



**SOCIETY OF
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**HEALTH
SECTION**



Health Watch

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475 N. Martingale Road, Suite 600
Schaumburg, Ill 60173-2226
Phone: 847.706.3500
Fax: 847.706.3599
www.soa.org

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Marjorie Rosenberg, FSA
Kwame Smart, FSA, FCIA
Kelsey Stevens, FSA, MAAA

Newsletter Editor

Marilyn McGaffin, ASA, MAAA
mmcgaffin@gmail.com

Program Committee Coordinators

Rick Pawelski, FSA, CERA, MAAA
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Ashlee Borcan, FSA, MAAA
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Casey Hammer, FSA, MAAA
2019 SOA Annual Meeting & Exhibit Coordinators

SOA Staff

Joe Wurzburger, FSA, MAAA, Staff Partner
jwurzburger@soa.org

Dee Berger, Section Specialist
lberger@soa.org

Julia Anderson Bauer, Publications Manager
jandersonbauer@soa.org

Julissa Sweeney, Senior Graphic Designer
jsweeney@soa.org

Letter From the Editor

By JoAnn Bogolin

This is my last issue as the editor of *Health Watch*, and what an issue it is! The biggest news I have to share is that beginning with this issue, the newsletter is undergoing “digitization.” Digitization means more than having an electronic version of *Health Watch*; it means making the newsletter interactive. Each article from *Health Watch* will have its own webpage with active links to content; readers will be able to shape each page to fit the device with which they are viewing it; and every article will be voice enabled so our audience can listen to an article rather than reading it. These are just a few features intended for our newsletter, and more features will roll out over time.

The second treat within this issue is a soup-to-nuts examination of consumer-driven health plans in “Consumers to the Rescue? A Primer on HDHP and HSAs.” A team from Milliman produced a concise but comprehensive article on what every new FSA should know about these health plans. This article is considerably longer than a typical *Health Watch* article because it will become part of the SOA’s curriculum and an essential read for many members of our community.

Also in this issue, we have two articles covering Medicare Advantage. Michelle Angeloni and Shelby Weber discuss Medicare Advantage experience data and considerations around and beyond ASOP 23. Nick Johnson and Michael Polakowski discuss value-based insurance designs (VBIDs); clarify the definition of “primarily health-related” when it comes to supplemental benefits; reinterpret the benefit uniformity requirement; and cover chronic care programs, rewards and incentives, and nominal gifts. The timing of this issue of *Health Watch* is ideal for the information provided in these articles to be considered in the CY2020 MAPD bid development process.

You will also have a chance to get to know Olga Jacobs a bit better through the leadership interview. Then Sudha Shenoy and Gail Stone interview Medicaid and risk adjustment experts to provide the community with information about the emerging practice of risk adjustment in the Medicaid population; Tim van



Laarhoven and Michael Cohen provide an in-depth discussion around the defunding of the cost-sharing reduction subsidy and what carriers and regulators are doing or can do in the face of this regulation change; Joanne Buckle and team provide an update on a research paper presented last year on alternative payment models for high-cost curative therapies; and Greg Fann continues his examination of the evolution of the individual market.

Given the size of this issue, I do not want to use any more space on my ramblings, except to say it has been an honor and outright pleasure serving as the editor of *Health Watch* because it has given me the chance to meet so many interesting, diverse and clever members of our community. To all of the authors, thank you so much for volunteering your time and sharing your knowledge! The community is grateful for all of your efforts! ■



JoAnn Bogolin, ASA, FCA, MAAA, is a member of the Health Section Council and managing director at Bolton Health Actuarial in Atlanta. She can be reached at jbogolin@boltonhealth.com.

Chairperson's Corner

By Karen Shelton

As I write my first Chairperson's Corner, I find myself reflecting on the Health Section Council leadership meeting that wrapped up earlier today. As we were discussing how the Health Section benefits its members, one theme bubbled to the top: *Our members need (and want) to be more broadly engaged in the industry in a timely and relevant manner.* It is extremely beneficial to have a working knowledge of what's going on in the industry as it unfolds, as well as the broad actuarial implications that go along with it. We become more credible sources of information and better actuaries by exploring these topics.

A blessing and a curse of being a health actuary is the diversity of the topics that we touch. The blessing is having a variety of interesting areas in which to work. The "curse," if you will, is the imperative to stay on top of current events in the industry at the right level of depth. For example, at the time of writing, new regulatory guidance on Section 1332 waivers was released. This is an area where I have zero experience; my domain is employer-sponsored health plans. I would not have even heard the buzz were it not for being the Health Section chair. Simply put, I need to find a better way to stay current.



I think the challenge with staying apprised of industry events stems from three areas:

- **Our jobs themselves tend to be fast-paced.** We are so focused on addressing the issues at hand that making time to keep a finger on the pulse of areas outside our immediate sphere of practice is a challenge.
- **Information is changing and can quickly become outdated.** I'm probably not alone in having a backlog of industry articles that I have every good intention of reading. By the time I get to them—assuming that even happens—the information is often “old news.”
- **The amount of information available can be overwhelming.** There's certainly no lack of information today. I just searched the Internet for news on Section 1332 waivers and got 2,230 hits. The challenge is narrowing in to the right level of detail from a reliable, unbiased source.

Wouldn't it be nice if there were a single site that was updated frequently with the latest industry happenings and their actuarial implications? It sure would go a long way to alleviate some of the challenges identified above! To this end, the Health Section Council will be leveraging social media—primarily LinkedIn—to bring you a synopsis of the latest developments in our industry, the skinny on the latest research and reminders for upcoming events. We hope that this will become a valued resource you visit frequently to easily stay informed.

We also encourage you to get involved. You can do this in a variety of ways. First, visit (and follow) the SOA Health Section's LinkedIn group page at [Bit.ly/SOAhealthLI](https://bit.ly/SOAhealthLI). Second, share and comment on posts. It's an opportunity to share information and insights so that we can learn from one another and build a community. Third, volunteer to write a short synopsis on a relevant topic for inclusion on our page. If you'd like to write, please reach out to our volunteer coordinator, Casey Hammer, at Casey.Hammer@milliman.com.

P.S. If you're still curious about Section 1332 waivers, check out the overview on the Health Section LinkedIn page at [Bit.ly/SOAhealthLI](https://bit.ly/SOAhealthLI). ■



Karen Shelton, FSA, MAAA, is a senior director of actuarial services within National Accounts at UnitedHealthcare. She can be reached at Karen_shelton@uhc.com.

Up Front With the SOA Staff Fellow

By Joe Wurzburger

I wrote in my column last issue about an upcoming “Influence Training for Actuaries” seminar that was offered at the Society of Actuaries (SOA) Annual Meeting & Exhibit. Since that time, the event occurred, and as I expected, it was fantastic. And as I had hoped, I got to meet several of you there.

The experience once again reinforced the notion that, generally speaking, we as actuaries could benefit from developing our soft skills, particularly with respect to communication. Andrew Sykes did an amazing job at the Influence Training for Actuaries seminar teaching us about the art of storytelling. I’d like to take this opportunity to pass along another few concepts for your consideration as you prepare for your next presentation.

SESSION FORMAT

With the SOA’s Health Meeting only a few months away, I know many of you are developing sessions to present in Phoenix. More often than not, that process looks something like this:

1. Choose a topic.
2. Recruit speakers.
3. Assign subtopics to each speaker.
4. Separately prepare mini-slide decks for each subtopic.
5. Combine the minidecks into one megadeck.
6. Take turns reading through slides during the session itself.

This format is referred to as a panel discussion, and there are times when it is the most effective format. But I think it is often simply the default. Session presenters prepare in this way because they didn’t really consider anything else.

Instead of following that process, I’d challenge you to try something more like this:

1. Choose a topic.
2. **Determine the best session format.**
3. Decide next steps based on the format chosen.
4. Recruit speakers.
5. Present your session at the SOA Health Meeting.
6. Rejoice at how awesome it was.

You’re probably thinking, what other types of session formats are there? I’m so glad you asked. You might consider an interactive forum, where an active moderator “interviews” the various panelists. There may be some slides, but much of it feels more spontaneous than that, even though the questions are often given thoughtful consideration in advance. Questions from the audience are mixed in along with questions prepared in advance by the moderator. Note that this format is particularly useful if you have recruited a VIP to be one of your presenters, as this requires virtually no prep on the part of the presenters outside of perhaps giving some thought to the questions being prepared by the moderator.

Don’t just do what has always been done. Think about what you can do to be impactful.

Another format to consider is a buzz group. This is a format in which session attendees are broken into groups that meet at round tables—maybe 8–10 people per table. Topics are assigned to each table, as is a table moderator, and the discussion flows from there. Each table typically reports out to the full group after a predetermined amount of time. Usually there is time for one table rotation as well so that each attendee gets to participate at two tables on separate topics. (If you select this format, make sure to notify SOA meeting planners about the necessary room setup, as the room will need to be equipped with round tables and easels with flip charts.)

There are many other session formats that could work, as well: moderated debates, mock trials, “Shark Tank”-style competitions, and so on. Be creative!

Audience Engagement

Maybe a panel discussion truly is the best format. If so, please consider ways to engage your audience. Did you know that the SOA’s new meeting app allows for polling at *every* session if desired? Find ways to incorporate live polling into your session so that your audience feels like a part of the action throughout the presentation.

Another way to make a session more engaging is to ask the audience questions. But don’t just ask, “So, how many of you already know about topic X?” Instead, be thoughtful about the questions you ask. Try to avoid simple yes/no questions and instead ask audience members to share opinions or stories from their experience. You must be careful not to stray into anti-trust territory here, but if done well, this type of audience engagement can help attendees connect with others in the room and raise the energy level of a session.

The Visual Component

On the topic of your slides, it is often true that “less is more.” This pertains not just to presentations at SOA meetings but also those back in your workplace. At times, more detail on a slide can be helpful, particularly if you anticipate the slides being used as a handout after the fact. But generally speaking, your slides should accompany your spoken word, not be seen as a suitable replacement for it. I’d encourage more graphics and less text. Give the audience a reason to listen to you rather than just read from the slide!

NOT HOW, BUT RATHER, SO WHAT?

Moving away from presentations at industry meetings, there are many other settings in which an actuary will be asked to present information. Whether we’re presenting to senior leaders within our own company or to important clients, we as actuaries tend to want to spend time talking about “how.” That is, how we were able to do the amazing work we just did! I mean, not just anyone can do stochastic modeling, or perform cash flow testing or any of the other awesome feats of actuarial strength that we can do. So let’s walk them through it, step by step.

Of course, you probably already realize that this is typically a poor strategy. Most likely your audience is very glad that you are paid to do that work so that they don’t have to think about it themselves. Rather, they want to know, “So what?” “What does your work mean to me?” “What strategic decisions need to be

made based on this analysis?” Tailor your communication with them accordingly. Detailed descriptions may be worth including in an appendix, but focus the meat of your time with your audience on what they are there to hear: What does this mean for me and my company?

PARTING THOUGHTS

The ideas I’ve shared may not apply in every situation. I’m sure there are examples of times when a panel discussion is best, slides with lots of words on them are essential, and you better believe my audience needs to hear exactly how I did all of that amazing work! And besides, the ideas I’ve shared are largely my opinions; you are welcome to your own.

But at the very least, I hope this gets you thinking. Next time you have a chance to communicate with an audience, whether it’s at an SOA meeting or at your place of employment, be thoughtful about how you approach the task. Don’t just do what has always been done. Think about what you can do to be impactful. Maximize your effectiveness and consider what will make your audience feel like their time is being used wisely. I promise it will be worth the effort. ■



Joe Wurzburger, FSA, MAAA, is Health staff fellow at the Society of Actuaries. He can be reached at jwurzburger@soa.org.

A person in a red jacket and blue jeans is rappelling down a rock face. The sky is a mix of blue and orange, suggesting a sunset or sunrise. The person is wearing a white beanie and has climbing gear on their harness. Two ropes are visible, extending from the person down towards the bottom of the frame.

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Consumers to the Rescue? A Primer on HDHPs and HSAs

By Fritz Busch, Barbara Collier, Jason Karcher and Steve Phillips

The rapid growth rate of per capita health costs in the U.S. has been a sore spot in economic forecasts for nearly a century.¹ From employer-provided health care to employer-sponsored health insurance to health maintenance organizations (HMOs) to today's latest products, U.S. health policy has evolved and, as a key driving force throughout this evolution, has long sought a tool that can limit annual health care expenditure growth to roughly the overall rate of inflation. A perennially hot topic in health policy is the combination of high-deductible health plans (HDHPs) with either a health savings account (HSA) or a health reimbursement account (HRA). HDHPs were born in the 1970s and became integrated alongside HSAs and HRAs into U.S. health and tax policy in the early 2000s. Many see them as crucial pieces of our health care system going forward. In this article, we examine the development of the HDHP and the HSA, the ideology behind them, current research on their impact on health care and some possible paths forward for both.

BRIEF HISTORY OF THE HIGH-DEDUCTIBLE HEALTH PLAN AND HEALTH SAVINGS ACCOUNT

The genesis of the HDHP in the U.S., particularly when paired with some form of tax-advantaged savings accounts such as an HSA or HRA, can be traced as far back as the 1970s to politically conservative groups such as the National Center for Policy Analysis (NCPA). The idea was embraced by many other groups and individuals, and HDHPs enjoyed broad bipartisan support and eventual enshrinement into the laws and tax code in the early 2000s. The history of HDHPs and HSAs is best viewed within two phases: before and after the 2003 Medicare Modernization Act (MMA).

Phase 1: Pre-MMA

Employer-provided health coverage has been a major part of how Americans receive health coverage ever since these benefits were excluded from taxation in the 1940s. Early benefit plans were often part of a single monolithic employee welfare

plan, without much choice for employees. The earliest roots of HDHPs go back to the idea of consumer empowerment. These ideas began to manifest themselves as far back as the mid-1970s, with the birth of cafeteria plans that allowed employees to select the benefits that best met their individual needs.² At about the same time, the Internal Revenue Service (IRS) created a health version of the flexible spending account (FSA). Still in use today, these accounts allowed some consumer choice in purchasing health care, but they primarily attempted to address tax issues arising from increasing deductibles and copays—a purpose still shared by today's HSAs.

As health care costs rose over time, so too did the level of cost sharing in the form of deductibles, copays, and coinsurance. Part of this cost-sharing trend aimed to reduce costs for employers and other plan sponsors by shifting costs to employees. However, this strategy was also intended to align consumer costs with medical trends, reduce the effect of deductible leveraging and increase incentives for consumers to be thoughtful purchasers of health services.

Another approach beyond the FSA was the HRA. First included in benefit plans in the 1960s to reimburse employees for those health expenses outside traditional employer-sponsored coverage, the funds in an HRA can be used to reimburse an employee for qualified medical expenses. These types of “defined contribution” health accounts grew in prevalence before being formalized in IRS guidance in 2002. Health FSAs and HRAs share many similarities, including the ownership of account funds by the employer and the requirement that they be offered as part of an employee benefits package.³ However, HRAs face fewer restrictions on account carry-forward and originally were not required to be offered as part of a group health plan sponsored by the employer.

