adjustment: Actual vs. Accrued



2015 Risk Adjustment: Actual vs. Accrued



2015 Risk Adjustment: Directional Shifts

- Most companies transferred in the same direction as 2014

		2015 Actual			
		Actual receivable	Actual payable	No transfer for 2015	Total
2014 Actual	Actual receivable	32%	11%	2%	45%
	Actual payable	6%	42%	1%	49%
	New in 2015	1%	5%	0%	6%
	Total	39%	58%	3%	100%

- Of companies in the data both years, 81% transferred in the same direction both years

2015 Risk Adjustment: Directional Accuracy

- As noted earlier, most companies accurately projected direction of transfer

		2015				
		Direction correct	Direction incorrect	Accrued zero	No 2015 statement	Total
2014	Direction correct	34%	3%	2%	1%	39%
	Direction incorrect	5%	1%	1%	0%	7%
	Accrued zero	26%	5%	12%	5%	48%
	New in 2015	2%	0%	4%	0%	6%
	Total	67%	9%	18%	6%	100%

- Compared to 2014, many fewer zero accruals
- Companies making a projection for the first time got the direction right most of the time (83%)

2015 Risk Adjustment: Magnitude

- Companies continue to underestimate magnitude of transfers, in both directions

		2015					
		Overshot	Undershot	Accrued zero	Direction incorrect	No 2015 statement	Total
2014	Overshot	7%	5%	1%	1%	0%	**14%**
	Undershot	8%	14%	1%	3%	1%	**25%**
	Accrued zero	11%	15%	12%	5%	5%	**48%**
	Direction incorrect	2%	3%	1%	1%	0%	**7%**
	New in 2015	1%	2%	4%	0%	0%	**6%**
	Total	**28%**	**39%**	**18%**	**9%**	**6%**	**100%**

2015 Risk Adjustment: Missing Data Bias?

- In aggregate, companies accrued for a net $94 million risk adjustment receivable
- Some companies who participate in risk adjustment did not file annual statements
- Actual risk adjustment transfers for these 11 companies totaled to a $371 million payment
  - 10 payments, 1 receipt
- Among the set of companies that did file annual statements, there was aggregate *pessimism* for 2015

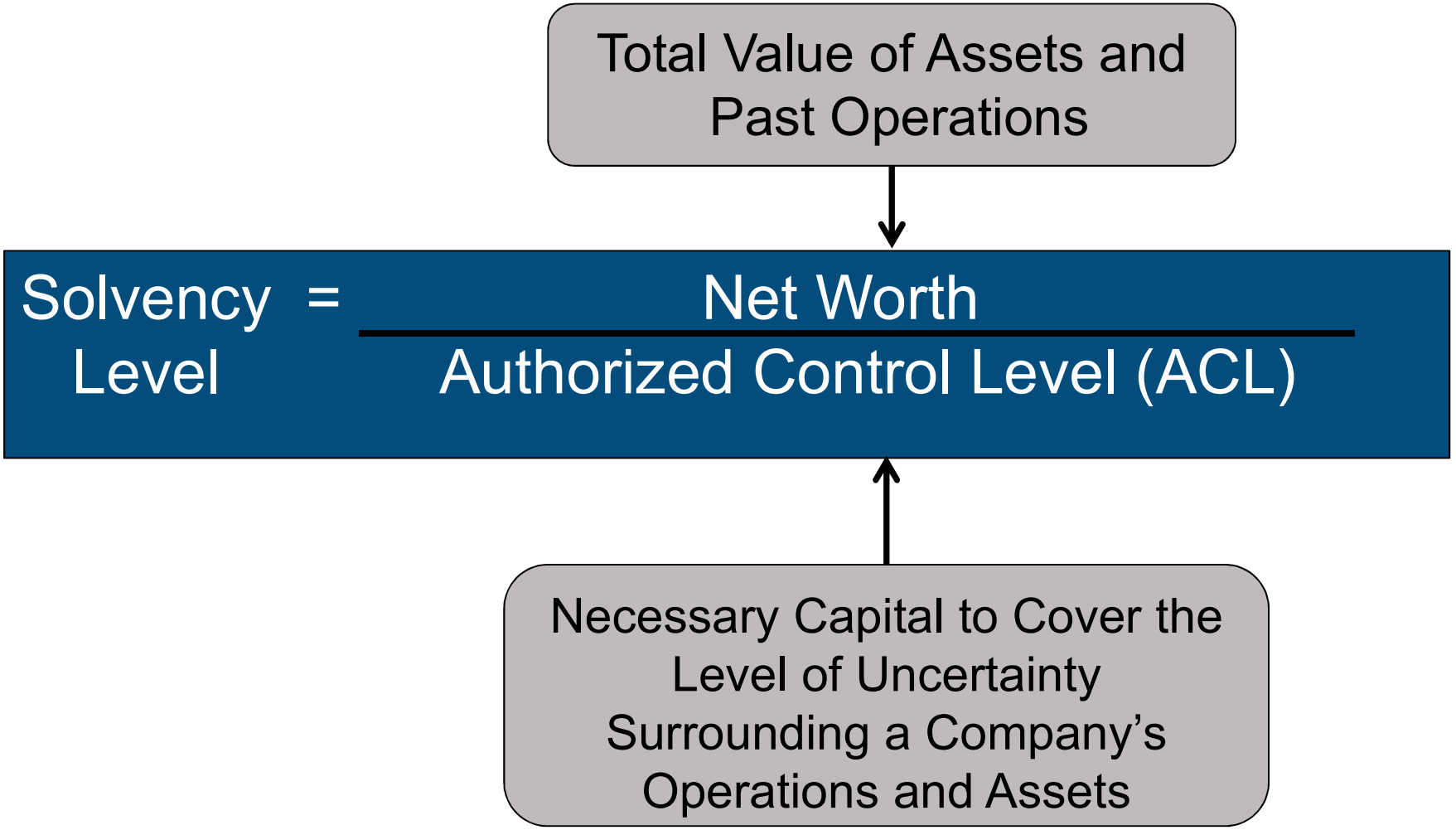
Risk Adjustment Case Study

- End of today: 3:15-5p

Risk Based Capital

SOCIETY OF ACTUARIES

Determining an Entity's Solvency Level



ACL Control Levels

$$\text{Solvency Level} = \frac{\text{Net Worth}}{\text{Authorized Control Level (ACL)}}$$

200% of ACL	150% of ACL	100% of ACL	70% of ACL
Company Action Level	**Regulatory Action Level**	**Authorized Control Level**	**Mandatory Control Level**
Below this, regulators require a formal plan to increase capital.	Below this, regulators can order capital increasing actions.	Below this, regulators *may* assume control.	Below this, regulators *must* assume control.