In the mid-1980s, the medical savings account (MSA) was first proposed as a solution for Medicare's long-term funding crisis by then-NCPA president John Goodman (now considered the “father of the HSA”). In 1990, the NCPA organized a task force of think tanks, universities and research organizations that produced a report that advocated self-insuring smaller medical expenses (i.e., much higher deductibles).⁴ Goodman and Gerald Musgrave expanded on that report in their 1992 book *Patient Power*.⁵ Subsequently, and largely as a result of the NCPA's work and advocacy in the area, Congress introduced numerous bipartisan bills in 1992 aimed at creating MSAs. None of these bills passed at the federal level, but several states did introduce and pass MSA laws. These early plans were not particularly successful, because the member contributions were not tax-deductible. Through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress first allowed a pilot project of tax-advantaged MSAs for small businesses and

the self-employed. Under this pilot, the total number of Archer MSAs allowed was 750,000,⁶ but only a small portion were ever purchased due to restrictions on them.⁷ HIPAA defined the cost sharing for plans eligible to have an Archer MSA, formally creating HDHPs and distinguishing HDHPs from plans with high cost sharing—a distinction that would be carried forward to the broader commercial market alongside the HSA.

Although the Archer MSA was short-lived (the program ended in 2005 nationwide, except for California), it set the stage for the advent of the HSA, which was introduced in 2003 by the MMA.

Phase 2: Post-MMA

In 2003, President George W. Bush signed the MMA. Although the title and the bill itself dealt predominantly with Medicare, the HSAs it introduced were not available to Medicare participants.⁸ The HSA represented a significant improvement over the Archer MSA. Under the legislation, HSAs were made a permanent feature of the tax code, were available to anyone purchasing a qualifying HDHP and could be funded by both employer and employee. As the value of the HDHP/HSA combination has become more broadly recognized, enrollment has continued to climb⁹—despite some health policy experts’ expectations that the Affordable Care Act (ACA) would slow HSA growth.

ANATOMY OF THE HDHP/HSA COMBINATION

As HDHPs and HSAs moved from the realm of health care reform theory to the U.S. Internal Revenue Code, both acquired specific definitions that must be met in order to receive the benefits that came with that formalization.

What Makes an HDHP?

What makes an HDHP different from a major medical policy? First, an HDHP has a specific meaning under the IRS code that governs the tax deductibility of the accompanying HSA. The IRS releases cost-sharing requirements each year for a plan to be HDHP-qualified. For 2019, the IRS defines HDHPs as health

plans “with an annual deductible that is not less than \$1,350 for self-only coverage or \$2,700 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed \$6,750 for self-only coverage or \$13,500 for family coverage.”¹⁰ These limits do not apply to out-of-network services. The annual deductible and out-of-pocket expenses are subject to inflation each year, though the HDHP out-of-pocket maximum is significantly lower than the maximum allowed under the ACA (which is \$7,900 for self-only coverage for 2019).^{11,12} The table in Figure 1 shows the HDHP limits for benefit years 2015 through 2019.

Second, an HDHP has limited first dollar coverage. For both medical and pharmacy services, individuals usually need to pay the full allowed cost (i.e., billed charges net of any insurer discounts) for services provided, up to the plan deductible. The only notable exception is that certain preventive care benefits can be covered by an HDHP prior to reaching the deductible,¹³ potentially with a copay or other cost sharing. Many services covered by HDHPs are subject to coinsurance after the deductible is met, while some require copays for select services. Once the individual meets the out-of-pocket maximum, the plan will pay 100 percent of the allowed cost. By law, an HDHP cannot cover costs for nonpreventive prescription drugs until the deductible is met.

To illustrate typical HDHP cost sharing, assume that a theoretical HDHP has a \$2,000 deductible, 25 percent member coinsurance, a \$6,750 out-of-pocket maximum and no copayments for self-only coverage. If an individual incurs \$8,000 in allowed claims, that individual will pay the first \$2,000 (which is subject to the deductible) and \$1,500 in coinsurance (25 percent of the next \$6,000 in allowed claims), for a total cost sharing of \$3,500. This calculation is very similar to that of a typical non-HDHP employer plan, though a non-HDHP would likely result in fewer costs for the individual as the deductible may be lower and certain services may be subject to copays only.

Figure 1
HDHP Cost-Sharing Limitations

Benefit Year	Self-Only Coverage		Family Coverage	
	Minimum Deductible	Out-of-Pocket Maximum	Minimum Deductible	Out-of-Pocket Maximum
2015	\$1,300	\$6,450	\$2,600	\$12,900
2016	\$1,300	\$6,550	\$2,600	\$13,100
2017	\$1,300	\$6,550	\$2,600	\$13,100
2018	\$1,350	\$6,650	\$2,700	\$13,300
2019	\$1,350	\$6,750	\$2,700	\$13,500

Limitations on HDHP deductibles and out-of-pocket limits are updated annually by the IRS. Values shown were published in IRS Revenue Procedures 2014-30, 2015-30, 2016-28, 2017-37, and 2018-30.

The interaction between individual expenditures, HDHP minimum deductibles and out-of-pocket maximums becomes more complicated for family coverage. HDHPs with self-only deductibles below the family minimum deductible (\$2,700 in 2019) are required to administer an aggregate deductible. That is, family members would be liable for the full allowed amount of services provided until the family deductible has been met in total, meaning that the first member of the family with claims could be responsible for meeting the entire family’s deductible before moving into the coinsurance corridor. All else equal, an aggregate deductible results in higher member liability and lower plan premiums.

However, if the self-only deductible is greater than the family minimum deductible, an embedded deductible approach could be used, where each member of the family is subject to the lesser of their own individual deductibles and the remainder of the family deductible. In this case, the first member of the family with claims would be responsible for meeting only their own deductibles prior to moving into the coinsurance corridor. Even in HDHPs with aggregate deductibles and out-of-pocket maximums, the total cost sharing incurred for each family member must stay below the ACA’s out-of-pocket maximum for an individual family member (\$7,900 in 2019).

What Makes an HSA?

By design, HDHPs expose enrollees to significant up-front costs in addition to premium payments. In return, they include savings accounts dedicated to paying for health expenditures, including deductibles and coinsurance under the HDHP. By far, the most common type of account is the HSA, although the HRA is also in use. Health FSAs are still common and can be “stacked” with an HSA in certain cases, but these are more popular with non-HDHP enrollees and are sometimes targeted specifically for vision and dental services.

HSAs allow those individuals or families whose only comprehensive medical coverage is through an HDHP to save money



for health care expenses on a pretax basis. Deposits can be made up to an annual maximum (illustrated in Figure 2) by both the employer and the employee, and amounts can be used for a variety of medical expenses—not just those under the HDHP.

If deposits are made through an employer’s payroll process, the amounts are deductible from payroll taxes as well as personal income tax, so that tax treatment of these contributions is identical to employer and employee contributions to group health plan premiums. Deposits made outside of payroll are still exempt from personal income tax but do not reduce payroll taxes. This means health expenses paid for by an HSA enjoy first dollar deductibility from income whereas expenses otherwise

Figure 2
HSA Contribution Limits

Benefit Year	Self-Only Coverage	Family Coverage
	Maximum Contribution	Maximum Contribution
2015	\$3,350	\$6,650
2016	\$3,350	\$6,750
2017	\$3,400	\$6,750
2018	\$3,450	\$6,900
2019	\$3,500	\$7,000

Limitations on HSA contributions are updated annually by the IRS. Values shown were published in IRS Revenue Procedures 2014-30, 2015-30, 2016-28, 2018-27, and 2018-30.

paid for out of pocket are only deductible when they exceed 7.5 percent of income, per IRS regulation. This tax preference is designed to encourage enrollees to adopt HDHPs and HSAs in lieu of more traditional coverage.

As mentioned earlier, the HSA balance is owned by the enrollee and remains in the account, potentially accruing interest, regardless of when the funds are deposited or where the enrollee chooses to obtain medical coverage in the future. Many HSA accounts also have an investment feature and function more like retirement accounts when the balance reaches a certain threshold. Any such investment growth accumulates tax-free. As long as funds in the HSA are used for eligible medical expenses, they remain tax-free at the time of withdrawal, which is a more favorable tax treatment than retirement account withdrawals.

HRAs and health FSAs are other types of tax-advantaged savings accounts. Both HRAs and health FSAs are only available in conjunction with employer-sponsored health plans, while HSAs can be used with individual coverage as well. The table in Figure 3 summarizes key features of HSAs, HRAs and FSAs.

THE THEORY OF HDHPS

The designers of HDHPs attempted to balance consumer empowerment and responsibility with the potential impacts

of the high deductible and the presence of the tax-preferred account.

Consumer Choice and Empowerment

A major tenet of HDHPs is encouraging individuals to take greater responsibility in selecting health services and controlling costs. As costs have increased steadily over the years, employers have shifted a larger share of claim payment responsibility to employees in order to keep their own costs down. The belief is that by “having skin in the game” individuals will be more conscientious about their behaviors, such as comparing prices between hospitals, physicians and pharmaceuticals and saving for future expenses. Theoretically, this behavior should help control costs in the present and may even limit future premium increases, as individuals will be more selective in the care they seek. Some have suggested, however, that future premium increases may actually be larger if care is avoided today and results in more catastrophic care needs later on. Examples of consumer behavior among individuals enrolled in HDHPs include the following:

- **Saving for health care services.** Because unused funds are owned by the HSA enrollee and are not lost, this encourages regular deposits into the account even if future health care expenses are not anticipated.

Figure 3
Comparison of Savings Accounts

Feature	HSA	HRA	FSA
Who owns the account?	Employee/individual	Employer	Employer
Who can contribute?	Employee/individual and employer	Employer	Employee and employer
Are contributions tax-deductible?	Yes	Yes; contributions made by employer are excluded from gross income	Yes, except long-term care contributions made by employer
What are the contribution limits?	See Figure 2	Unlimited*	\$2,700 in 2019
Can the funds roll over to the next year?	Yes	Yes, but not required and commonly forfeited at employment termination	Yes, but not required; most employers have an annual “use-it-or-lose-it” policy
What distributions are tax-free?	Medical, prescription drugs, dental, vision, long-term care premiums, Medicare premiums	Medical, prescription drugs, dental, vision, health insurance premiums, long-term care premiums and expenses*	Medical, prescription drugs, dental, vision
What distributions are not eligible?	Amounts covered under another health plan (subject to penalties)	Amounts covered under another health plan	Health insurance premiums, long-term care premiums or expenses, amounts covered under another health plan
Is an HDHP required?	Yes	No, but can be used with HDHP	No, but can be used with HDHP

*Contributions to qualified small employer HRAs (QSEHRAs) are limited to \$4,950 for self-only coverage and \$10,000 for family coverage. Currently, only QSEHRAs can be used to pay individual market premiums. Like other HRAs, QSEHRAs can also be used to cover expenses but must be integrated with an individual market policy and were created through the 21st Century Cures Act in December 2016. A proposed rule to allow large employers to pay for individual market premiums via an HRA was released on October 23, 2018, and is not covered in this article.

- **Selecting a more appropriate treatment venue, such as using urgent care instead of the emergency room.** Because enrollees are exposed to significant first dollar cost sharing, the benefits of finding a lower-cost provider or treatment accrues directly to them. There are many consumer tools that facilitate this process.
- **Avoiding unnecessary care.** Similarly, “shopping” may lead an enrollee to forgo treatment for minor ailments or avoid those treatments that have marginal benefit.
- **Selecting generic prescription drugs instead of higher-cost, brand-name prescription drugs.** In addition to the direct impact of lower costs, generic drug prices tend to grow more slowly than brand drug prices, so continued use of generic substitutes can lead to compounded savings.
- **Comparing quality ratings of providers.** Online tools for quality rankings of providers are also growing and becoming more sophisticated.
- **Negotiating prices with providers, particularly for costs under the deductible.** Lower cost-sharing requirements under many plans do not encourage enrollees to investigate or question provider charges as they have little stake in the outcome. In contrast, enrollees with HDHPs are exposed to potentially more out-of-pocket costs and “own” the money in their HSA (though not money in their HRA) so their interest in the outcome of a discussion with providers related to their charges is likely much greater.
- **Improving their own health and taking other illness avoidance measures.** If enrollees make the connection between better health and lower out-of-pocket costs, the combination of the HDHP and an HSA provides incentives for the enrollee to reap the benefits of any health improvement activities they might undertake.

Paired with an HDHP, an HSA is an important vehicle for saving for future health services. Employers may contribute to the HSA on employees’ behalf, and employee contributions are usually automatically deducted from paychecks and deposited into the HSA throughout the year. Because individuals are able to see the funds in their HSAs, they may be more careful about spending.

At the same time, consumers with urgent care needs may not have the time to engage in proactive consumer behaviors, such as shopping for lower-cost alternatives, but will still be exposed to the initial brunt of these costs. Individuals with higher-cost chronic care needs are more likely to hit their out-of-pocket limit, in which case cost considerations are less likely to be a part

of their decision-making process. For those with known medical conditions, the total of premiums plus the out-of-pocket limit, cash flow timing and provider access are more likely to shape plan selection; plan design and account funds are much less likely to have an impact on the actual care received and costs incurred.

Is “High” Actually High?

In theory, an HDHP should balance the minimum deductibles against the expected cost. For instance, an HDHP could lose its effectiveness with a relatively low deductible, as individuals will not be as cost-conscious. Alternatively, an HDHP with a relatively high deductible could result in individuals paying the full cost of health care services except for truly catastrophic, large-dollar claims (balanced by lower up-front spending on premiums).

We analyze various deductible levels against continuance tables to determine the amount of claims subject to an HDHP’s deductible level. Figure 4 summarizes the probability that claims are higher than the deductible for a typical enrollee in a commercial health plan. Continuance tables are based on the Milliman *Health Cost Guidelines* and reflect an assumed market average discount on nationwide billed charges.

Figure 4
Claims vs. Deductible

Deductible	Probability Claims Exceed the Deductible
\$1,000	53%
\$1,350	48%
\$1,500	45%
\$2,000	40%
\$2,500	35%
\$3,000	32%
\$5,000	24%
\$10,000	15%

For more information on the Milliman Health Cost Guidelines, see <http://www.milliman.com/Solutions/Products/Resources/Health-Cost-Guidelines/Health-Cost-Guidelines---Commercial/>.

Using our assumed discounts, an individual has a 48 percent chance of having at least \$1,350 in claims, while a deductible level of \$3,000 (slightly higher than the family minimum deductible) would be met by only 32 percent of individuals. However, these percentages can vary significantly by expected utilization. To the extent that HDHPs result in decreased utilization with respect to a typical employer plan, these plans would show a lower probability that individuals meet a given deductible.

Plans with better-than-average discounts, plans in less expensive regions or plans with lower-than-average morbidity will see fewer enrollees meet deductibles, while plans with lower-than-average discounts, plans in more expensive regions or plans with better-than-average morbidity will see more enrollees meet deductibles. Regardless of reimbursement level, geographic area or morbidity level of enrollees, as the deductible increases further, the individual pays an ever-higher percentage of claims and has more of an incentive to minimize costs. In the end, the “high-ness” of a deductible will depend on the individual’s level of utilization and its associated costs.

Impact of HDHPs and Savings Accounts on Claims

Ultimately, a member’s insurance use is determined not only by the deductible level of that person’s plan but also by the funding received from the employer or personally invested in the account. Because the employer solely funds the HRA or FSA and those funds are less portable, people are more likely to behave in a way that uses the dollars in an HRA or FSA more freely than the dollars that they have personally invested in their HSAs.

In the case of either HSAs or HRAs/FSAs, the associated HDHP has an assumed reduction in utilization as members try to avoid the additional out-of-pocket costs subject to their deductibles. However, the inclusion of employer-funded amounts offsets some of the assumed utilization savings as the member is not truly responsible for all out-of-pocket costs until the deductible is met. Figure 5 outlines the utilization reductions and offsetting utilization increases for certain combinations of deductible and coinsurance for HDHPs and savings accounts, respectively, based on the Milliman *Health Cost Guidelines*. Account funding is likely to be on the lower side of the cited ranges if the employee owns the account (in other words, if the account is an HSA), but on the higher side if an employer-owned account such as an HRA or FSA is used.

For example, if an average member had costs of \$400 per member per month (PMPM) before utilization adjustments, we would expect a \$3,000 deductible with 20 percent member coinsurance would reduce the utilization and thus the associated costs to \$372 PMPM ($\400×0.930), resulting in a \$28 PMPM

reduction from utilization adjustments alone. However, if the plan had an associated account balance of \$1,500 annually, the costs would be expected to lie between \$7.44 ($\372×0.02) and \$18.60 ($\372×0.05) PMPM higher than without the funded amount, and likely toward the lower end when the account is an HSA and toward the higher end otherwise.

The utilization adjustments outlined here assume that all types of members have an equal likelihood of selecting an HDHP plan with an HRA/FSA/HSA balance. However, research shows that healthier members or members with higher incomes are more likely to select HDHP plans because they have the expectation that the savings in premium will be greater than the additional cost sharing.¹⁴ The potential for antiselection is particularly relevant in the individual market, where enrollees can always select their own plans, or in employer markets where employees are given the choice between an HDHP and a richer plan design (that is, a plan with lower member cost sharing). Because of the opportunity for selection bias, employers who offer employees a choice between HDHPs and richer plans should ensure that there is a sufficient premium differential among the plans to control the risk of antiselection. Employers should also recognize that offering plan choices drives overall aggregated costs upward due to employees’ financial incentives to select the plan that is expected to work best for them.

HDHP Prevalence in the Market

Based on studies by America’s Health Insurance Plans (AHIP), the number of enrollees in HSA-qualified HDHPs has grown from approximately 1 million in 2005 to more than 20 million in 2016.¹⁵ Two-thirds of enrollment in 2005 was in the individual market, but enrollment in HSA-qualified HDHPs grew significantly in the large-group market so that now almost four out of every five HDHP enrollees are in the large-group market. Individual market HSA-qualified HDHP enrollment growth continues, but enrollment gains have been much more gradual.

Employers in both the small- and large-group markets have incentives to offer HSA-eligible HDHPs, as these plans shift costs to employees while theoretically reducing their use of services. However, incentives are different in the individual market,

Figure 5
Allowed Cost Impact of Plan Design and Account Funding

Deductible	Member Coinsurance	Impact of Plan Design	Impact of Account Funding*
\$1,350	0%	4%	1%–4%
\$3,000	20%	–7%	2%–6%
\$6,000	40%	–15%	1%–7%

*Assumes plan funding is equal to 50 percent of the plan deductible. For more information on the Milliman *Health Cost Guidelines*, see <http://www.milliman.com/Solutions/Products/Resources/Health-Cost-Guidelines/Health-Cost-Guidelines---Commercial/>.

as enrollees may select their own carrier and plan, with a wider variety of benefit richness since the ACA's implementation of metallic tiers starting in 2014. Also, individual market enrollees generally pay some or all of their own premiums, though many market participants are eligible for federal premium tax credit subsidies that can significantly reduce the cost of coverage. In general, one might expect the individual market's transition to less healthy, older and lower-income enrollees with more benefit design choices to result in selection of richer benefit designs, as are seen in employer coverage. However, with the exception of those with incomes under 200 percent of the federal poverty level (who qualify for rich variations of silver plans with highly subsidized cost sharing), the general trend has been toward leaner plan designs such as HDHPs. This phenomenon results from a number of other factors, including (1) the high cost of unsubsidized or lightly subsidized premiums, (2) premium tax credit leveraging that can make premiums for bronze plans and lower-cost silver plans appear disproportionately attractive because they are indexed to the second-lowest-cost silver plan, (3) the tax, portability and ownership qualities of HSAs and (4) age curve compression, which can often make older enrollees better off with leaner plan selections, even upon a worst-case scenario analysis.¹⁶ Silver and bronze plans are very popular on the individual market for all of these reasons, and many of them are HDHPs.

The most recent market shift in the implementation of HDHPs and HSA-like accounts has been in the Medicaid market. Several states, including Indiana and Arkansas, implemented HSA-style



accounts where Medicaid beneficiaries make monthly contributions.¹⁷ However, states have struggled to pinpoint the segments of the Medicaid population to cover through these programs, in part due to concerns about whether Medicaid recipients behave similarly to commercial market enrollees when faced with an account-based health plan.

THE PRACTICE OF HDHPS

Studies conducted over the past 10 years attempted in various ways to measure the impact of HDHPs on claim costs, quality of care, consumer behavior and financial burdens. A majority suggest HDHPs have favorable effects. However, several studies refute this point or run contrary to other research. This section summarizes some of this research.

Claim Costs

Several studies have found cost savings in the form of reduced health expenditures between 5 percent and 15 percent for HDHPs:

- A 2011 study analyzed claim and enrollment data for more than 800,000 households and found that families with HDHPs spent 14 percent less on health care compared to similar families in non-HDHPs.¹⁸
- A 2010 study analyzed more than 75,000 members over three years and found HSA enrollees spent between 5 percent and 7 percent less than non-HSA enrollees.¹⁹
- A 2015 study analyzed 13 million employees and found that employers who offered HDHPs had 5 percent lower health costs than employers who did not offer HDHPs.²⁰

Additionally, a 2013 study tracked data over four years from two large employers—one with an HDHP and one without—to analyze the impact of HDHPs on costs. The study found that the large employer with the HDHP experienced 0.26 fewer physician office visits, 0.85 fewer prescriptions filled and 0.018 more emergency room (ER) visits per enrollee per year.²¹ However, the data provided do not show whether the reductions in office visits and prescriptions are related to unnecessary care or whether the utilization reduction may result in health complications in the future. At least one study indicates that reduced utilization occurs in preventive care, which is a key concern surrounding HDHPs.²² Reduced health care utilization, including preventive care, has also been found to be a function of plan design features.²³

While the majority of studies point to lower costs with HDHPs, a few studies support different conclusions. Some have observed that the use of HDHPs has not resulted in any change in

costs and that various utilization decreases for chronic disease sufferers are not associated with statistically significant cost reductions.^{24,25}

On a raw level, HDHP cost savings are primarily driven by three factors: (1) the relative health of individuals selecting the different plans, (2) the utilization impact arising strictly from plan design and funding, and (3) cost savings resulting from increased consumer engagement. Most early studies of HDHP savings did not separate these, but more recent studies often make some effort to address savings based on health status and selection versus other drivers.²⁶ Additionally, HDHPs have not shown a clear ability to bend the cost curve beyond their impact in the initial year of adoption, though savings over non-HDHP coverage appear to be retained from year to year.

Consumer Behavior and Health Outcomes

A 2016 study measured consumer behaviors among *individuals* enrolled in HDHPs and found the following (with their prevalence in parentheses):²⁷

- Saving for future health services (40 percent).
- Comparing prices (14 percent).
- Comparing quality (14 percent).
- Negotiating prices for services (6 percent).

However, consumers' behaviors may be to the detriment of their health. As we noted earlier, several studies indicated varying degrees of reduced preventive care. If consumers forgo preventive care, health conditions may worsen and lead to higher costs in the future.²⁸ A majority of employers' spending on preventive care goes toward cancer screenings and cancer prevention such as mammograms, colonoscopies and HPV vaccinations. If less use of preventive care comes with missed opportunities for early cancer diagnosis, effects may extend beyond long-term costs to the length and quality of lives. Little research has been done into how health outcomes vary for individuals enrolled in HDHPs versus those enrolled in other types of plans. This limits the ability to draw any conclusions as to the effects of any appropriate care reductions. Additionally, few studies we are aware of speak to the long-term impacts of cost savings for those forgoing medical treatment.²⁹

Financial Burdens

Members with higher-deductible plans are obligated to pay higher shares of costs as they begin to incur claims. If a member has several office visits early in the policy period, the member will pay 100 percent of the costs of the visits up to the deductible. Many non-HDHP designs include copays for primary care and specialist care visits, limiting the member's obligation to a fixed value per visit, such as \$50. The higher share of costs may

be a burden to members. For example, a 2017 Federal Reserve Board report indicated that about 40 percent of adults would not be able to cover a \$400 unexpected expense.³⁰ This may also lead to HDHP enrollees forgoing necessary care until it becomes a critical need.

A 2016 study analyzed the 2011–2013 Medical Expenditure Panel Surveys conducted by the Agency for Healthcare Research and Quality (AHRQ).³¹ The study found HDHPs were most financially burdensome for low-income adults. Among adults with employer-sponsored insurance and incomes below 250 percent of the federal poverty level, about 27 percent to 30 percent of adults with an HDHP, approximately 20 percent of adults with low-deductible plans and approximately 15 percent of adults with no-deductible plans had out-of-pocket health care costs exceeding 20 percent of family income. If members are unable to pay their share of health care costs, hospitals and physicians will not receive their share of reimbursement, potentially leading to higher fees to cover the bad debt associated with nonpayment.

Individuals do not always have all the information needed to utilize HDHPs effectively.

Other Factors That Could Make HDHPs Work Better

Although various studies have had conflicting conclusions regarding the effectiveness of HDHPs, there are some additional factors that could make them more effective.

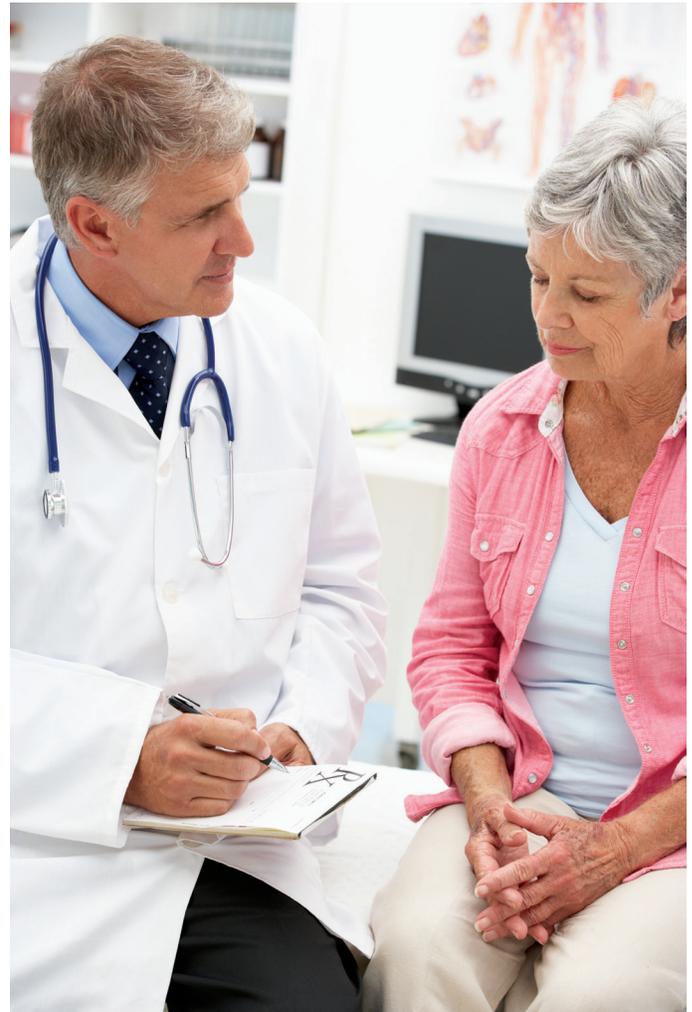
1. **Cost transparency.** Costs in the health care system are not always transparent, and it is difficult for members to price shop in the current market. Providers may charge patients different rates for the same services depending on insurance coverage, and coverage specifics may even be impacted by billing procedures. As a result, many patients cannot know their share of the costs until they receive invoices from providers. Additionally, providers may not know the full cost until the medical services have been performed, particularly when service cost is dependent on factors that are not known before a procedure.

Because of the lack of cost transparency, patients may find it difficult to make health care decisions based on cost. While HDHPs should encourage individuals to choose efficient and cost-effective providers, individuals do not always have all the information needed to make that decision. With greater cost transparency from both providers and insurance companies, individuals may be better informed.

2. **Discussions between providers and patients.** Providers and patients should have discussions about the costs of potential treatments or prescription drugs. Providers are in a good position to determine the effectiveness of various treatments based on their experience and can help patients assess treatment options, including considerations for costs. These discussions may be particularly important in value-based care arrangements in which providers are compensated based on the quality and effectiveness of care. These discussions are also important in “reference-based” plans, which target a threshold dollar amount for services, beyond which the enrollee would pay 100 percent of the excess.
3. **Pre-funding of HSAs.** Both employers and employees are eligible to contribute to HSAs. In most cases, HSA contributions are made evenly throughout the year. If medical services are incurred early in the year, individuals may not have enough HSA funds available to cover the costs. Allowing employers and employees to contribute funds in lump sums may ease this concern.
4. **Allowing more first dollar coverage.** The high deductible on all services is a blunt instrument that might cause people to forgo necessary services. Suggestions include paying for most primary care services (not just preventive care services) and paying for certain chronic condition supplies and testing, such as those related to diabetes.
5. **Lengthened consumerism.** HDHPs could be redesigned to increase an individual’s “skin in the game.” One way would be through different plan designs, such as allowing higher out-of-pocket maximums but lower deductibles so the “consumerism” effects are felt longer by way of coinsurance.

The Impact of Drug Coupons

Recently, much attention has been paid to various drug reimbursement strategies by manufacturers and pharmacy benefit managers. Of particular importance in the context of HSAs and HDHPs is the concept of drug coupons. In contrast to a rebate, a drug coupon is provided directly to the enrollee and pays for a portion of that person’s drug costs. These coupons are often tied to brand-name drugs and can significantly reduce the medication’s price for the enrollee while increasing plan costs for employers by incenting the higher-cost prescription. Coupons present a lifeline to those seeking an otherwise unaffordable medication. However, coupons remove incentives that underlie HDHPs and create possible tax issues with the IRS. For these reasons, many insurers and self-insured plan sponsors prohibit coupons or do not allow them to be credited toward the deductible and out-of-pocket maximum.



THE FUTURE OF HSAs

Although health care policy has been a sensitive topic since the passage of the ACA in 2010, improvements to HDHPs and HSAs became a focus when Republicans took control of both houses of Congress in 2014. Although most of these changes have not been passed, numerous bills and regulatory guidance have been proposed that can generally be grouped into the following categories:

- Changes that expand which plans can be paired with HSAs.
- Changes that expand the ability of individuals to contribute to HSAs.
- Changes that allow HSAs to be used for a broader variety of expenses.
- Changes that expand the scope of HSAs beyond major medical health care.

Expansion of Plans That can be Paired With HSAs

One of the core limitations of the HSA is the pairing with qualifying HDHPs. Various proposals have considered expanding the range of possible pairings.