Company Action Level Formula

$$Company\ Action\ Level = H0\ risk + \sqrt{(H1\ risk)^2 + (H2\ risk)^2 + (H3\ risk)^2 + (H4\ risk)^2}$$

H0: Affiliate Risk
Pro rata share of each affiliate's RBC requirement attributed to the parent.

H1: Asset Risk
Accounts for risk that an insurer's invested assets will decline in value.

H2: Underwriting Risk
Accounts for risk that claim costs will exceed premium revenue.

H3: Credit Risk
Accounts for risk of default and capitation payment credit risk.

H4: Business Risk
Accounts for risk that administrative expenses will be higher than expected.

Avoiding Regulator Control

- Minimize the ACL
  - Minimize claims to reduce starting point for H2 calculation
  - Lower reinsurance attachment points
  - Share risk with providers
  - Maximize capitation discount factor in H2 calculation by fixing capitation payment for at least 12 months
  - Lease or rent assets rather than purchase

Avoiding Regulator Control

- Maximize capital and surplus
  - Maximize profit
  - Increase administrative spending on quality improvement items
  - Minimize overall admin spending
  - Obtain more capital by issuing stock or surplus notes

Calculations and Penalties

H1: Asset Risk
Accounts for risk that an insurer's invested assets will decline in value.

- Value of each of the assets is multiplied by an RBC factor (which is larger for riskier assets)
- Resulting products are summed to get total H1
- Additional penalty applied to portfolios that are concentrated in smaller number of securities issuers

Calculations and Penalties

- Determine claims (net of reinsurance recoveries) from annual statement
- Multiply by a factor that varies by line of business and premium volume
- Reduce result by managed care discount factor, determined by allocating claim costs to five categories

H2: Underwriting Risk
Accounts for risk that claim costs will exceed premium revenue.

Calculations and Penalties

H3: Credit Risk
Accounts for risk of default and capitation payment credit risk.

- Each type of receivable included in the RBC formula has an associated factor
- Resulting products are summed to get total H3 risk

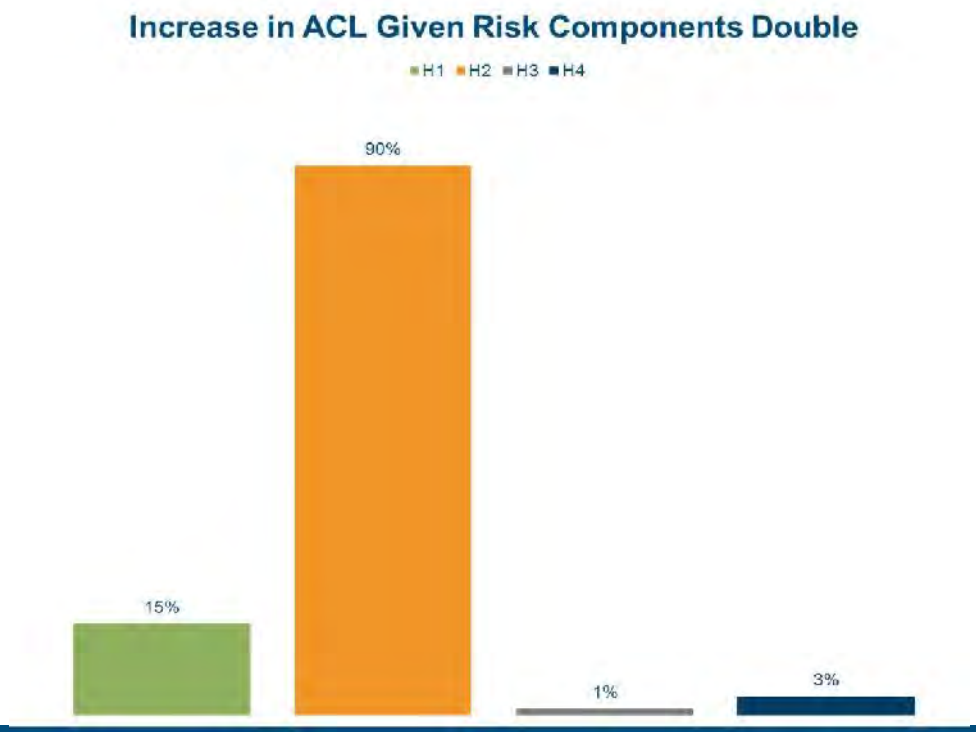
Calculations and Penalties

- Determine administrative costs and multiply by an RBC factor
- Penalty applied to entities growing too quickly
- Avoidable if H2 risk does not increase more than 10 percentage points faster than growth in premium

H4: Business Risk
Accounts for risk that administrative expenses will be higher than expected.

Why is H2 So Important?

$$\sqrt{H1^2 + H2^2 + H3^2 + H4^2} \approx \sqrt{H2^2} = H2$$




RISK

Rate Filings and Actuarial Memoranda

SOCIETY OF ACTUARIES

Filing of Rates

- Part I - Standardized data template
- Part II - Written description justifying the rate increase
- Part III - Rating filing documentation
- Rates Template
- Other templates you might need to know?

Rate Filing

- For any product subject to a rate increase, a Rate Filing Justification must be submitted
  - Rate increases under review threshold (e.g. 10%) – Parts I & III
  - Rate increase above review threshold – Parts I, II, and III

URRT

- Part I (Standardized Data Template)
  - Historical and projected claim experience
  - Trend projections related to utilization and service or unit cost
  - Claims assumptions related to benefit changes
  - Allocation of overall rate increase to claims and non-claims costs
  - Per enrollee per month allocation of current and projected premium
  - 3 year history of rate increases for the product

Worksheet 1

Unified Rate Review v2.0.3 [Add Product] [Validate] [Finalize]

Company Legal Name: **ABC Insurer** State: **CO**
HIOS Issuer ID: **00000** Market: **Individual**
Effective Date of Rate Change(s: **1/1/2016**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2014 to 12/31/2014

	Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period	$22,695,911	$314.59	100.00%
Incurred Claims in Experience Period	$18,484,878	256.22	81.45%
Allowed Claims:	$22,716,349	314.88	100.09%
Index Rate of Experience Period		$315.00	
Experience Period Member Months	72,144		

Section II: Allowed Claims, PMPM basis

Experience Period: on Actual Experience Allowed | Projection Period: 1/1/2016 to 12/31/2016 | Mid-point to Mid-point, Experience to Projection: 24 months