HSAs Could be Paired With all ACA Bronze and/or Catastrophic Plans

Bronze and catastrophic plans have very high deductibles—ones that meet the minimum requirements but can even exceed the maximum allowed cost-sharing amounts for an HDHP. Catastrophic plans fail to meet the IRS's HDHP requirement that nonpreventive costs cannot be covered until the deductible has been met, because these plans must cover the first three primary care clinic visits at no or low cost sharing. Given the high levels of cost sharing inherent in these plans, it seems reasonable that the same HDHP/HSA pairing logic and the benefits of consumerism could apply to these plans as well.

Line up ACA and HDHP Maximum Out-of-pocket Limits

If HDHP limits are increased to align with the ACA's higher maximum limits on annual cost sharing, issuers offering ACA-compliant coverage would be able to craft a wider range of plan designs that comply with HDHP requirements and ensure that HSAs are available in the bronze tier. This proposal is somewhat more limited than allowing HSAs to be paired with all bronze and catastrophic plans, but it retains more of the clear consumer empowerment components of current HDHPs.

Allow Medicare-eligible Individuals to use HSAs

Medicare-eligible individuals are, in aggregate, some of the highest users of services, and Medicare-related topics often drive health policy. As a result, any tool engaging consumerism in this population could reap outsized benefits in terms of overall utilization. The Medicare MSA presents an account-based option within the Medicare framework;³² however, enrollees selecting an MSA may not deposit their own funds into the account. Additionally, federally mandated reimbursement levels and limits on non-MSA benefit designs could limit consumer incentive to shop around beyond that already present in the Medicare Advantage market. Although continued access to and ability to fund an HSA would provide a tax-advantaged environment, it may be less likely to result in the desired consumer empowerment that underlies the HDHP/HSA pairing because of the overall higher level of utilization in this population.

Allow Anyone to use an HSA

The idea of universal availability of the HSA has also been proposed, which would make HSAs more similar to typical investment accounts. HSAs would have the distinct advantage of allowing individuals to select a health plan that is consistent with their willingness to bear risk for higher health expenses. However, it would also likely reduce the ability for HSAs to

TIMELINE OF THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP) AND THE HEALTH SAVINGS ACCOUNT (HSA)

Mid-1980s	The kernel of the idea promoted by John Goodman
1996	HDHP initially defined by Health Insurance Portability and Accountability Act alongside the Archer Medical Savings Account
2003	The current HDHP and HSA formalized in the Medicare Modernization Act
2006	HDHP limits modified by the Health Opportunity Patient Empowerment Act
2010	HSAs modified in small ways by the Affordable Care Act

meaningfully reduce costs, as the focus of these accounts could shift from their role in assisting with health care costs to their role as an investment vehicle.

Expansion of Contributions

Although contributions are not as often a feature of discussion in the HDHP/HSA policy debate, two contribution-related proposals have been a consistent feature of proposed HSA legislation.

Allow Contributions to Match the Out-of-pocket Maximum

The maximum contribution amount for an HSA is about half of the maximum out-of-pocket limitation for HDHPs. This means an individual enrolled in a lean HDHP may be paying for a significant portion of costs with dollars that are not tax-advantaged. By allowing HSAs to cover all enrollees' health care expenses under any HDHP design, these plans would see an additional tax benefit. Further, employers may be more willing to consider leaner HDHPs and bring the corresponding potential for increased consumer influence on prices. However, these higher deductibles may also result in more avoided care and higher costs down the road if not paired with a sufficiently high HSA amount.

Allow Spousal Catch-up Contributions in Family HSAs

Currently, only one spouse can make contributions to an HSA starting at age 55 when both spouses are enrolled in the same plan. Allowing both spouses to make catch-up contributions would remove this "marriage penalty" and allow for greater savings.

Expansion of Major Medical use of HSA Funds

While HSAs can be used for a variety of major medical expenses, there are limits. Proposals to remove the limitations are described next.

Allow use of HSAs for Health Care Premiums

Currently, HSAs cannot fund premium payments. This may not be as much of a concern with employer-sponsored coverage, where premiums are typically paid via payroll deduction. However, the ability to use HSA funds to pay for other coverage could result in increased uptake of insurance in the individual market. Because HSA funds are tax-advantaged, this would remove one of the key differences between individual versus employer-sponsored coverage. Current limitations on HSA contributions, however, imply that most or all of the HSA would be spent on premiums instead of medical costs, limiting their value in deferring or defraying costs through consumerism.

Allow use of HSAs for Over-the-counter Health Supplies

One of the changes in the ACA was to remove the ability for HSAs, HRAs and FSAs to be used to purchase over-the-counter (OTC) medical supplies, including medications that are not typically covered by health insurance. These supplies can be an important part of everyday medical care, and allowing HSAs to be used in this capacity could encourage individuals to self-treat for minor injuries for which they might otherwise seek medical attention. However, this too would reduce the amount of funds available to pay for current HSA-eligible medical expenses.

Allow use of HSAs for Direct Primary Care Arrangements

Under a basic direct primary care arrangement, an individual pays a set monthly retainer to a physician up front and can see that physician as needed.³³ The IRS has ruled that this, in essence, constitutes a health insurance plan, and correspondingly, HSA funds cannot cover its cost. Direct primary care arrangements have increased in popularity as individuals and primary care doctors seek more personal care. Like HSAs, this arrangement aligns with consumer empowerment and could create cost reductions. However, as with OTC supplies, HSA dollars spent on direct primary care would redirect funds away from HSA-eligible medical expenses.

Expansion of Nonmajor Medical use of HSA Funds

The last category of proposals relates to nonmajor medical use of HSAs and tends to be both less explored and more controversial.

Allow use of HSAs for Fitness Equipment

One topic of debate is the role of wellness in reducing overall expenses. Proposals have been made to expand the use of HSAs to cover nonmedical wellness items, in particular fitness equipment such as treadmills. In theory, allowing individuals to use HSA funds to encourage wellness would be offset by significantly reduced health expenses associated with healthier living. Critics argue that this allowance would create a new tax avoidance for a purchase and activity that an individual would normally do.

Allow use of HSAs to Pre-fund Long-term Care Needs

Funding for long-term care (LTC) is a major crisis in our health care system. The amount and duration of LTC expenses represents a financial risk that has led to rising rates for LTC insurance and significant instability in the market segment. This also represents a major financial crisis for state Medicaid budgets. If HSAs can be expanded to accommodate LTC costs, they may be able to be part of the solution to a pressing need.

CONCLUSION

From their genesis in the latter half of the last century to their current place as a conservative cure-all for our health care system, HDHPs and the related funding mechanisms continue to be significant topics in the health policy debate. Because of their relatively recent rise to prominence, the jury is still out on just how effective HDHPs and HSAs are in the quest to reduce health care expenditures and improve quality and patient outcomes. Although there are signs these plans reduce costs, there are also signs that the reduction is at least partly due to the avoidance of beneficial services and that reductions do not compound year over year. More research is needed to assess the value these plans can offer, and thus determine what changes may allow HSAs to maximize their benefit to our health care system. ■



Fritz Busch, FSA, MAAA, is a consulting actuary at Milliman Inc. He can be reached at fritz.busch@milliman.com.



Barbara Collier, FSA, MAAA, is a consulting actuary at Milliman Inc. She can be reached at barbara.collier@milliman.com.



Jason Karcher, FSA, MAAA, is an actuary at Milliman Inc. He can be reached at jason.karcher@milliman.com.



Steve Phillips, FSA, MAAA, is an actuarial director at Anthem. He can be reached at steven.phillips@anthem.com.

ENDNOTES

- 1 Several charts are available from Health System Tracker. Peterson-Kaiser, n.d., https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-per-capita-basis-health-spending-grown-substantially_2017_document_the_long-term_phenomena (accessed December 19, 2018).
- 2 Cafeteria plans were formally enshrined in Section 125 of the Internal Revenue Code in November 1978 and are often also referred to as Section 125 plans.
- 3 Recent proposed changes by the Trump administration significantly alter the HRA landscape but are beyond the scope of this article.
- 4 In many ways, higher deductibles are more consistent with the typical notion of insurance as protection against catastrophic events, as the enrollee pays for small routine expenses out of pocket but still has protection against large, unpredictable expenses, as with other elements of our financial safety system.
- 5 An additional and important academic work by Goodman and economist Mark Pauley outlining the combination of tax incentives, medical savings accounts and catastrophic insurance was published in *Health Affairs* in 1995. See Pauly, M. V., J. C. Goodman, J. Feder, L. Levitt, S. M. Butler, D. M. Cutler, and G. R. Wilensky. 1995. Incremental steps toward health system reform. *Health Affairs (Millwood) Spring*:125–139, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.14.1.125>.
- 6 The Archer MSA was named after Representative Daniel Archer, who proposed the amendment containing MSAs.
- 7 Access to MSAs was limited to small employers and self-employed individuals, and tax-free contributions could be made only by either the employee or the employer, but not both, during any taxable year.
- 8 Medicare MSAs were also introduced in this bill.
- 9 America's Health Insurance Plans. Health savings accounts and high deductible health plans grow as valuable financial planning tools. *America's Health Insurance Plans*, April 2018, https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf (accessed November 7, 2018). AHIP notes in this report that HDHPs have increased fairly steadily in enrollment from about 1 million lives in 2005 to almost 22 million lives in 2017.
- 10 IRS Revenue Procedure 2018-30. 26 CFR 601.602. <https://www.irs.gov/pub/irs-drop/rp-18-30.pdf> (accessed November 7, 2018).
- 11 The initial ACA out-of-pocket limit for 2014 was set equal to the HDHP out-of-pocket limit. However, the ACA limit is indexed by premium growth, while the HDHP limit is indexed by the consumer price index. Because health care premiums have grown faster than consumer prices, the ACA limit has increased so that it is now significantly higher than the HDHP limit.
- 12 There are different deductible and out-of-pocket maximums for Archer MSA plans, which are not covered in this section as they have largely been replaced by HSAs.
- 13 For preventive services allowed to be covered on a first dollar basis, see Publication 969 (2017), Health savings accounts and other tax-favored health plans. *IRS.gov*, March 8, 2018, https://www.irs.gov/publications/p969#en_US_2017_publink1000204037 (accessed December 19, 2018). Additionally, the ACA requires non-grandfathered health coverage to provide several preventive services with no cost to the enrollee. See Preventive health services, *Healthcare.gov*, n.d., <https://www.healthcare.gov/coverage/preventive-care-benefits/> (accessed December 19, 2018).
- 14 McDevitt, R. D., A. M. Haviland, R. Lore, L. Laudenberger, M. Eisenberg, and N. Sood. 2014. Risk selection into consumer-directed health plans: an analysis of family choices within large employers. *Health Services Research* 49, no. 2:609–627. doi:10.1111/1475-6773.12121.
- 15 Supra note 9.
- 16 An example of a worst-case scenario analysis would be evaluating the sum of premium costs and the plan's out-of-pocket cost limit.
- 17 These accounts have typically been funded by the state following a nominal monthly contribution based on enrollee income.
- 18 Beeuwkes Buntin, M., A. M. Haviland, R. McDevitt, and N. Sood. 2011. Healthcare spending and preventive care in high-deductible and consumer-directed health plans. *American Journal of Managed Care* 17, no. 3:222–230.
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Medicare Advantage Experience Data: Pitfalls and Concerns Beyond ASOP #23

By Michelle Angeloni and Shelby Weber

Medicare Advantage organizations (MAOs) face many challenges when preparing their Medicare Advantage (MA) bids for the upcoming year. In particular, when organizations assess their emerging claims experience or review a prior year's data, they may struggle with the quality of data available. MAOs must consider influences both internal and external to the claims adjudication process as they review and use their data. Is the claims experience consistent with the plan benefit package (PBP) and provider contracts? Does the claims experience seem reasonable compared to prior years and benchmarks? MAOs must evaluate these and other important questions as they prepare their historical data for bid development.

INTERNAL CONSIDERATIONS

MAOs must use appropriate data to price their bids, both in order to comply with required bid instructions and to increase accuracy of future projections; however, this task is not always a simple one. Depending on how many vendors they contract with, the complexity of provider contracts and how they store and perform quality assurance on their own data, MAOs can have many data-related concerns. These concerns may include items that are internal to the claims adjudication process, including the following topics.

Does the Data Contain the Required Elements?

MAOs must properly store and classify all relevant data for their covered members and benefits. This may include eligibility, fee-for-service (FFS) claims data, and capitated encounter and payment data received from all vendors that process this data. These vendors may include the MAO's third-party administrator as well as any specialized vendors (e.g., for a fitness or transportation benefit).

MAOs must compare the data they have to the benefits covered in that period to identify any missing elements. Once the MAO has collected data from all vendors, it must assess the quality of

the data and address any deficiencies. MAOs will need to consider several potential areas of concern, such as these:

- **Missing information.** MAOs may struggle to obtain complete data at the level of detail required to perform bid pricing. For certain benefits, an MAO may have difficulty receiving claims data at the member level (i.e., the MAO may not have tracked the data at that level of detail or may not have ready access to it). There may also be instances when the MAO or its vendor did not track encounter data associated with capitation arrangements.
- **Aggregate data.** Some vendors may provide data for several services that are covered under their contract with the MAO but may not include enough detail to allow for an accurate allocation to the corresponding services. For instance, a vendor adjudicating a vision benefit may provide claims data for both hardware and exam services in the same data set, but might not provide enough information to distinguish between the two to correctly populate the Bid Pricing Tool (BPT).
- **Integration of benefits.** Some vendors may provide data for a service that integrates Medicare and Medicaid benefits. MAOs will need to be able to segregate the two benefits and use only the subset of data covered by Medicare.
- **Medicare- vs. non-Medicare-covered benefits.** Some service categories (such as vision and hearing) include services that are covered by traditional Medicare and other services that are covered only via supplemental benefits. If a supplemental benefit is offered, the MAO must be able to identify and separate claims for Medicare-covered vs. non-Medicare-covered services.
- **Incomplete data.** Depending on the vendor and benefit, there may be significant lags in the completion of the data. Additionally, if the MAO recently switched vendors or renegotiated contracts, it will need to ensure it is receiving complete information that reflects the terms of the contract in place at the time of service.
- **Eligibility.** MAOs must confirm that the claims and encounter records are consistent with the eligibility records. In general, beneficiaries with end-stage renal disease (ESRD) cannot join an MA plan. Thus, Part C data must exclude all claims for ESRD individuals. However, this will change in 2021 as Medicare beneficiaries with ESRD will be allowed to enroll in MA plans.
- **Utilization considerations.** MAOs will need to identify any claim records that could lead to over- or underreporting



utilization if handled incorrectly. Depending on the situation, this could include claim records with \$0 paid, records that reflect adjustments or denials, utilization records for a benefit such as transportation that includes both an original and return trip, or instances where multiple visits (such as to a chiropractor) are included on one claim form. In addition, sufficient data must be collected in order to determine the unique number of utilizers for each service category to satisfy BPT reporting requirements.

- **Paid amount considerations.** MAOs must understand the contents of each dollar amount field to ensure data are used appropriately. For instance, capitated encounter data may include a “paid” amount field. However, this field may be purely informational, reflect the capitated payment or reflect a payment made in addition to the capitated payment. Additionally, the total payment to a provider may be in the form of multiple components (e.g., a capitated payment and an additional administrative fee). Also, some organizations track the paid amount both before and after a sequestration adjustment. The MAO should understand each source of paid data and confirm it has accurately captured all payments associated with a given service.
- **Classification.** MAOs will need to classify data into the categories the BPT and PBP require for bid pricing. This classification can be a complex process that incorporates

numerous claim elements and decision-tree logic to ensure appropriate classification, account for denials or adjustments and assign various utilization metrics (e.g., days vs. admits). Consistent classification of claims also allows for meaningful benchmark testing and multiyear analyses.

Tools built around grouping software allow MAOs to efficiently perform such classification and provide a platform for consistent benchmarking. Milliman developed one such tool that sorts data into benefit service categories based on current medical code sets and can mitigate an MAO’s expense associated with annual Centers for Medicare and Medicaid Services (CMS) PBP definition compliance.

There will be nuances associated with each benefit, and MAOs must understand those nuances to be able to identify errors and appropriately use the data for bid pricing.

Is Claims Experience Consistent With Benefit Parameters and Provider Contracts?

MAOs frequently work with many vendors to adjudicate each of the benefits covered by the plan. This can quickly lead to poor outcomes if the MAO does not periodically audit the data and correct discrepancies. When MAOs audit their data, they may be able to identify and stop adjudication errors concurrently, thereby reducing the amount they would have had to attempt to recover retroactively.

Identifying adjudication errors is important from both a financial standpoint and a bid preparation standpoint. MAOs will need to handle adjudication errors correctly when reporting data in the BPT, populating the financial reconciliation and determining the appropriate experience basis for bid pricing. MAOs should audit their data to identify claims that may be inconsistent with the PBP or provider contracts. Examples of this may include the following:

- **Capitated arrangements.** MAOs may contract with certain vendors under a capitated arrangement. MAOs should validate that the vendor is receiving the correct contracted amount and that they are covering services consistent with the PBP for eligible members only. Additionally, MAOs should confirm that the covered services are being paid only under the specified capitation arrangement and are not additionally being erroneously paid as FFS as well. This is especially important as plan sponsors reshape reimbursement arrangements with their providers, which may require significant modifications to existing claim-processing systems.
- **Member cost sharing.** MAOs should audit their data to confirm that vendors and providers are charging the plan's beneficiaries correct member cost sharing according to the PBP and CMS rules. It is possible for a vendor or provider to charge an erroneous copayment to a member (or no copayment at all), resulting in the MAO over- or underpaying for a benefit. Furthermore, CMS maintains specific cost-sharing limits for certain services, and all services are subject to a maximum effective member cost share of 50 percent of the negotiated reimbursement rate. MAOs should monitor data to ensure compliance with all CMS rules.
- **Benefit coverage.** MAOs should confirm providers and vendors are providing their beneficiaries with the correct coverage for each of their plans. MAOs likely vary their coverage across their product portfolio. As part of a periodic audit, MAOs should validate that each plan is being adjudicated and covered at the correct level for that particular plan.

The earlier plan sponsors detect these issues in emerging experience, the faster they can take corrective action and recoup any amounts owed to them.

Is Claims Experience Reasonable Compared to Internal Expectations?

After gathering, understanding and cleaning the data, the MAO should review experience and compare to what it expected for

that book of business. This actual-to-expected comparison will help the MAO understand emerging financial results, identify new adjudication or contracting issues, identify areas of utilization management improvement and set assumptions for the upcoming bid year.

MAOs should perform this actual-to-expected review throughout the year, as well as during the year-end financial statement reporting process. Delaying this experience data review until early spring (when Medicare bids are typically prepared) may result in unexpected outcomes, late changes and avoidable discrepancies. MAOs can prepare for the upcoming bid cycle during the year-end financial statement reporting process by reviewing and reconciling claims, gathering certain settlement items and developing incurred but not reported (IBNR) completion factors.

EXTERNAL CONSIDERATIONS

As part of the MA bid development process, MAOs will also need to address several considerations external to the claims adjudication process. These items may be driven by competitive benchmarks or regulatory influences, including the following.

Is Claims Experience Reasonable Given External Benchmarks?

MAOs should compare their claims experience to both the plan's expected results and external benchmarks. External benchmarks should consider the plan's geographic area, covered benefits, risk score and level of utilization management. Through external benchmarking, the MAO will be able to identify opportunities for improvement and areas where it may be an outlier. It can react to this information by implementing changes or programs that will be reflected in the upcoming bid year.

Is Claims Experience Being Prepared to Comply with CMS Requirements for Bid Pricing?

To expedite bid pricing, MAOs should prepare their claims experience data in compliance with CMS requirements from the beginning. Some common problem areas and solutions are presented here.

- **Nonbenefit expenses.** Payments must be categorized as a nonbenefit expense or a medical claims expense consistent with CMS guidance. MAOs may pay an "administrative fee" to a vendor for adjudicating a certain benefit. The classification of this expense as nonbenefit expense or medical claims expense in the BPT may depend on how the *total* vendor payment is structured. Likewise, an MAO may consider certain internal expenses to be an "administrative expense" rather than a medical claims payment (e.g., for a nursing hotline benefit). The classification of these expenses in the

BPT must be consistent with the classification of these expenses in the PPB.

- **Capitation encounters.** CMS requires encounter data for all services to be incorporated into the BPT, including for those services that are provided under a capitation arrangement. If accurate encounter data are not available, plans are required to disclose the deficiency and develop a corrective action plan for future years.
- **Global payment allocation.** Global payments related to capitation or risk-sharing arrangements are required to be allocated proportionally to the net cost of services covered under the contract for Worksheet 1 reporting. MAOs must ensure appropriate classification of benefits and isolation of different provider contracts in order to accurately complete such an allocation.

MAOs must take care to comply with CMS guidance. This will minimize any potential issues during the desk review and audit processes and will similarly reduce the likelihood of having to resubmit bids to address deficiencies.

CONCLUSION

Collecting, reviewing and reacting to Medicare Advantage claims experience is crucial to the success of the plan. Successful data maintenance involves addressing data quality issues, rectifying adjudication errors, comparing to internal and external benchmarks and making the necessary adjustments to comply with CMS guidelines. Employing these controls will lead to optimal financial results and efficient processes. ■



Michelle Angeloni, FSA, MAAA, is a consulting actuary at Milliman Inc. She can be reached at michelle.angeloni@milliman.com.



Shelby Weber, ASA, MAAA, is an associate actuary at Milliman Inc. She can be reached at shelby.weber@milliman.com.

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Leader Interview

With Olga T. Jacobs

Olga T. Jacobs, FSA, MAAA, is vice president of actuarial strategy and operations at UnitedHealthcare (UHC). She has more than 25 years of actuarial experience, predominantly in pricing, product development, rate filings and regulatory rating compliance of group medical products.

Olga served as an elected member of the Society of Actuaries (SOA) Board of Directors from 2014 to 2017. She previously served on the SOA Inclusion & Diversity Committee and was the chairperson in 2017. Olga also served on the SOA Health Section Council and is the former chair of the SOA Leadership & Development Section Council. She has been a member of the SOA Examination Committee for more than 18 years and currently is on the faculty of the Fellowship Admission Course. Olga is also serving her second year as a contributing editor for *The Actuary* magazine. She received the SOA Outstanding Volunteer Award in 2013.

ON BEING AN ACTUARY

Health Watch (HW): How and when did you decide to become an actuary?

Olga T. Jacobs (OTJ): When I was in my senior year of college, I accepted the offer of full-time employment into the Travelers Actuarial Student Program. I don't think I *decided* that being an actuary was going to be my career until I became an FSA. Up until that moment, I would still say, "If I can't pass exams, I will go back to school for my MBA," and try my hand at a different set of exams!

HW: What other careers did you consider? Or if you have had other careers, can you describe them?

OTJ: High school students who were good in math and science seemed to be pushed to study engineering, so I joined the crowd. Off I went to Penn State to study engineering. Once I had two years of engineering studies under my belt, I concluded that I did not want to be an engineer. I didn't know what to do. So with no guidance, I switched my major to math. This switch in majors still allowed me to graduate on time. I also felt that an education of the logical thinking of math could be applied to



any job. The word "actuary" never entered my vocabulary until I was looking for summer internships after my junior year and got the internship with the Travelers.

HW: What was your favorite job before you became an actuary?

OTJ: As an adult, the only job I've had has been in the actuarial field. Looking back, so many of the jobs I held during my youth had such a huge influence on me. My first job was that of paper delivery girl. Together with my sister, we delivered *The Easton Express* to 70 neighbors. What a great opportunity to learn self-discipline, motivation and communication. Now, in 2018, it boggles the mind that a business enterprise entrusted a 12-year-old girl to collect their revenue and that a parent let that girl enter strangers' homes to get that revenue.

HW: What has been most crucial in your development as an actuary?

OTJ: Wow, that is a tough question. I think it's the recognition that your development never stops. You begin with the foundational technical knowledge from the credentialing process. But you cannot stop there. You need to continue to develop new skills, whether they are technical, such as Visio; creative—a three-hour presentation on health care reform that doesn't put attendees to sleep; or business—how to listen to understand.

HW: Looking at your career as an actuary, do you see any important learning milestones or turning points in your career?

OTJ: First one that pops into my head is when I was asked to run an underwriting department for the middle market group

segment (employers of 51–3,000). I was shocked to see that the actuarial manuals that we agonized over to the fourth decimal point were never sold without adjustment.

During that role, I learned how important relationships are, and that trust was the key to those relationships. The sales team needed to trust me. Brokers needed to trust me. And I needed to trust them. That level of trust could not be built over email. It was face-to-face. And once that trust was broken, it was virtually impossible to get back. The old adage is true: years to build, moments to break.

Leading a team is about setting the vision and empowering the team members to achieve their business goals (while they grow personally and professionally).

HW: As an actuary, what keeps you awake at night?

OTJ: Nothing! I am so confident in our profession. We can handle any challenge that comes! Truly!

I worry about the potential lack of cognitive diversity in our profession. I worry about the balance of a “traditional” undergraduate education in actuarial science and the potential influence of the credentialing process on it. Actuaries of my era came from such varied undergraduate educational backgrounds. Very few were actuarial science majors. I consider that cohort lucky, as we actually had two educational foundations: the one we learned at school and then the actuarial one that we learned on the job and at night after work studying for our exams. We were trained educationally as engineers, teachers, accountants, physicists, and so on. Our educational background brought a good deal of diversity in our thinking and solving of business problems. What happens to our ability to solve some of society’s biggest problems if our educational backgrounds are all the same?

ON BEING A LEADER

HW: How much did your actuarial training prepare you for this role? What additional training—formal, informal or otherwise—did you need to be successful?

OTJ: Achieving your credential is a testament to perseverance, dedication, time management, setting and meeting goals, integrity, teamwork and so forth. Aren’t those qualities that you want in a leader?

HW: What are the most important lessons you’ve learned in your role?

OTJ: That leadership is not found at the top of an organization chart. You may be given the title of leader but that doesn’t make you a leader. Leadership must be earned. Leadership is how you act every day. Everyone is watching.

HW: Let’s say you’re hiring your successor. If you’re presented with two actuaries with equivalent experience and training, what characteristics will help you choose one over the other?

OTJ: My successor? Interesting. I would choose the unselfish one. The one who has demonstrated that they are driven more by the success of their team than their own success. The one who will give opportunities of professional and personal growth to each and every team member, even if that growth means losing your valued team member to another team. The one who will take the blame when things go wrong and pass the credit to the team when things go right.

HW: Describe the biggest one or two challenges that you have faced in your role.

OTJ: Teaching those outside the actuarial department the difference between “actuary” and “actuarial.” [Laughs.]

Building a global sense of community given that our actuarial talent is spread across the country. Building trusting relationships with the people I work with every day when we are just voices on the phone to each other.

Having a balanced life.

HW: What advice would you give to another actuary going into a leadership position for the first time?

Earn your team’s trust. Earn your team’s respect.

Be authentic. Your team wants to know who you are, what you stand for, what you won’t put up with. They don’t want a “talking head” spewing jargon.

Put away the calculator. Leading a team is about setting the vision and empowering the team members to achieve their business goals (while they grow personally and professionally). Your job is to remove the obstacles that are before them. You need to allow them to innovate and solve problems even if it is not how you would have approached or solved the problem. ■

At the Intersection of Risk Adjustment and Social Determinants of Health

By Sudha Shenoy and Gail S. Stone

Risk adjustment (RA) is the statistical process of setting capitation payments for health plans to reflect the expected costs of providing care to their members. Because of differences in health status and treatment needs, expected costs can vary significantly among plan members.

To the extent that risk-adjusted payments reflect the differences among a plan's enrollees and the eligible population, such payments can reduce competition among plans for favorable risks, mitigate the effects of adverse selection and encourage plans to enroll high-cost patients by furnishing the resources needed to provide efficient and effective treatment.

WHAT ARE SOCIAL DETERMINANTS OF HEALTH?

The social determinants of health¹ (SDH) refer to the elements of a person's social and environmental living circumstances that affect his or her health (see Figure 1).

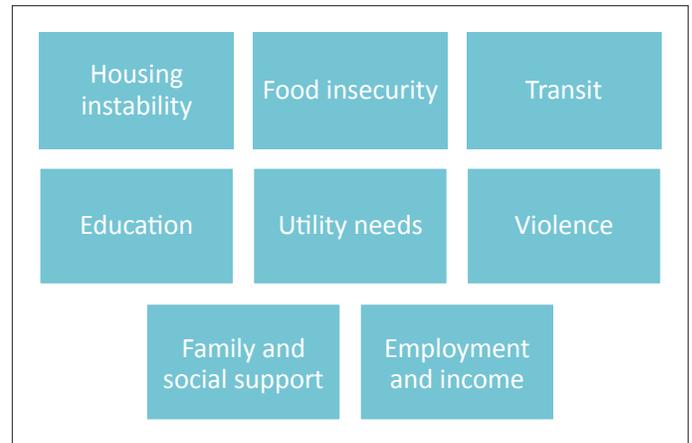
HOW DO SDH IMPACT HEALTH CARE COSTS?

SDH have an important influence on health, health care outcomes and spending. Adding SDH to an RA model will enhance the effectiveness of the prediction by considering health-influencing factors that cannot be found in claims data. Very few states and plans have adopted SDH into their RA methodologies.

INTERVIEW

We talked with Medicaid and RA experts Arlene Ash, Ph.D.; Matt Varitek, FSA, MAAA; Mike Schoeberl, FSA, MAAA; and Brandon Barber to learn more about emerging practice at the intersection of RA and Medicaid. Arlene Ash is a professor and chief, Division of Biostatistics and Health Services Research at UMass Medical School. Matt Varitek is an actuary at Arizona Health Care Cost Containment System (AHCCCS). Mike Schoeberl is a consultant at Forma Actuarial Consulting Services. Brandon Barber is a consultant at Evolent Health.

Figure 1
Social Determinants of Health



RA is a particularly hot topic in Medicaid today. Please share reasons for this increased interest.

Arlene Ash: There has been an enormous push to move Medicaid members into capitated payment contracts, such as accountable care organizations (ACOs), versus fee-for-service payment arrangements. RA is needed for these risk contracts to work well.

Brandon Barber: With the Affordable Care Act (ACA) and Medicaid expansion plans, RA may be in the forefront, but it is not necessarily a hotter topic than in the past. Medicaid is unique to each state, which has been a challenge for those in the industry to measure the impact from state to state.