Benefit Category	Utilization Description	Utilization per 1,000	Average Cost/Service	PMPM	Pop'l risk Morbidity	Other	Cost	Util	Projections, before credibility Adjustment: Utilization per 1,000	Average Cost/Service	PMPM	Credibility Manual: Utilization per 1,000	Average Cost/Service	PMPM
Inpatient Hospital	Days	297.57	$3,151.10	$78.17	0.973	0.901	1.047	0.996	287.32	$3,112.29	$74.52	391.88	$3,112.29	$101.64
Outpatient Hospital	Services	1,307.13	900.11	98.05	0.973	0.901	1.057	1.006	1,287.14	923.31	99.04	1755.52	923.31	135.07
Professional	Services	11,677.79	99.44	96.77	0.973	0.901	1.052	1.006	11,499.25	99.16	95.02	15683.66	99.16	129.59
Other Medical	Services	536.01	151.00	6.71	0.973	0.901	1.052	1.006	527.81	150.57	6.62	719.87	150.57	9.03
Capitation	Services	0.00	0.00	0.00	0.973	0.900	1.007	0.996	0.00	0.00	0.00	0.00	0.00	0.00
Prescription Drug	Services	4,719.36	89.37	35.13	0.973	0.901	1.084	1.007	4,656.45	94.62	36.72	6350.86	94.62	50.08
Total				$314.88							$311.91			$425.41

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	44.75%	55.25%	$374.60	$193,103,453
Paid to Allowed Average Factor in Projection Period			0.711	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$265.34	$137,296,555
Projected Risk Adjustments PMPM			12.55	(6,469,387)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$278.89	$143,765,942
Projected ACA reinsurance recoveries, net of rein prem, PMPM			10.37	5,345,621
Projected Incurred Claims			$268.52	$138,420,321
Administrative Expense Load		12.74%	43.25	22,294,246

Worksheet 2

Product-Plan Data Collection [Add Product] [Validate] [Finalize]

Company Legal Name:	**ABC Insurer**
HIOS Issuer ID:	**00000**
Effective Date of Rate Change(s):	**1/1/2016**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		ABC Insurer HMO							
Product ID:		00000CO001							
Metal:		Gold	Silver	Bronze	Bronze	Catastrophic	Silver	Silver	
AV Metal Value		0.783	0.700	0.619	0.600	0.590	0.681	0.686	0.
AV Pricing Value		0.976	0.867	0.648	0.010	0.743	0.779	0.774	0
Plan Type:		HMO	HMO	HMO	HMO	HMO	HMO	HMO	P
Plan Name		HMO Gold	HMO Silver Plus	HMO Bronze	HMO Bronze Elite	HMO Catastrophic	HMO Silver	HMO HDHP Silver	PP(
Plan ID (Standard Component ID):		00000CO001000	00000CO001000	00000CO001000	00000CO001000	00000CO001000	00000CO001000	00000CO001000	00000C
Exchange Plan?		Yes	Yes	Yes	No	Yes	Yes	No	
Historical Rate Increase - Calendar Year - 2		0.00%							
Historical Rate Increase - Calendar Year - 1		0.00%							
Historical Rate Increase - Calendar Year 0		-8.57%							
Effective Date of Proposed Rates		1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1/2016	1/1
Rate Change % (over prior filing)		15.57%	16.50%	12.21%	0.00%	4.72%	0.00%	0.00%	
Cum'tive Rate Change % (over 12 mos prior)		15.57%	16.50%	12.21%	-999.00%	4.72%	-999.00%	-999.00%	-
Proj'd Per Rate Change % (over Exper.		16.01%	-2.41%	-0.76%	#DIV/0!	138.97%	7.28%	#DIV/0!	-
Product Threshold Rate Increase %		15.47%							

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	000CO0010001	000CO0010002	000CO0010003	000CO0010004	000CO0010005	000CO0010006	000CO0010007	000CC
Inpatient	$8.58	$9.32	$8.70	$5.30	$0.00	$1.17	$0.00	$0.00	
Outpatient	$11.40	$12.38	$11.56	$7.04	$0.00	$1.56	$0.00	$0.00	
Professional	$10.94	$11.88	$11.09	$6.75	$0.00	$1.50	$0.00	$0.00	
Prescription Drug	$4.23	$4.59	$4.29	$2.61	$0.00	$0.58	$0.00	$0.00	
Other	$0.76	$0.83	$0.77	$0.47	$0.00	$0.10	$0.00	$0.00	
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
Administration	$5.83	$6.33	$5.91	$3.60	$0.00	$0.80	$0.00	$0.00	
Taxes & Fees	$2.65	$2.88	$2.69	$1.64	$0.00	$0.36	$0.00	$0.00	
Risk & Profit Charge	$1.37	$1.49	$1.39	$0.85	$0.00	$0.19	$0.00	$0.00	
Total Rate Increase	$45.76	$49.70	$46.40	$28.26	$0.00	$6.26	$0.00	$0.00	
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	

Average Current Rate PMPM	$296.26	$319.28	$281.30	$231.46		$132.78	$294.56	$292.43	
Projected Member Months	515,489	87,633	128,796	51,549		711	87,633	51,549	

Worksheet 2, cont'd.

Section III: Experience Period Information

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	00000CO0010001	00000CO0010002	00000CO0010003	00000CO0010004	00000CO0010005	00000CO0010006	00000CO0010007	00000CO0020001	00000CO0020002	00000CO0
OK	$ 314.59	Premium Information	Plan Adjusted Index Rate	$314.59	$316.96	$334.64	$260.79	$0.00	$117.13	$273.64	$0.00	$373.30	$378.02	
OK	72,144		Member Months	72,144	13,760	22,893	22,459	0	171	366	0	5,734	6,761	
OK	$22,695,911		Total Premium (TP)	$22,695,843	$4,361,370	$7,660,914	$5,857,083	$0	$20,029	$100,152	$0	$2,140,502	$2,555,793	
			EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	1
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
			Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
OK	$22,716,349	Claims Information	Total Allowed Claims (TAC)	$22,716,349	$4,849,210	$7,524,286	$3,988,687	$0	$10,789	$96,688	$0	$3,073,590	$3,173,099	
			EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	1
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
			Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
			Allowed Claims which are not the issuer's obligation:	$4,231,472	$783,797	$859,743	$1,464,648	$0	$194	$9,030	$0	$600,824	$513,235	
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0		$0	$0		$0	$0	
			Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%		0.00%	0.00%	#DIV/
OK	$18,484,878		Total incurred claims, payable with issuer	$18,484,878	$4,065,413	$6,664,543	$2,524,039	$0	$10,595	$87,658	$0	$2,472,766	$2,659,864	
			Net Amt of Rein	$1,784,999.22	$347,351.06	$692,980.19	$366,000.46	$0.00	$0.00	$0.00	$0.00	$159,740.65	$218,926.86	
			Net Amt of Risk Adj	-$3,778,999.99	-$806,695.01	-$1,251,709.80	-$663,541.81	$0.00	-$1,794.79	-$16,084.66	$0.00	-$511,310.00	-$527,863.92	
OK	$ 256.22		Incurred Claims PMPM	$256.22	$295.45	$291.12	$112.38	#DIV/0!	$61.96	$239.50	#DIV/0!	$431.25	$393.41	#DIV/
OK	$ 314.88		Allowed Claims PMPM	$314.88	$352.41	$328.67	$177.60	#DIV/0!	$63.09	$264.18	#DIV/0!	$536.03	$469.32	#DIV/
			EHB portion of Allowed Claims, PMPM	$314.88	$352.41	$328.67	$177.60	#DIV/0!	$63.09	$264.18	#DIV/0!	$536.03	$469.32	#DIV/

Worksheet 2, cont'd.

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	00000CO0010001	00000CO0010002	00000CO0010003	00000CO0010004	00000CO0010005	00000CO0010006	00000CO0010007	00000CO0020
OK	$ 339.47		Plan Adjusted Index Rate	$338.66	$367.70	$326.56	$258.82	$0.00	$279.90	$293.55	$291.47	$(
OK	515,489	Premium Information	Member Months	515,489	87,633	128,796	51,549	-	711	87,633	51,549	-
OK	$174,994,085	Premium Information	Total Premium (TP)	$174,577,634	$32,222,654	$42,059,622	$13,341,912	$0	$199,009	$25,724,667	$15,024,987	
		Premium Information	EHB Percent of TP, [see instructions]	99.56%	99.62%	99.57%	99.46%		99.50%	99.61%	99.42%	
		Premium Information	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	
		Premium Information	Other benefits portion of TP	0.44%	0.38%	0.43%	0.54%	100.00%	0.50%	0.39%	0.58%	100.(
OK	193,103,453	Claims Information	Total Allowed Claims (TAC)	$192,987,519	$31,797,035	$44,584,760	$16,707,394	$0	$114,488	$30,335,540	$17,844,497	
		Claims Information	EHB Percent of TAC, [see instructions]	99.56%	99.62%	99.57%	99.46%		99.50%	99.61%	99.42%	
		Claims Information	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	
		Claims Information	Other benefits portion of TAC	0.44%	0.38%	0.43%	0.54%	100.00%	0.50%	0.39%	0.58%	100.(
		Claims Information	Allowed Claims which are not the issuer's obligation	$55,778,693	$6,150,691	$11,249,839	$6,639,599	$0	$46,219	$10,041,179	$5,995,241	
		Claims Information	Portion of above payable by HHS's funds on behalf of insured person, in dollars	$10,249,718	$6,062	$3,979,316	$261,513		$0	$3,553,973		
		Claims Information	Portion of above payable by HHS on behalf of insured person, as %	18.38%	0.10%	35.37%	3.94%		0.00%	35.39%		#DIV/0!
OK	138,420,321	Claims Information	Total Incurred claims, payable with issuer funds	$137,208,826	$25,646,344	$33,334,921	$10,067,795	$0	$68,268	$20,294,361	$11,849,256	
OK	5,345,621	Claims Information	Net Amt of Rein	$5,344,568	$986,471	$1,287,633	$408,446	$0	$6,092	$787,547	$459,975	
		Claims Information	Net Amt of Risk Adj	-$6,470,042	-$1,194,205	-$1,558,786	-$494,458	$0	-$7,375	-$953,391	-$556,838	
OK	$ 268.52		Incurred Claims PMPM	$266.17	$292.66	$258.82	$195.31	#DIV/0!	$96.02	$231.58	$229.86	#DIV/0!
OK	$ 374.60		Allowed Claims PMPM	$374.38	$362.84	$346.17	$324.11	#DIV/0!	$161.02	$346.17	$346.17	#DIV/0!
			EHB portion of Allowed Claims, PMPM	$372.71	$361.46	$344.68	$322.36	#DIV/0!	$160.22	$344.82	$344.16	#DIV/0!

Rate Filing

- Comments on URRT
  - Index rate, as used in the URRT, has a wholly different meaning than is typically used in manual rating.
  - Profit & Risk Load on Worksheet 1, Section III: Previously it was unclear whether it means profits before or after federal income tax. This should be an after-tax amount.
  - Individual market submissions must have an experience period that is a full calendar year and in all cases should be 12 months long.

Rate Filing

- Comments on URRT
  - Brand new carriers have no previous experience.
  - On Worksheet 2, does not allow for the deletion and addition of columns, need to start from the beginning as product offerings change.
  - On Worksheet 2, for terminating products, 0.01 used for the pricing value.
    - Terminated non-ACA plans included in the experience pool should be grouped together and listed as catastrophic plans
    - Terminated ACA plans should be listed in their own column

Rate Filing

- Comments on URRT
  - Many insurers don’t price in the exact order or format as the URRT illustrates, so are left filling in the appropriate cells at the end
  - Many insurers do not calculate "change" in premiums at the level asked for in Worksheet 2 (IP, OP, PR, Rx). Additionally, many insurers do not have an "Other" bucket (ambulance, etc..), or do not have an "Other" definition that matches up to the definition used in the URRT.

Rate Filing

- Part II, Written Justification
  - Only submitted for rate increases over threshold (state may decide otherwise)
  - A simple and brief narrative describing the data and assumptions that were used to develop the rate increase, including:
    - Explanation of the most significant factors causing the rate increase including the relevant claim and non-claim expense increases
    - Brief description of the overall experience of the policy including historical and projected expenses and loss ratios

Rate Filing

- Part III
  - An actuarial memorandum containing the reasoning and assumptions supporting the data contained in Part I.
    - To be submitted for all rate increases
    - Specified format by CMS

Actuarial Memo Contents

- Part III, Rate Filing Documentation
  - Actuarial Memorandum Contents Outline
    - General Information
    - Proposed Rate Increase(s)
    - Experience Period Premium and Claims
    - Benefit Categories
    - Projection Factors
    - Credibility Manual Rate Development
    - Credibility of Experience
    - Paid to Allowed Ratio
    - Risk Adjustment and Reinsurance

Actuarial Memo Contents

- Part III, Rate Filing Documentation
  - Actuarial Memorandum Contents Outline (cont'd)
    - Non-Benefit Expenses and Profit & Risk
    - Projected Loss Ratio
    - Single Risk Pool
    - Index Rate
    - Market Adjusted Index Rate
    - Plan Adjusted Index Rates
    - Calibration
    - Consumer Adjusted Premium Rate Development
    - AV Metal Values
    - AV Pricing Values

Actuarial Memo Contents

- Part III, Rate Filing Documentation
  - Actuarial Memorandum Contents Outline (cont'd)
    - Membership Projections
    - Terminated Products
    - Plan Type
    - Warning Alerts
    - Effective Rate Review Information (Optional)
    - Reliance
    - Actuarial Certification
  - Data Sources, Assumptions, Methods, and more on each element in enough detail to comply with directions in instructions as well as ASOPs

Professionalism and Pricing

SOCIETY OF ACTUARIES

Code of Conduct

SOCIETY OF ACTUARIES

Code of Conduct
Precept 1: Professional Integrity

- Be honest
- Use Skill and Care
  - Don’t be deceitful or intentionally misrepresent
- Don’t do anything illegal, or that would hurt our reputation
  - Includes using 3rd party relationships to engage in improper activity