Mike Schoeberl: Although RA has always been of critical interest to payers, the awareness and understanding of RA has increased among the provider community as payments have moved toward more accountable care models. Increasingly, RA is also being used in outcomes analysis and provider performance measurement. For example, the state of Minnesota has several shared-savings contracts with provider organizations, and RA has been a critical part of the target-setting and performance measurement process.

Matt Varitek: While Arizona does not apply diagnosis-based RA within its long-term care (LTC) programs, adding this component could, as in acute care, provide more fairness in provider payments. Even if the capitation rates paid to our health plans were not formally adjusted due to measuring the respective risk profile of each plan's membership, it would allow us to conduct longitudinal assessments and provide a more complete understanding of the forces affecting medical expenses.

Have you experienced any issues or concerns over your current RA methodology from either a state, client or managed care organization (MCO)/ACO perspective?

Brandon: A state's RA model requires recalibration to the state experience before it can be applied, and misinterpretations of the models are not uncommon. Transparency also needs to be improved within a state's RA program, and a plan should be able to calculate its own risk score independently. States that use pharmacy data to calculate risk scores face a challenge, since drugs-to-risk-factor mappings are not updated often enough to reflect generics and new drugs entering the market.

Mike: Providers frequently believe that the RA and resulting performance measurement does not consider risk factors that are not captured through diagnostic information. When assessing performance at the provider level, you also need to consider the overall credibility of the results, since you're frequently working with smaller population segments whose results could be overly influenced by random events.

There is a growing recognition that we need a more holistic approach to health care.

Today there are more performance-based payment models than in the past and more providers' payments are tied to quality and health outcomes. Do you see a potential shift or refinement in how RA will be applied in the future?

Arlene: In addition to RA for payment, there is increasing recognition that quality measures need to be adjusted to account for expected large differences in quality outcomes, based on large differences in patient mix.

Brandon: Many states currently apply a quality withholding, which is distributed based on measures of performance such as the Healthcare Effectiveness Data and Information Set (HEDIS). The state of Tennessee is integrating quality and RA directly through payment on a medical episode basis. RA is usually applied at a member year level and not concurrent with the payment year, but now it would be applied at a member episode level. A member can have a high-risk profile, but their episodes can be managed well. Traditionally, a member with a high-risk profile and fewer claims in a given year will come out ahead from a plan perspective. The difference here is the episode needs to be triggered first and then the plan is paid

based on the risk profile relevant to the episode at the same time of care.

SDH has been getting a lot of attention recently in the literature. Has your state or client considered this as a refinement to its current RA method?

Mike: Integrating SDH into performance measurement and payment models has been encouraged legislatively in Minnesota. From my perspective, most of the activity prior to and resulting from this legislation has been around data development and research. However, the state has integrated SDH into at least one provider payment model that I'm aware of.

Arlene: In 2014 MassHealth [Massachusetts' Medicaid system] contracted with the University of Massachusetts Medical School to support developing a risk model for payment that considered SDH in addition to medical risk. This SDH model is more accurate than the old model, and MassHealth has used it for payment since 2016. It is widely viewed as fairer to plans that care for vulnerable subgroups and better for managing health care.

Matt: We are supportive of the SDH concept, and this aligns with the vision of the agency. As a state agency, though, we have budget concerns and constraints, but we may consider use of SDH in the future. We need to consider how they will get applied and the impact on policy as well as implementation issues.

Brandon: SDH will grow in popularity. Their value is widely supported by data, and providers will buy into the use of SDH. We know they are clearly tied to health outcomes, and so the issue is not acceptance of the idea but rather standardizing the collection and categorizing the data.

How will SDH RA impact or potentially impact the following: Payments to providers? State budgets? Care and outcomes for beneficiaries? Accuracy of the RA process?

Arlene: Inadequate RA rewards plans for enrolling low-risk members, for whom it is easy to achieve better-than-average outcomes at lower-than-average cost. RA is needed to reward plans for better-than-*expected* outcomes and lower-than-*expected* costs. For example, in modeling emergency department visit rates for MassHealth, members with mental illness and/or substance use disorder with unstable housing used 50 percent more than average; adjusting for medical problems reduced their apparent overuse to 18 percent. However, only by adding



“housing problems” to the model could we accurately predict their entire excess emergency department (ED) use.

Brandon: SDH can be added as supplemental factors into existing RA models. This would improve the accuracy of the risk models. For example, a diabetic person with no transportation is at higher risk for major complications and subsequent costs than a diabetic person with transportation. SDH RA may not lead to change in state budgets but may modify the case mix ratio for an ACO or MCO. Budget neutrality may still be the overall expectation.

Mike: If we believe that funding should increase or decrease with the risk of a population, RA can be viewed as a means of more equitably distributing a state’s Medicaid budget. If SDH can explain risks that diagnostic data does not, it is reasonable to include it as part of a methodology for equitable distribution of limited dollars.

Why do you believe that Massachusetts was able to adopt this approach more easily versus other states?

Arlene: Massachusetts is a progressive state and reducing health disparities is a priority. Leadership wanted fairer payment formulas that encourage and support care for vulnerable populations. There is much interest in SDH from other states, but big programs have inertia and competing priorities.

Matt: How one implements RA and the timing will depend on confidence in the formula or program. It will be a slow rollout for any change to the current methodology.

Brandon: States tend to be slow to adopt SDH as they have no access to quantifiable metrics. Since Massachusetts has blazed a trail, this could lead other states to consider the use of SDH.

Can you comment on the experience in the early years of the Massachusetts program? What, if any, was the effect on health plan behaviors? What, if any, was the effect on beneficiary health?

Arlene: We are eager to learn; however, the first SDH model was only implemented in October 2016. It is too early to say.

I understand that acquiring the needed data in an SDH program can be a big challenge. Have you experienced this, and if so, how have you worked around this?

Mike: A process needs to be in place to collect data, and depending on the state, some of the information could be scattered throughout various government departments. Similar to medical claims data, there are substantial privacy concerns with information that might indicate a need for SDH, which increases the challenges of collecting and centralizing the information. Other SDH indicators might require the development of data analysis algorithms, which can be challenging if there are no precedents or common standards.

Brandon: SDH indicators are typically not on the patient record, but some are adding these indicators creatively by working with consumer data agencies or accessing public legal data. The community needs to be educated on how to collect data. Electronic medical records vendors could create discrete data fields or questionnaires to capture these elements. ICD 9/10 codes currently exist for homelessness, but providers do not code well. Ideally, ICD-10 diagnoses for these conditions could be created, which would both minimize disruption to provider workflows and maintain the current claim-based risk-scoring approach.

Arlene: We are creative in using the imperfect resources we have. For example, we use “at least three different addresses

within a 12-month period” to infer “unstable housing”; we calculated a neighborhood stress score (NSS) by geocoding a member’s address and then used census data to create a measure of how “tough” the neighborhood is. NSS and homelessness affect health costs, over and above medical risk.

Long-term services and supports (LTSS) costs are usually removed from the RA model due to not having a good measure of need for these services. Is there a current process in place to incorporate these services in the future?

Matt: SDH for LTC populations seems feasible and is needed. A housing situation such as whether heating or air conditioning is needed impacts the health situation. I am particularly interested in better understanding environmental impacts (e.g., air quality, water quality or exposure to dangerous by-products of extractive industries) and their effects on health care costs. The Medicaid LTC population is more likely to stay on the books for the remainder of their lives. Therefore, we will be able to observe the quality and cost improvements of this population versus a commercial or short-term population.

Arlene: We have used data collected for determining nursing home certifiability to predict LTSS costs for seniors who are eligible for both Medicare and Medicaid. However, such data are not available for everyone. It’s on our workplan to develop a model to pay for combined medical plus LTSS costs for the managed-care-eligible population.

Any final thoughts you would like to share with *Health Watch* readers?

Matt: A concern with a state perspective is that we need to align with the legislature and budget committee as well as obtain the governor’s buy-in. If one state implements something new, then this makes it easier to influence our state legislature as we can point to a state with a proven record. Having or being able to prove cost savings and improved health outcomes is beneficial for bringing on change. If Medicaid were more of a standard program like Medicare, there would be fewer issues and less variety. CMS could package the program and provide optional benefits.

There is a growing recognition that we need a more holistic approach to health care. There are forces that impact health that are not controllable by physicians. There needs to be research on all forces that impact health, and we should be prepared to make an investment in SDH.

Mike: From a risk-measurement perspective, I see SDH indicators as potentially useful add-ons to diagnostic information. From a payment perspective, it is critical to address comorbidity issues, since many SDH are not mutually exclusive and even those between diagnostic conditions and SDH indicators overlap. If the cost impact of an SDH is already captured in the members’ diagnostic information, there may not be a strong rationale to consider additional adjustments.

Arlene: MassHealth’s use of an SDH payment model is currently budget neutral within the Medicaid program. However, the state uses money from many other “buckets,” for example, the prison and welfare systems, to address residents’ needs. We should be able to pool data sets and borrow money across state agencies—and in partnership with other groups, such as those working to build more affordable housing and helping people to find jobs. We have made some progress in merging information across agencies and systems but need to do more to create value from more holistic approaches to help people “get back on their feet.”

Brandon: I would like to stress the value of innovation in RA. Massachusetts has been a leader in the use of SDH in its RA methodology, while Tennessee has combined quality and RA by using episode-based payments. We should share ideas within the industry and learn together. To do this we need a forum for states to share best practices, challenges and lessons learned. ■



Sudha Shenoy, FSA, CERA, MAAA, is vice president, Actuarial Services, at Evolent Health. She can be reached at sushenoy@evolenthealth.com.



Gail S. Stone, FSA, MAAA, is director, Actuarial Services, at Evolent Health. She can be reached at gstone@evolenthealth.com.

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Medicare Advantage: Changes and Updates to Enhanced Benefits

By Nicholas Johnson and Michael Polakowski

Medicare Advantage (MA) plans must provide all medical services that are covered under original Medicare and must have cost sharing that is no greater, in aggregate, than the cost sharing that would be charged under original Medicare. The Centers for Medicare and Medicaid Services (CMS) also permits MA organizations (MAOs) to reduce cost sharing below original Medicare levels and/or provide items and services that are not covered under original Medicare. MAOs offer these additional items and services to attract and retain members, encourage healthy behaviors and incentivize the appropriate use of health care services.

The primary avenue for providing such items and services is through supplemental (i.e., non-Medicare-covered) benefits. Other avenues include rewards and incentives (for healthy activities) or nominal gifts. CMS requires a supplemental benefit to meet three conditions:

1. Not be covered by original Medicare.
2. Be primarily health-related.
3. Incur a medical cost for providing the benefit.

CMS also requires all plan benefits to be offered uniformly to all plan enrollees.

Recent laws and regulatory changes have relaxed the requirements around supplemental benefits in ways that provide MAOs greater flexibility in benefit offerings and plan designs. The remainder of this article discusses those changes.

VALUE-BASED INSURANCE DESIGN

The MA Value-Based Insurance Design (VBID) model was the first of CMS's recent easings of benefit requirements. CMS first offered the VBID model option for MA plans in seven states in 2017. An additional three states were added in 2018, and 15 more were added for the 2019 plan year. The CHRONIC Care Act, included in the Bipartisan Budget Act of 2018, expanded the VBID model to all states in 2020.

According to CMS,

The Medicare Advantage Value-Based Insurance Design (VBID) Model is an opportunity for Medicare Advantage plans to offer supplemental benefits or reduced cost sharing to enrollees with Centers for Medicare & Medicaid Services (CMS)-specified chronic conditions, focused on the services that are of highest clinical value to them. The model tests whether this can improve health outcomes and lower expenditures for Medicare Advantage enrollees.¹

MAOs electing to participate in the VBID model are granted flexibility around the uniformity requirement of supplemental benefits. VBID plans can reduce cost sharing for certain services or select providers or offer additional services for members with targeted chronic conditions.

To date, only 13 MAOs from 10 parent organizations have elected to participate in the VBID model.² The limited participation is partially because of the current limited geographic footprint and marketing restrictions in place during the first two years of the program. In addition, applicants had to overcome robust cost-savings metrics and administrative hurdles associated with filing and certifying a VBID.

With the introduction of nonuniform benefit requirements in 2019 (discussed later), VBIDs may be less attractive to MAOs because MAOs can now offer nonuniform Medicare Part C supplemental benefits for any plan without the filing requirements of the VBID. However, only a VBID plan may offer nonuniform Part D benefits for select enrollees.³

SUPPLEMENTAL BENEFITS: REINTERPRETATION OF "PRIMARYLY HEALTH-RELATED" DEFINITION

Beginning in 2019, CMS is expanding its interpretation of which benefits satisfy the "primarily health-related" requirement for supplemental benefits. Previously, CMS maintained a stricter interpretation of the term such that benefits were required to prevent, cure or diminish an illness or injury, but could not serve only daily maintenance purposes.

Chapter 4 of the *Medicare Managed Care Manual (MMCM)* offers a nonexhaustive list of permitted supplemental benefits under the previous interpretation of "primarily health-related."⁴ Example benefits include acupuncture, chiropractic services, fitness benefits, meals and weight management programs. Each benefit has specific limitations. For example, meals may be offered after a surgery or inpatient stay or to help a member with a chronic condition transition to a healthier lifestyle. Any use of benefits must be primarily medically related. The *MMCM* also provides examples of benefits not permitted, such

as cosmetic services, maid services, massages or cellphones, as these benefits are not sufficiently health-related.

The 2019 Final Call Letter formalized CMS’s reinterpretation of “primarily health-related” and outlined three options for qualifying as a supplemental benefit under the expanded definition:⁵

1. Diagnose, prevent or treat an illness or injury, or compensate for physical impairments.
2. Act to ameliorate the functional and/or psychological impact of injuries or health conditions.
3. Reduce avoidable emergency and health care utilization.

In a follow-up memo, CMS provided examples of supplemental benefits that are permitted under the reinterpretation of “primarily health-related.”⁶

- **Adult day care services.** Assistance with activities of daily living (ADLs) and social work services provided at an adult day care center that help with specific injuries or health conditions are permitted. Services that are primarily recreational or social are not permitted.
- **Home palliative care.** Home palliative care that is used to reduce symptoms for terminally ill members and is not already covered by Medicare is now permitted.
- **In-home support services.** These services assist individuals with disabilities or medical conditions in performing ADLs or instrumental ADLs (IADLs).
- **Respite care.** Respite care may be provided for caregivers of members for a short duration to improve injuries or health conditions of members or to reduce avoidable health care utilization.
- **Nonopioid pain management.** This pain management may be provided to assist a member to treat or improve an injury or illness. The treatment must be medically approved and may include therapeutic massage (i.e., must have a medical focus and may not be primarily for relaxation).
- **Memory fitness benefit.** Memory fitness may be provided as long as the primary focus is medical, such as improving the functional or psychological impact of an injury or health condition.
- **Home and bathroom safety devices.** Some non-Medicare-covered safety devices (such as shower grab bars or stair treads) may be offered, as well as safety inspections.

- **Transportation.** Nonemergency transportation (including a health aide to assist the member) may be provided to obtain plan-covered health care services.
- **Over-the-counter (OTC) benefits.** Non-Medicare-covered OTC items that are available without prescriptions may be provided. CMS has clarified OTC items may include pill cutters, pill crushers, pill bottle openers or personal electronic activity trackers in addition to OTC items historically permitted.