Code of Conduct
Precept 2: Qualification Standards

- Make sure you're qualifies
  - Basic education
  - Experience
  - Continuing education
- Must be qualified even if qualification standards for a particular assignment do not exist

Code of Conduct
Precept 3: Standards of Practice

- You must satisfy applicable Standards of Practice
  - It's your responsibility to know what those are and keep up with changes
  - If no Standard applies to the work, use professional judgment and generally accepted actuarial principles and practices
  - If you depart from the Standards you must justify the departure

Code of Conduct Precepts 4, 5 and 6: Communications and Disclosure

- Actuarial communications must:
  - Be clear and appropriate
  - Identify the responsible actuary
  - Indicate who can provide supplementary information
  - Identify the Principal
- You must disclose sources of compensation in relation to an assignment
- If you are not independent you must disclose this to the Principal
- Disclosure is required based on your firm, regardless of your operating location versus other work done in other locations for the Principal

Code of Conduct
Precept 7: Conflict of Interest

- You should not perform Actuarial Services involving an actual OR potential conflict of interest, unless:
  - You are able to act fairly
  - You have disclosed the conflict to all Principals
  - All Principals have agreed on your performance of the services

"There is no moral precept that does not have something inconvenient about it." Denis Diderot

Code of Conduct
Precept 8: Control of Work Product

- You should make sure your work is not used to mislead others
  - Recognize the risks of misquotation and misinterpretation
  - Construct and present your Actuarial Communication to avoid this
  - Include limitations on the distribution and utilization of the Communication

Code of Conduct
Precept 9: Confidentiality

- Don’t disclose confidential information
  - Unless Principal authorizes
  - Unless required by Law

Code of Conduct
Precept 10: Courtesy and Cooperation

- Use courtesy and respect
- Cooperate with others in the Principal's interest
  - Differing opinions are ok; sharing your thoughts on another actuary's work should be objective, thoughtful and respectful
  - You can work for a Principal even if another actuary is already doing so
  - It's ok to give alternative opinions to a Principal
  - You can (should) consult with the prior/current actuary, but only with consent of the Principal
  - And if you are the prior actuary, you should cooperate with the new actuary

Code of Conduct
Precept 11: Advertising

- Don’t use false or misleading advertisement for Actuarial Services
  - Including the need for actuarial services
  - Including one actuary versus another
  - Includes all media trying to influence any person or organization

Code of Conduct
Precept 12: Titles and Designations

- Your title and designation should be only used in a way that is authorized by the organization
  - "Title" means from an actuarial organization

Code of Conduct Precept 13 and 14: Violations of the Code

- If you are aware of a material violation of the Code by another Actuary:
  - First discuss it with the other actuary
  - If not resolved, then you should disclose to the Counseling and Discipline body
    - Unless contrary to law, or violating confidentiality
- Material violation:
  - Important
  - Affects the outcome of a situation

Code of Conduct Precept 13 and 14: Violations of the Code

- If you are asked to provide information or cooperate with a counseling or disciplinary body, you should do so promptly and truthfully
  - Subject to restrictions of the Law, or confidentiality

- The ABCD stresses the “C”
  - http://www.abcdboard.org/

Applicability Guidelines (under revision process)

SOCIETY OF ACTUARIES

Applicability of ASOPs to Health Pricing Work

Task: *Estimate incurred health claim liabilities*

Possible ASOPs:
ASOP 1 – Introductory Actuarial Standard of Practice
ASOP 5 – Incurred Health and Disability Claims
ASOP 11 – Financial Statement Treatment of Reinsurance Transactions Involving Life or Health Insurance
ASOP 12 – Risk Classification (for All Practice Areas)
ASOP 21 – Responding to or Assisting Auditors or Examiners in Connection with Financial Statements for All Practice Areas
ASOP 23 – Data Quality
ASOP 25 – Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
ASOP 28 – Statements of Actuarial Opinion Regarding Health Insurance Liabilities and Assets
ASOP 41 – Actuarial Communications
ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies

Applicability of ASOPs to Health Pricing Work

Task: *Perform trend analysis (aggregate and components)*

Possible ASOPs:

ASOP 1 – Introductory Actuarial Standard of Practice
ASOP 5 – Incurred Health and Disability Claims
ASOP 7 – Analysis of Life, Health, or Property/Casualty Insurer Cash Flows
ASOP 8 – Regulatory Filings for Health Plan Entities
ASOP 12 – Risk Classification (for All Practice Areas)
ASOP 23 – Data Quality
ASOP 25 – Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
ASOP 41 – Actuarial Communications
ASOP 42 – Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims
ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies

Applicability of ASOPs to Health Pricing Work

Task: *Design, use, and/or update risk classification systems*

Possible ASOPs:

ASOP 1 – Introductory Actuarial Standard of Practice
ASOP 12 – Risk Classification (for All Practice Areas)
ASOP 23 – Data Quality
ASOP 25 – Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages
ASOP 41 – Actuarial Communications
ASOP 42 – Determining Health and Disability Liabilities Other Than Liabilities for Incurred Claims
ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies

Applicability of ASOPs to Health Pricing Work

Task: *Prepare actuarial certification of compliance for small group carriers*

Possible ASOPs:

ASOP 1 – Introductory Actuarial Standard of Practice

ASOP 23 – Data Quality

ASOP 26 – Compliance with Statutory and Regulatory. Requirements for the Actuarial Certification of Small Employer Health Benefit Plans

ASOP 41 – Actuarial Communications

Applicability of ASOPs to Health Pricing Work

Task: *Develop rates, plan design, quality standards, data/claims analysis for products and self-funded plans.*

Possible ASOPs:

1, 3, 4, 5, 6, 7, 8, 11, 12, 17, 18, 23, 25, 26, 27, 35, 41, 42, 44, 45, new MV/AV ASOP

Applicability of ASOPs to Health Pricing Work

Task: *Provide analysis on risk-sharing programs, including reinsurance, risk corridor, risk adjustment, experience rating, and rate stabilization funds.*

Possible ASOPs:

1, 3, 5, 7, 8, 11, 12, 18, 23, 25, 41, 42, 45

Applicability of ASOPs to Health Pricing Work

Task: *ACA-related filings, including rate filing, cost-sharing reduction calculations, reinsurance, risk adjustment, risk corridors, medical loss ratios, and actuarial value (AV) and minimum value (MV) certifications.*

Possible ASOPs:

1,5, 7, 8, 11, 12, 17, 23, 25, 41, 42, 45, and new AV/MV ASOP

ASOP 41: Actuarial Communications

SOCIETY OF ACTUARIES

ASOP 41:
Actuarial Communications

Requirements for Actuarial Communications

Form and content: appropriate to the circumstances

Clarity: uses appropriate language, taking into account intended users

Timing: reasonable, considering needs of intended users

Identification of Responsible actuary

ASOP 41: Actuarial Communications

Actuarial Report

- Should be completed if the actuary intends the findings to be relied upon by any intended user
  - One or several documents, could be different formats

- Report contents:
  - Actuarial findings
  - Methods, procedures, assumptions and data
  - Clear enough for another actuary to make an appraisal of reasonableness

- Specific Circumstances: Can limit the content, but must be prepared to identify such circumstances and justify limiting the content of the actuarial report.

ASOP 41: Actuarial Communications

All communications should disclose:

- Identification of Responsible Actuary
- Identification of Actuarial Documents
- Disclosure in actuarial reports:
  - Intended users, scope and intended purpose
  - Acknowledgment of qualification
  - Limitations or constraints on the findings
  - Documents comprising the actuarial report
  - Assumptions or methods prescribed by law
  - Deviation from the guidance of an ASOP

ASOP 41: Actuarial Communications

Additional Disclosures Within an Actuarial Report

- Uncertainty or Risk
- Conflict of Interest
- Reliance on Other Sources
- Responsibility for assumptions and methods – next slide
- Information Date of Report (data)
- Subsequent Events -- disclose if:
  - Becomes known after the information date, but before the report is issued
  - Material effect if reflected in findings, and
  - Impractical to revise the report

ASOP 41: Actuarial Communications

If an assumption or method is specified by law or selected by another party, 3 choices:

1. If it does not conflict with your judgment, no disclosure obligation
2. If it significantly conflicts with your judgment, must disclose
    a. Assumption or method set by another party
    b. The party who set it
    c. The reason they are setting it and not you
    d. That it conflicts with your judgment or you are unable to judge
3. If you are unable to judge the reasonableness, disclose per #2 above

ASOP 41: Actuarial Communications

- Other requirements
  - Explanation of material differences
  - Oral communications
  - Responsibility to other users
  - Retention of other materials

ASOP 23: Data Quality

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ASOP 23 - Data Quality

- Revised December 2004
- Accuracy and validity of analysis depends on quality of data
- Reliance ranges for accepting without any checking to complete verification
- Standard does not require audit of data

ASOP 23 - Data Quality

- Considerations on Selecting Data
  - Intended purpose
  - Reasonableness and comprehensiveness
  - Internal & external consistency
  - Cost, feasibility, and benefit of obtaining alternative data
  - Sampling method

ASOP 23 - Data Quality

- May rely on data supplied by others
- Accuracy of data supplied by others is their responsibility
- Should disclose such reliance
- Should review to identify values that are questionable

ASOP 23 - Data Quality

- Disclosures
  - Source of data
  - Potential bias due to imperfect data
  - Adjustments made
  - Extent of reliance on data by other
  - If reviewed and if not reviewed, any limitations on work product
  - Any limitations due to uncertainty about the quality of the data
  - Any unresolved concerns
  - Any conflicts with law, regulation, etc.

Literature Review and Resources

SOCIETY OF ACTUARIES

Start With - Your Company Website

- Intranet
  - Branded
  - Reviewed by Legal
- Internet
  - Some companies share information

Actuarial Organizations

- Society of Actuaries (http://www.soa.org)
  - Research
  - Presentation archives
- American Academy of Actuaries (http://www.actuary.org)

Think Tanks/Publications

- Rand Corporation (http://www.rand.org)
- Kaiser Family Foundation (http://www.kff.org)
- Robert Woods Johnson Foundation (http://www.rwjf.org)
- Health Affairs (http://www.HealthAffairs.org)

Government Agencies

- CMS (http://www.cms.gov)
- Congressional Budget Office (http://www.cbo.gov)
- MedPac (http://www.medpac.gov)
- Centers for Disease Control (http://cdc.gov)
- National Center for Health Statistics (http://cdc.gov\nchs)

Consultant Websites

- Milliman (http://www.milliman.com)
- Towers Watson (http://www.towerswatson.com)
- AONHewitt (http://www.aonhewitt.com)
- Mercer (http://www.mercer.com)
- Wakely (https://www.wakely.com/)

And, last but not least…

- Google (http://www.google.com)

Literature Review and Resources

APPENDIX

SOCIETY OF ACTUARIES

Literature Review
American Academy of Actuaries

Exposure draft of an addendum to the October 2012 practice note,

Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act for 2015 and Beyond. (September 1, 2014)
https://www.actuary.org/files/RRPN_exposure_draft_092614.pdf

Society of Actuaries
Commercial Health Care: What's Next?

http://www.theactuarymagazine.org/category/web-exclusives/commercial-health-care-whats-next/

- The Old and the Beautiful
  - Norris, Leida, Rode, Gray
  - http://www.theactuarymagazine.org/the-old-and-the-beautiful/
- The Next Generation High Risk Pool
  - Leif, Bykerk
  - http://www.theactuarymagazine.org/next-generation-high-risk-pool/
- The Entrepreneur and the Specter of Health Care
  - Swacker
  - http://www.theactuarymagazine.org/entrepreneur-specter-health-care/

Literature Review and Resources
Other Society of Actuaries Research

Provider Payment Arrangements, Provider Risks, and Their Relationship with the Cost of Health Care, by Juliet M. Spector, FSA, MAAA, Brian Studebaker, MA, and Ethan J. Menges
https://www.soa.org/Research/Research-Projects/Health/2015-provider-payments-arrangements-risk.aspx

Indications of Pent-up Demand, by Rebecca Owen, FSA, MAAA and Daniel Maeng, PhD
https://www.soa.org/Research/Research-Projects/Health/2015-pent-up-demand-health.aspx

Modeling Long Term Healthcare Cost Trends, by Thomas E. Getzen, iHEA and Temple University
https://www.soa.org/research/research-projects/health/research-hlthcare-trends.aspx

Health Care Costs – From Birth to Death (joint project HCCI/SOA), by Dale Yamamoto
http://www.soa.org/Research/Research-Projects/Health/research-health-care-birth-death.aspx

For more on SOA health research, please visit
http://www.soa.org/research/research-projects/health/default.aspx

Literature Review and Resources
SOA's Health Watch August 2015 Issue

- The ACA's Medical Loss Ratio Provisions: Looking Back By Rowen Bell
- Health Care Reform: Essential Health Benefits and Actuarial Value By Catherine Knuth
- A Regulatory Perspective on Rate Review Before and After the Affordable Care Act By Annette James and Jaakob Sundberg
- The Individual Market and ACA Products: Starting from First Actuarial Principles By Kurt Wrobel
- 30 Surplus and the ACA By Daniel Pribe
- The Affordable Care Act's Five-Year Anniversary—Wall of Comments: A compilation of feedback from the actuaries in the Health Section
- Medicaid and the ACA By Rebecca Owen
- 39 Medicare Advantage: Five Years after the ACA By Andrew Mueller and Caroline Li
- ACA Impact on Employers—The Road Ahead and the Road Behind By Sujaritha Tansen and Brian Stentz
- The Role of the Affordable Care Act in Payment Reform By Juliet Spector
- Taxes and Fees Introduced by the ACA By Rowen Bell and Mike Gaal
- The CLASS Act and Its Aftermath By Robert Yee
- https://www.soa.org/Library/Newsletters/ACA@5/2015/August/aca-2015-iss1.pdf