The follow-up memo further clarified some limitations of the expansion of supplemental benefits. Services that are “solely or primarily used for cosmetic, comfort, general use, or social determinant purposes” do not satisfy the expanded definition. Rather, CMS clarified that the service must “focus directly on an enrollee’s health care needs and be recommended by a licensed medical professional as part of a care plan, if not directly provided by one.” Thus, a given benefit may be approved by CMS but, for a beneficiary to receive the benefit, it will need to be recommended by a licensed medical professional.

Recent laws and regulatory changes have relaxed the requirements around supplemental benefits in ways that provide MAOs greater flexibility in benefit offerings and plan designs.

REINTERPRETATION OF BENEFIT UNIFORMITY REQUIREMENT

In addition to the reinterpretation of “primarily health-related,” CMS is also using regulatory guidance to reinterpret the benefit uniformity requirement. In the 2019 final rule, published in the Federal Register in April 2018, CMS stated that plans would be permitted to provide different benefits or cost sharing based on a member’s health status as long as “similarly situated individuals are treated uniformly.”⁷ This is a significant departure from prior guidance, which required MAOs to provide identical services and cost sharing for all members within a plan. CMS permits MAOs to offer nonuniform benefits for members with common medical conditions beginning in 2019.

The new regulation allows plans to tailor Part C benefits (but not Part D benefits) based on the health status of a member.



Any flexibility must be uniformly applied to all members with a certain health status, and plans may only change benefits, not plan premiums. For example, a plan may offer to all members with diabetes:

- Reduced cost sharing for endocrinologist visits.
- More frequent foot exams (a supplemental benefit).
- A lower deductible.

Any benefit enhancement must be for health care services related to the specific disease or condition. Members receiving the enhanced benefits must have their disease or condition documented by a plan provider.

In the final rule, CMS emphasized that such flexibility is not unlimited. For example, MAOs cannot deny or limit services based on health criteria. CMS reiterated its obligation to protect high-risk beneficiaries and intends to review plan offerings to ensure that discriminatory benefits are not offered.

SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL

The CHRONIC Care Act further relaxes both the “primarily health-related” and uniformity requirements starting in 2020. The act permits MAOs to offer additional supplemental benefits for chronically ill members and requires only that supplemental

benefits “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.”

This benefit does not need to be offered to every chronically ill member, but only those the MAO believes will be helped by the supplemental benefit. The member must have a documented medical condition by a plan provider to be eligible. Chronic supplemental benefits (such as social support) do not need to be primarily health-related.

As of January 2019, CMS has not yet provided additional guidance on the permitted benefits for 2020 but has communicated an intent to do so before the 2020 MA bid deadline.

Through the three changes discussed in this section, beginning in 2020, MAOs may offer three types of supplemental benefits:

1. **Standard** (permissible for 2019 benefit year): The benefit satisfies the expanded definition of “primarily health-related” and is available to all members.
2. **Targeted** (permissible for 2019 benefit year): The benefit satisfies the expanded definition of “primarily health-related” and is available to all members with a particular disease or health status.

3. **Chronic** (new for benefit year 2020): The benefit is available to chronically ill members the plan believes will benefit from the supplemental benefit. Chronic supplemental benefits do not need to be primarily health-related.

REWARDS AND INCENTIVES

MAOs may offer rewards and incentives to enrollees for participating in activities designed to improve health, prevent injuries or encourage the efficient use of health care resources. For example, a rewards and incentives program may be used to encourage enrollees to get preventive screenings. All members of a plan must be eligible to participate, and the rewards or incentives must be available based only on participation, not on outcomes (such as weight loss).

Rewards and incentives may be included in marketing materials but are not considered a plan benefit. The expense for the program is included in the nonbenefit expense portion of the bid. There is no dollar limit for rewards and incentives; however, the value for a reward and incentive may not exceed the value of the associated health activity.

Beginning in 2019, MAOs may include a reward or incentive to members for completing a health risk assessment.⁸ Previously a health risk assessment was not permitted to be part of a rewards and incentives program.

NOMINAL GIFTS

Nominal gifts are designed to attract the attention of prospective enrollees and/or encourage retention of current enrollees. They may not have a value exceeding \$15; must not be cash, meals, or a drug or health benefit; and must be offered to all current and prospective enrollees. Unlike a rewards and incentives program, they are not required to be tied to an activity that requires participation.⁹ There are no recent changes to the guidelines for nominal gifts.

CONCLUSION

Through the expansion of the VBID model to all states, regulatory and statutory changes to the “primarily health-related” and benefit uniformity requirements for covered benefits, and an expansion of permissible rewards and incentives, MAOs have considerable additional flexibility in providing benefits to MA enrollees in 2019 and 2020.

Because of the relatively late timing (with respect to MA bid filing deadlines) of guidance from CMS on the reinterpretation of

“primarily health-related” and benefit uniformity, many MAOs may have found it difficult to incorporate new benefits into their 2019 plan designs. With an additional year of preparation and increased flexibility for 2020, it is possible that more MAOs will incorporate additional supplemental benefits into their 2020 plan designs. As the 2020 MA bid season approaches, MAOs should consider how to utilize this flexibility to improve health outcomes for current enrollees and attract new enrollees. ■



Nicholas Johnson, FSA, MAAA, is principal and consulting actuary at Milliman Inc. He can be reached at nick.johnson@milliman.com.



Michael Polakowski, FSA, MAAA, is consulting actuary at Milliman Inc. He can be reached at michael.polakowski@milliman.com.

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The Evolution of the Individual Market (Part II)

By Greg Fann

Part I of this article series was included in the March 2017 issue of *Health Watch*.¹ It was written a few months after Donald Trump's election to the presidency and 2018 Affordable Care Act (ACA) regulations were finalized. With legislative repeal efforts ongoing and general regulatory uncertainty, the appropriate time to publish Part II has been in flux. In terms of stability in the ACA individual markets, the waters are now as calm as they have ever been. Legislative repeal efforts have failed, and a new divided Congress brings assurance of at least two years of no material changes. President Trump issued a series of regulations in 2017 and 2018 that has brought dynamic changes to the market. As these changes are being implemented, the market has become more profitable and issuers are returning in 2019. Now is the right time to chronicle the past two years and anticipate what to expect in the next two.

Part I carried us from pre-ACA markets through the final 2018 regulations implemented by the Obama administration in 2016. The article indicated that Part II “will discuss the transition from the current market rules to a more decentralized system that seeks to offer coverage incentives with more flexible choices, a likely scenario under a Trump administration.”² Recent guidance provides states that additional flexibility of waiving ACA rules within their borders.³ This article begins where we left off in 2017, and it is segmented into four sections, each representing a year with two notable items and a flair of alliteration to keep things interesting.

2017: RATE INCREASES AND REPEAL FAILURES

The year 2017 marked the four-year-old ACA's first time in the swimming pool without a life jacket. An initial three-year discovery period allowed issuers to participate in the market with federal risk corridors and reinsurance acting as stabilizing mechanisms. This allowed health plans to test the waters with some temporary risk protections and provided some incentive to be more aggressive without market-specific historical data in a price-sensitive market.

In determining 2017 ACA premiums, insurers had two years of ACA experience to analyze. It was suggested by health actuaries

and other commentators that 2017 might be the telling year to evaluate the market conditions based on carrier participation, as health plans evaluate two years of transitional experience before committing to participate in a riskier market without the temporary risk mitigators.⁴ The industry responded with high rate increases that some observers considered a “one-time pricing correction”;⁵ others were more pessimistic and said the overall ACA model design was unsustainable. The number of both issuers and enrollees dropped for the first time in 2017.

The ACA's struggles greased the wheels of “repeal and replace” efforts from a Republican Congress and a new Republican president. The House of Representatives passed the American Health Care Act (AHCA) in May 2017.⁶ The individual market design incorporated in the legislation was largely based on 2016 policy proposals featuring “age-based tax credits.”⁷ Such a feature is somewhat tax equitable to the deductibility of premiums in group markets, but more highly leveraged for individuals in low tax brackets. At the time, I noted that such a proposal would likely “attract the most people across the age and income spectrum,”⁸ be administratively simpler and not involve the Internal Revenue Service.

This article begins where we left off in 2017, and it is segmented into four sections, each representing a year with two notable items.

Then it was the Senate's turn. The methodology in the Senate's first attempt, the Better Care Reconciliation Act (BCRA), aligned more closely with the ACA's income-based subsidies than the AHCA's age-based tax credits. It was quickly derided by critics as “Obamacare-lite.”⁹ The BCRA and other Senate repeal attempts that followed came critically close to passage, but all were unanimously rejected by Democrats and none could align the slim-majority Republicans. The stalled legislation increased both the speed and the importance of regulatory action by the executive branch, which changed the market dynamics beginning in 2018.

2018: THE CSR PARADOX AND THE CBO

As Congress explored various repeal bills in 2017, President Trump provided some interesting commentary throughout the process. In a Rose Garden ceremony celebrating the AHCA passage, he spoke of coming reductions in premiums and deductibles.¹⁰ A month later, he derided the legislation as “mean”



and said that perhaps the Senate could be “more generous, more kind.”¹¹ Throughout the failed Senate efforts, he frequently dangled cost-sharing reduction (CSR) payments as a negotiating tool.¹² In October 2017, after receiving a legal recommendation from the Department of Justice, President Trump discontinued the CSR payments. Critics were quick to paint this maneuver as “sabotage,” but the mechanical results largely boosted premium subsidies and benefited subsidized enrollees.

While others, including yours truly,¹³ had previously written about this paradoxical impact, it was the report from the Congressional Budget Office (CBO) that brought this truth to the attention of the members of Congress who don’t frequent actuarial consulting websites. It remains unclear how well this resonated. House Democratic Whip Stenny Hoyer, who had directed the CBO to report on the impact of the matter, characterized the CBO’s findings as “sabotage that will cause premiums to rise 25 percent.”¹⁴

The CBO’s report on consumer impact actually stated that

because tax credits would increase and gross premiums for plans other than silver plans in the marketplaces would not change substantially, many people with income between 200 percent and 400 percent of the FPL [federal poverty level] would, compared with outcomes under the baseline, be able to pay lower net premiums for insurance that pays for the same share (or an even greater share) of covered benefits. As a result, more people would purchase plans in the marketplaces than would have otherwise and fewer people would purchase employment-based health insurance—reducing the number of uninsured people, on net, in most years.¹⁵

As an “overall effect,” CBO stated, “Most people would pay net premiums for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise.”¹⁶

Of course, the good news for the market was increased government subsidies, which meant bad news for taxpayers. The favorable new environment attracted enrollment in 2018 that was larger than expected by some observers, particularly those who give more credence to nonfinancial measures such as government-sponsored outreach efforts. It should be noted that the “good news” did not come without the cooperation of states. Most states allowed issuers to properly reflect the additional CSR-induced costs only in silver plans in 2018; others are making this change in 2019.

2019: MORE ISSUERS AND MORE OPTIONS

The benefit of the redesigned market in 2018 has not gone unnoticed. Issuer profitability is at record levels.¹⁷ The beneficial changes have reignited insurer interest in ACA markets, with 17 percent more state-level insurers entering markets in 2019 after a 28 percent reduction in 2017 and a 21 percent reduction in 2018.¹⁸ Partially reflecting the high profitability, the average premium level in 2019 is lower than the prior year for the first time.¹⁹

Like most mechanisms associated with the ACA, bad news begets good news and vice versa. The good news and bad news in 2018 are being reversed somewhat in 2019. The higher taxpayer burden in 2018 is dampened in 2019 by the lower resulting premiums and subsidy obligations. Conversely, the consumer benefits of 2018 may be more complicated and more challenging to obtain in 2019. At the time of this writing, active open enrollment statistics are lower than the same time period last year. It is too early to tell if this signifies enrollees’ need

for time to figure out their options or a reduced enrollment for 2019.

The 2019 consumer enrollment decisions are complicated for two reasons. First, more issuers are present in many markets. Second, more off-market options are available and these plans are relatively more attractive with the 2019 repeal of the individual mandate penalty. A brief numerical example illustrates the more complicated process.²⁰

Figure 1 represents the 2017 premium environment. An individual is assumed to be at income level with a \$200 maximum contribution²¹ and a \$500 premium subsidy.²² The \$500 subsidy could be used to purchase the desired level of coverage.

Figure 1
Premium Levels With CSR Funding (2017)

	Bronze	Silver	Gold	Platinum
Unsubsidized Premium	600	700	800	900
Subsidized Premium	100	200	300	400

Figure 2 represents the 2018 premium environment after the CSR change. The silver premium is increased to account for the lack of cost-sharing funding, and the new subsidy is \$650. The individual would now have favorable choices of an additional \$150 subsidy for a gold or platinum plan, or to use only \$100 to obtain a bronze plan for free. It would be unwise to select the silver plan unless the actual CSR benefit was desired (typically beneficial between 100 percent and 200 percent of FPL).

Figure 2
Premium Levels Without CSR Funding (2018)

	Bronze	Silver	Gold	Platinum
Unsubsidized Premium	600	850	800	900
Subsidized Premium	0	200	150	250

The decisions presented in 2017 and 2018 are both straightforward, with 2018 being more attractive. Figure 3 considers the addition of a competitor in the marketplace that is priced 12 percent below the current issuer.

Figure 3
Unsubsidized Premium Levels Without CSR Funding (2019)

	Bronze	Silver	Gold	Platinum
Current Issuer	600	850	800	900
New Issuer	528	748	704	792

The premium subsidy is now calculated based on the gross premium of the new issuer. Figure 4 illustrates the resulting subsidized premiums, which are \$102 higher to remain with the current issuer (\$52 for the bronze plan). A change to the new issuer would result in premiums similar to the prior rates of the old issuer, but the individual may be unfamiliar with the new issuer or deem it less desirable. At higher income levels with higher net premiums, the availability of short-term plan options may also be a decision point. In general, competition in the ACA-subsidized markets gives consumers more choices, but it will complicate the decision making and may result in higher net premiums.

Figure 4
Subsidized Premium Levels Without CSR Funding (2019)

	Bronze	Silver	Gold	Platinum
Current Issuer	52	302	252	352
New Issuer	0	200	156	244

Additional regulatory changes allow for employer flexibility to utilize health reimbursement arrangements (HRAs) to procure individual coverage.²³ Employer migration of employees has been shown to add stability to individual markets.²⁴ An original guiding principle of the ACA was a “single risk pool” concept that would seek to close doors between various risk pools (i.e., individual and group) and enroll everyone in distinct risk pools. We have certainly drifted away from that ideal with the new HRA regulation, the 21st Century Cures Act, repeal of the individual mandate penalty and expansions of alternative options. It remains to be seen whether these markets will play nice together, but resistance to the concept is much less than it was five years ago.²⁵

A more holistic view of 2019 yields an interesting perspective on the individual ACA market and the viability of the ACA as a whole. In a sense, the 2018 changes made the market even more attractive to people who were already relatively more attracted to it, and the 2019 changes provided exit opportunities for those whose regulatory path to an ACA internal solution was less clear. Calling this a multipronged solution seems like a stretch, but effectively the two large segments of eligible ACA enrollees have benefited from either of these actions.