Literature Review and Resources
Society of Actuaries Recordings

2014 Health Meeting sessions

Sessions 5, 18, 27: Overview and breakdowns of the 3 Rs
Session 6: Rate Review 101
Session 8: Specialty Drugs
Session 7: The ACA's Effect on Large Employers
Session 19: ACA-Rate Review
Session 20: The ACA and the Economy
Session 22: Behavioral Finance for Health Actuaries
Session 28: Exchanges 101
Session 29: Post-ACA Medical Benefit Plan Design
Session 31: Creative Ways to Bend Trend
Session 33: Predictive Models in Healthcare
Session 43: Exchanges – What Happened? What is Going to Happen?
Session 86: Private Exchanges: New Directions in Employer Benefits
Session 90: ORSA for Health Actuaries – Getting the Most Out of It
Session 101: Professionalism Consideration for Pricing Actuaries

https://www.soa.org/Professional-Development/Event-Calendar/2014/Health-Meeting/Agenda-Day-2.aspx
https://www.soa.org/Event-Calendar/2014/Health-Meeting/Agenda-Day3/
https://www.soa.org/Professional-Development/Event-Calendar/2014/Health-Meeting/Agenda-Day-4.aspx

Literature Review and Resources
Society of Actuaries Recordings

2015 Health Meeting sessions
Session 7: Statistics 101 for Health Actuaries
Session 8: Financial Reporting and the Affordable Care Act
Session 10: Actuarial Opinions Revisited
Session 12: The Latest on the ACA: From the Industry, Congress, and the Supreme Court
Session 13: Big Data, Behavioral Data and Predicting Health Outcomes
Session 21: Statistics 102 for Health Actuaries
Session 25: Doctors without Networks: Alternative Arrangements for Medical Benefits
Session 26: The Affordable Care Act and Dental: Past, Present, and Future
Session 34: Rate Review Hot Topics
Session 51: The Latest on Public Exchanges
Session 52: Evolving Guidance for Capitation Rate Setting
Session 63: Pricing in the ACA for 2016: Commercial Rate Filings – "The Uncertainty Continues"
Session 72: Predictive Modeling: What's New, and How to Use It
Session 99: Enterprise Risk Management and ORSA

https://www.soa.org/Professional-Development/Event-Calendar/2015/Health-Meeting/Agenda-Day-2.aspx
https://www.soa.org/Professional-Development/Event-Calendar/2015/Health-Meeting/Agenda-Day-3.aspx
https://www.soa.org/Professional-Development/Event-Calendar/2015/Health-Meeting/Agenda-Day-4.aspx

Literature Review and Resources Payment Reform Initiatives Outcomes

Visit the payment reform webpage and join the list serve

- Monthly informal calls on this issue
- Lots of free continuing education

http://www.chqpr.org/index.html

Literature Review and Resources American Academy of Actuaries

CMS ACA Regulation Review Video Modules Members have access to videos prepared by CMS on several key regulations implementing provisions of the ACA. To access the site, log in to the Academy's members-only page and select the link for ACA Regulation Review Videos.

Academy Committees oriented on policy: get involved, earn free CE:

http://www.actuary.org/content/health-practice-council-committees

Professionalism committees are created as needed to develop and revise ASOPs.

Examples of Health Practice Council committees (policy):

- Individual and Small Group Markets Committee
- AV/MV Work Group
- Risk Sharing Subcommittee
- Premium Review Work Group
- Financial reporting and Solvency Committee
- Health Solvency Subcommittee

Communications and deliverables on website (issue briefs, letters to policymakers, practice notes)

Literature Review and Resources American Academy of Actuaries

American Academy of Actuaries Professional Webcast Recordings:
http://www.actuary.org/professionalism-webinars

Webcasts for pricing health actuaries:

- Unknown Unknowns: Challenges to Professionalism
- New Report on Actuaries' Perceptions of Key Ethical Issues Facing Profession
- Up to Code: Are You Keeping Up to Code?
- Disclosure in the Real World: ASOP No. 41 Case Studies
- Precept 13: Preserving Integrity and Public Trust
- Where the Rubber Meets the Road: Applying the Code of Professional Conduct and ASOPs in Your Daily Work
- Setting the Ground Rules: Revised ASOP No. 1 and Other Key Information for Actuaries
- Professionalism Webinar: Improving Your Practice Through Peer Review
- Webinar: Precept 13—How Do I Comply in a Self-Regulating Profession?
- Professionalism Webinar: ABCD Requests for Guidance—Insight and Case Studies
- Professionalism webinar: U.S. Qualification Standards—Key Aspects and your FAQs Answered
- Code of Professional Conduct webinar: Applying the same code in uncertain economic times
- The Profession's Responsibility to the Public Webinar
- Webinar: Revised ASOP No. 41: Actuarial Communications
- Academy Webinar: Best of "Up to Code"
- You've got Qualification Standards questions? The Academy has answers
- The Importance and Benefits of Understanding the Code

Literature Review and Resources Great Links

CMS Information Hub on Exchange and 3Rs The CMS Regtap series provides useful information on implementing health reform. To register for access to the site, visit http://www.regtap.info/login.php.

CCIIO's Regulation and Guidance http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html

The Robert Wood Johnson Foundation and the George Washington University's Hirsh Health Law and Policy Program teamed together to provide a helpful resource on a variety of topics of the ACA, including delivery system reform, Medicaid, Medicare and tax policy. http://www.healthreformgps.org/.

Visit HealthShare TV to hear thoughts from industry experts on all kinds of issues, including Medicaid expansion, health care delivery improvement, cost, quality, ACOs and much more. http://www.healthsharetv.com/

Literature Review and Resources
Health Affairs

Health Affairs Theme Issues that would appeal to a health pricing actuary. Visit http://misc.soa.org/HealthAffairs.pdf for directions on how Health Section members get free access to Health Affairs.

April 2015: Cost and Quality of Cancer Care
December 2014: Children's Health
November 2014: Collaborating For Community Health
October 2014: Specialty Pharmaceutical Spending And Policy
September 2014: Advancing Global Health Policy
June 2014: Economics of Health Care: Costs, Savings, and Value
March 2014: The ACA and Vulnerable Americans: HIV/Aids; Jails
February 2014: Early Evidence, Future Promise of Connected Health
December 2013: The Future of Emergency Medicine: Challenges and Opportunities
October 2013: Economic Trends And Quality Trade-Offs
September 2013: Navigating The Thorns That Await The ACA
August 2013: Health IT, Payment And Practice Reforms
July 2013: States, Medicaid And Countdown To Reform
June 2013: Medicaid Expansion And Vulnerable Populations
May 2013: Tackling The Cost Conundrum

Literature Review and Resources Congressional Budget Office (CBO)

CBO Publications on a variety of the topics mentioned earlier:

- Budgetary and Economic Effects of Repealing the Affordable Care Act
- The 2015 Long-Term Budget Outlook
- Effects of the Affordable Care Act on Health Insurance Coverage – Baseline Projections
- Proposals for Health Care Programs – CBO's Estimate of the President's Fiscal Year 2016 Budget
- Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update

http://www.cbo.gov/topics/health-care

Literature Review and Resources Medical Inflation

ALTARUM INSTITUTE Health Sector Indicators Briefs (monthly)

http://altarum.org/our-work/cshs-health-sector-economic-indicators-briefs

Health Care Cost Institute (HCCI) Trend Reports
http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report

NHE Projections Released CMS' Office of the Actuary published their widely read annual article on National Health Expenditures Projections.

Literature Review and Resources Employer Actions

Employer Penalty Flowchart
Kaiser Family Foundation's flowchart is an excellent visual summary of the 2014 and beyond affect of not offering affordable health insurance. http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/attachment/employer-penalty-flowchart-v3-071513/

Employer-Sponsored Insurance and Health Reform: Doing the Math
NIHCR Research Brief No. 11 This research brief describes the financial considerations around employers' decision to offer and not offer health insurance, and why for most but not all employers, continuing to offer health insurance makes sense financially. http://www.nihcr.org/ESI-and-Health-Reform

Changing the ACA's Definition of Full-Time Work
Discussion of how the ACA's definition of full-time employment (at least 30 hours per week, compared to the traditional 40 hour week) may affect employment.
http://americanactionforum.org/research/changing-the-acas-definition-of-full-time-work

Literature Review and Resources Reference Based Pricing

Reference Pricing: Stimulating Cost-Conscious Purchasing and Countering Provider Market Power In this essay, author James Robinson describes how this design has increased consumerism and put pressure on providers' prices.
http://www.nihcm.org/expert-voices-reference-pricing-stimulating-cost-conscious-purchasing-and-countering-provider-market-power

Literature Review and Resources Specific Coverages

National Institute for Health Care Reform (NIHCR): State mandates
www.nihcr.org/State_Benefit_Mandates.html

Does Bariatric Surgery Impact Medical Costs Associated With Obesity?
A team of researchers from the School of Medicine and the Bloomberg School of Public Health at the Johns Hopkins recently undertook a multi-year analysis of health insurance claims data to examine this question and found that although the procedure's success rate is well-documented, the surgery does not have a similar "reducing" impact on health care costs.
http://www.jhsph.edu/news/news-releases/2013/weiner-bariatric-surgery.html

AHRQ Research on Medication Adherence As part of AHRQ's *Closing the Quality Gap: Revisiting the State of the Science* series, the Medication Adherence Interventions report summarizes the evidence available on the comparative effectiveness of interventions and policy approaches to improve medication adherence, as well as demographic and delivery mode influences on results, and unintended consequences of interventions. The research includes references to the connection of adherence to health outcomes. http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1249&pageaction=displayproduct

GAO Reports on Savings from Generic Drugs The U.S. Government Accountability Office (GAO) released a literature review on the cost savings achieved by greater generic drug use.
http://www.gao.gov/assets/590/588064.pdf

Literature Review and Resources
Pent Up Demand / Induced Demand

Indications of Pent-up Demand

This is preliminary examination of the use of services that are likely to be deferred or even avoided due to financial constraints as a result of lack of health insurance.

https://www.soa.org/Research/Research-Projects/Health/2015-pent-up-demand-health.aspx

Oregon Medicaid Lottery Studies

Pent Up Demand of the Newly Insured In this Milliman Health Reform Briefing Paper, actuary Rob Damler shows how early efforts in Indiana can help inform other States and actuaries on what may occur as they venture into the new health insurance exchange marketplace in 2014. http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf

RAND Corporation Research Briefs: Skin in the Game How Consumer-Directed Plans Affect the Cost and Use of Health Care By Amelia Haviland, Roland McDevitt, M. Susan Marquis, Neerai Sood, Melinda Beeuwkes Buntin http://www.rand.org/pubs/research_briefs/RB9672.html

Literature Review and Resources Geographical Variation

Affordable Care Act Plans and Premiums in Rural America The National Advisory Committee on Rural Health and Human Services discusses pricing and premiums for rural populations with regards to the 2014 market. http://www.hrsa.gov/advisorycommittees/rural/publications/plansruralamerica.pdf

Study Concluded that Spending Variation Driven by Regional Differences in Health Status and Hospital www.nihcr.org/spending_variation.html

Geographical Variation in Health Care Spending The National Institute for Health Care Reform (NIHCR) Research Brief No. 7 by Chapin White, finds that health status and hospital prices are major factors that drive differences in regional health care spending. http://www.nihcr.org/spending_variation.html

The Dartmouth Atlas of Health Care has collected a wealth of data on geographic differences by region, by hospital and by topic and much more. Also related to this topic, Nancy Walczak, FSA, was featured at a Society of Actuaries webcast on January 14, 2013 on this same subject, giving actuaries an overview of findings from a recent 20-month long study of private health plans that was commissioned through the Affordable Care Act is available for purchase on the SOA's website archive. http://www.dartmouthatlas.org/

Medicare Payment Advisory Commission's June 2013 Report: Medicare and the Health Care Delivery System has a chapter devoted to geographic adjustment of payments for the work of physicians and other health professionals. http://www.medpac.gov/documents/Jun13_EntireReport.pdf

Literature Review and Resources 3Rs

Headwinds cause 2014 risk corridor funding shortfall By Scott Katterman, FSA, MAAA
http://www.milliman.com/insight/2015/Headwinds-cause-2014-risk-corridor-funding-shortfall/

Transitional reinsurance at 100% coinsurance: What it means for 2014 and beyond By Hans K. Leida PhD, FSA, MAAA, Doug Norris, PhD, FSA, MAAA, Daniel Perlman, FSA, MAAA,
http://us.milliman.com/insight/2015/Transitional-reinsurance-at-100-coinsurance-What-it-means-for-2014-and-beyond/

Risk adjustment: overview and opportunity: Top 10 notable issues related to the federal risk adjuster By Mary van der Heijde, FSA, MAAA and Jordan Paulus, FSA, MAAA
http://us.milliman.com/insight/2015/Risk-adjustment-Overview-and-opportunity-Top-10-notable-issues-related-to-the-federal-risk-adjuster/

Risk Corridors Episode IV: No New Hope By Hans K. Leida PhD, FSA, MAAA, Doug Norris, PhD, FSA, MAAA, Daniel Perlman, FSA, MAAA,
http://us.milliman.com/uploadedFiles/insight/2014/risk-corridors-no-new-hope.pdf