This is useful to understand, because while we as insurance professionals may view all of this as a clunky mess lacking any real design, consumer sentiment is of more interest to Congress than fidelity to insurance or structured policy principles. The catalyst for ACA repeal is identical to the impetus for the ACA itself, and that is a critical mass of people who don’t have a reasonable health insurance solution in the marketplace of last

resort. Relatively speaking, people eligible for ACA markets are happier than they have ever been (at least those who are good at math are), and we see that in the polling results.²⁶ This all bodes well for a more stable market, and there are more improvement opportunities in 2020 for states that are interested.

2020: STATE FLEXIBILITY AND SETTling MARKETS

Section 1332 of the ACA created opportunities for waivers in commercial markets that allow states to bypass some of the marketplace requirements, mandates and benefit requirements constructed by the ACA.²⁷ Beginning in 2017, this section explicitly allowed states to pursue the ACA's objectives in innovative ways, with federal approval and within limits. Specifically, states can use the federal funds provided through the ACA and redistribute them in a more efficient, equitable manner to provide incentives and create broader market appeal.

Regulatory guidance was first issued by the Obama administration in December 2015. Relative to new guidance in October 2018,²⁸ the prior guidance limited states' abilities to innovate. A notable requirement was that the guardrail measurements were required to be met not only on an average enrollee basis, but on certain subsets of the population as well. These restrictions have effectively limited state waivers to reinsurance and restrained the market improvement opportunities available to states. The recent flexibility granted for state innovation waivers signals opportunity to enhance market attractiveness within the ACA framework.²⁹ States should begin work now if they want to pursue a Section 1332 waiver for 2020.

The year 2020 also represents the first pricing year for which issuers will have a full year of experience in the new CSR world. Although the market dynamics are always evolving, with issuer changes and risk adjustment challenges, premiums will be developed from a post-CSR risk mix. Unless a surprising number of new regulatory changes are introduced as we approach 2020, we should expect a settling of markets and more stability at the federal level. Of course, this could be offset by vigorous state-level activity.

ONWARD

The individual market continues to evolve. Without fail, "government intervention drives marketplace changes, which, in turn, creates a recurring need for more government intervention."³⁰ The individual market remains small yet important. It is often a last resort for those seeking health insurance, and it is the only major medical insurance option available to individuals without coverage through government programs or their employers. It must be developed and maintained in a way that is attractive to both insurers and consumers.

The grand legislative efforts to repeal the ACA have failed, prompting an abundance of regulatory activity that has largely been viewed with suspicion but has been beneficial thus far. Additional changes for 2019 were regarded by some as volatile, but issuers have not responded with market exits or high rates as some expected. States will take various approaches over the next few years, some trying to retain the original ACA model with an individual mandate and discouragement of non-ACA-compliant plans. Other states will utilize Section 1332 to reallocate the subsidies and correct some of the unintended consequences of the law. We should look forward to more stability at the federal level, but more variations at the state level.

As mentioned, the ACA environment is as calm as it has ever been. There is some concern that two lingering lawsuits in particular could create some waves. The more recent (and higher profile) case challenges the constitutionality of the ACA based on severability of the individual mandate tax from other ACA mechanisms. The older case, and likely of more actuarial interest, concerns the equity of the ACA risk adjustment methodology.³¹ If the market is left undisturbed by the legal environment, we will find out if the current satisfaction in both segments of the bifurcated market will endure.

In Part I, I wrote that "we should be encouraged that any proposed ACA market change will be heavily scrutinized."³² That has largely held true, but I would like to see the scrutiny turn from reactionary to reflective. The immediate negative reaction to the Section 1332 guidance is a good example; states have real opportunities to improve their marketplaces that have not existed in the past.³³

As actuaries, we can facilitate the progress toward a reflective perspective as we offer our collective insights to help sustain the challenging individual market. If you are interested in being a part of this endeavor or just staying abreast of the latest dynamics, please join the Individual/Small Group Subgroup discussion³⁴ as we journey onward. ■

The views expressed herein are those of the author alone and reflect information as of December 2018. They do not represent the views of the Society of Actuaries, Axene Health Partners LLC or any other body.



Greg Fann, FSA, FCA, MAAA, is a consulting actuary with Axene Health Partners LLC (AHP) in AHP's Temecula, California, office. He can be reached at greg.fann@axenehp.com.

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Navigating Cost-Sharing Reduction Subsidy Defunding

By Tim van Laarhoven and Michael Cohen

As part of the Affordable Care Act (ACA), carriers in the individual market are required by law to offer silver plans to eligible individuals with richer benefits than a standard silver plan, with the requirement that the carrier must charge the same premium as the standard plan. These richer benefit plans for lower-income enrollees are referred to as cost-sharing reduction variant (CSR) plans. Before October 2017, carriers used to be refunded by the federal government for the increased benefits offered in the CSR plans; however, the Trump administration ended these subsidies. As a result, issuers needed to account for the additional benefits in their premiums moving forward. This paper will examine why CSR defunding produces pricing uncertainty and how regulators can possibly alleviate these risks.

A standard silver plan has a federal actuarial value (AV) of approximately 70 percent, meaning that on average, the plan

pays 70 percent of the medical costs, while the enrollees pay 30 percent. Enrollees in the income-based CSR plans will generally pay fewer out-of-pocket expenses than a standard silver plan. There are three types income-based CSR variants with AVs of 73 percent, 87 percent, and 94 percent (see Table 1). Eligibility for each of the cost-sharing variants depends on an enrollee's income, defined as the family's income in relation to the federal poverty level (FPL).¹ In 2017, CSR enrollees represented approximately 60 percent of the overall exchange population, as the enhanced cost sharing was a major driver of enrollment.²

Table 1
Enrollment in CSR Plans by Eligible Income (2017)

Eligible Income (FPL)	Corresponding CSR Variant AV	Percent of Eligible Enrollees in CSR Plan
200%–250%	73%	71%
150%–200%	87%	85%
100%–150%	94%	91%

Based on 2017 Open Enrollment report, limited to *Healthcare.gov* states.

THE NEW WORLD: COST-SHARING SUBSIDIES NO LONGER REIMBURSED BY THE FEDERAL GOVERNMENT

In October 2017, the Trump administration stopped funding carriers for the CSR plans. Consequently, the CSR liability was transferred from the government to the carrier and, therefore, has to be considered in the carrier's premiums.

The lack of CSR funding creates the following pricing risks:

- Increased sensitivity to how a product will be competitively positioned, as small differences in premiums could yield large liability changes.
- Increased need to understand premium differences among the metal levels given the increased chance for metal shifting.

While we do not explore it in this article, carriers need to understand how risk adjustment may differ as a result of these two pricing risks.

WHAT HAVE CARRIERS DONE TO ACCOUNT FOR THE UNFUNDED CSR LIABILITY?

In 2018, many carriers adjusted their premiums to account for the increased CSR liability (except when disallowed by state regulators). The methodology on how plans were loaded varied, but the two primary methods were as follows:



- Carriers loaded the CSR liability onto on-exchange silver premiums but not onto any other metal levels.³
- Carriers loaded premiums across all metals,⁴ on and off exchange, to account for the CSR liability.

For 2019 pricing, the vast majority of states instructed carriers to load on-exchange silver plans. When carriers loaded only on-exchange silver premiums to cover the CSR liability, there were two related effects. First, the advance premium tax credit (APTC) increased, which provided APTC-eligible consumers with more APTC dollars. This increase in silver premiums, relative to other metal levels, allowed consumers to have lower premiums if they purchased a non-silver plan. In effect, this meant that bronze and gold net premiums were often lower for subsidy-eligible enrollees.⁵ This resulted in some consumers shifting from silver to bronze or gold. As shown in Table 2, the increase in APTC subsidies made a substantial impact on a consumer’s decision to select a silver plan, particularly if the consumer was not eligible for an 87 percent or 94 percent CSR plan.

Table 2
Enrollment in Silver Plans by FPL (2017, 2018)

Enrollee Income (FPL)	Percent of Enrollees That Enrolled in Silver (2017)	Percent of Enrollees That Enrolled in Silver (2018)
250%–400%	53%	35%
200%–250%	71%	53%
150%–200%	85%	79%
100%–150%	91%	89%

Based on 2017 and 2018 Open Enrollment report, limited to *Healthcare.gov* states.

Table 3
CSR Loading in a Two Carrier, One Metal Market, With Rationale Policyholders

Metal Tier	Insurer	Member Months	Premium for Silver 70%	CSR Liability	Premium Charged	Funding Surplus
Silver 70%	Carrier A	100	\$500	\$0	\$511	\$11
Silver 73%	Carrier A	100	\$500	\$21	\$511	(\$11)
Silver 87%	Carrier A	100	\$500	\$121	\$511	(\$111)
Silver 94%	Carrier A	100	\$500	\$171	\$511	(\$161)
Composite*	Carrier A	400	\$500	\$79	\$511	(\$68)
Composite	Carrier B	0	n/a	n/a	n/a	n/a
Composite	Total	400	\$500	\$79	\$511	(\$68)

*Calculated on a per member per month basis.

UNDERSTANDING THE PRICING UNCERTAINTY INTRODUCED BY CSR LOADING

To illustrate the pricing risk that loading premiums to cover the CSR liability creates, we have created a simplified market. The market has the following conditions:

- There are two carriers.
- Both carriers have identical plan designs and networks.
- The carriers assumed they would maintain their CSR and non-CSR historical enrollment when pricing.
- Policyholders purchased the plan with the lowest premium available to them.

Table 3 shows what would happen if Carrier A had filed a premium rate of \$511⁶ per member per month (PMPM) and Carrier B had filed a premium rate of \$646⁷ PMPM. All policyholders, assuming they act rationally, would select Carrier A’s plan.

As you can see, Carrier A had a shortfall of \$68 PMPM, since only \$511 PMPM was received for the expected \$579 PMPM in claim liabilities. In addition, Carrier B had no enrollees, which may result in Carrier B exiting the market or pricing aggressively in future years to gain enrollment. While this scenario is illustrative and arguably extreme, it does highlight a key feature of the individual market: Slight differences in premiums can produce large differences in enrollment and profitability.

This example is further complicated by the fact that the pricing differences between the second-lowest-cost silver and other metal levels could also cause metal shifting. For example, if the lowest-cost gold plan were cheaper than the second-lowest-cost

silver, there could be significant migration into gold plans (thus increasing plan liability).

Finally, the additional plan liability due to CSR defunding exacerbates the underlying dynamic of the individual market. In theory, risk adjustment is expected to somewhat compensate carriers for differences in anticipated liability; however, the ACA risk adjustment program assumes in aggregate that issuers have priced sufficient premiums to cover aggregate claims, which may not be the case if plans misprice for CSR defunding.

The impact of CSR liability loading will take some time to be fully understood and could result in differing levels of profitability based on a carrier's membership mix. This is something that both carriers and regulators should understand when reviewing financial results.

HOW COULD REGULATORS MITIGATE THE PRICING RISK?

Consideration of only loading silver on-exchange plans and leaving other plans unaffected could result in the following benefits:

- Allowing subsidy-ineligible enrollees to access an affordable silver plan off exchange.⁸
- Increasing the APTC credit for all policyholders on exchange.
- Avoiding an increase in cost to other metal levels.
- Reducing the incentive for member disenrollment.
- Helping maintain the overall risk-pool health.

It is important to note that the loading of CSR liabilities only onto on-exchange silver plans does produce some pricing uncertainties that could be mitigated by regulators. Three alternatives that regulators could consider follow.

Alternative 1: Quantify and Modify the Risk Adjustment CSR Load

Risk adjustment is designed to compensate carriers for actuarial risk. However, the ACA risk adjustment model was designed before the defunding of CSR payments. CMS could study to what extent the current model is appropriately compensating carriers in this new world. To the extent that CSR variant plans are being under- or overcompensated, the methodology should be updated. Given the time lags involved in updating the risk adjustment methodology, additional steps may be necessary for the short term.

Alternative 2: Allow for the Filing of Multiple CSR Liability Loads

A regulator could allow carriers in the market to file what their premium load would be based on their final competitive positioning. Although this places greater burden on regulators and carriers, it may be an alternative to ensure adequate premiums. For example, a regulator could ask carriers to submit all of the following with their rate filing:

- CSR load if the lowest silver.
- CSR load if the second-lowest (benchmark) silver.⁹
- CSR load if more than 10 percent above the benchmark.¹⁰
- Any other condition(s) prescribed by the regulator.

Based on the submissions, regulators could select pricing to maintain appropriate premium levels for expected claims costs.

Alternative 3: Prescribe the CSR Load

Regulators could instruct all carriers to load silver premiums by a fixed percentage, removing uncertainty and creating a level playing field when filing rates. The percentage used would have to be state specific and require somewhat advanced projections to account for morbidity and metal shifting. By ensuring sufficient premiums, it is more likely that risk adjustment will effectively compensate issuers given that, in aggregate, premiums will be sufficient for the statewide liability.

CONCLUSION

Early financial results appeared favorable for carriers in 2018; Fiedler suggests that carriers will earn positive underwriting



profit margins of 10.5 percent of premium, up from 1.2 percent in 2017.¹¹ However, premiums could be lower if some uncertainty were reduced. We believe one of the sources of this uncertainty is CSR loading. This article highlighted some of the issues that CSR loading causes issuers and how regulators can further mitigate pricing risks for their states.

The pricing risk from CSR loading remained when pricing 2019 premiums, but for pricing 2020 premiums, regulators may be better prepared to implement alternative methods to mitigate the pricing risks that CSR defunding creates. More research could be completed to better understand the implications of CSR defunding; in the meantime, we hope this paper creates a better understanding of the risks caused by CSR defunding and potential solutions. ■



Tim van Laarhoven, ASA, MAAA, is associate actuary at Wakely Consulting Group. He can be reached at tim.vanlaarhoven@wakely.com.



Michael Cohen, ASA, FCIA, FIA, is a senior consultant at Wakely Consulting Group. He can be reached at michael.cohen@wakely.com.

ENDNOTES

- 1 Carriers must also provide cost-sharing reduction plan variants for American Indians or Alaska Natives, regardless of income. For purposes of this paper CSR variant will refer only to income-based CSR variant.
- 2 Based on the 2017 Open Enrollment report, limited to states without a state-based exchange (SBE). SBEs do not report their CSR plan statistics to a federal database in the federal report used in this analysis. Some SBE states do make this information available through their exchange.
- 3 There was a variation of this loading in which states required a “substantially similar” off-exchange plan that did not get the premium load.
- 4 The inclusion or exclusion of catastrophic in all metals varied by state.
- 5 Assuming a bronze premium is \$250 without APTC applied, if your APTC increased from \$200 to \$240 because of silver loading, your bronze premium would decrease from \$50 to \$10, further incentivizing buying bronze if you are relatively healthy.
- 6 Based on historical enrollment, assumed mix 50 percent Silver 70 percent and 50 percent Silver 73 percent.
- 7 Based on historical enrollment, assumed mix 50 percent Silver 87 percent and 50 percent Silver 94 percent.
- 8 Assuming stand-alone off-exchange silver plans are offered.
- 9 The benchmark plan or the plan at which APTC amounts are determined. Technically the benchmark plan is set as the Essential Health Benefits portion of a premium. Regulators would need to take this distinction into account.
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New Report on Evaluating Payment Models for High-Cost Curative Therapies

By Joanne Buckle, Didier Serre, Anne Jackson and Jessica Naber

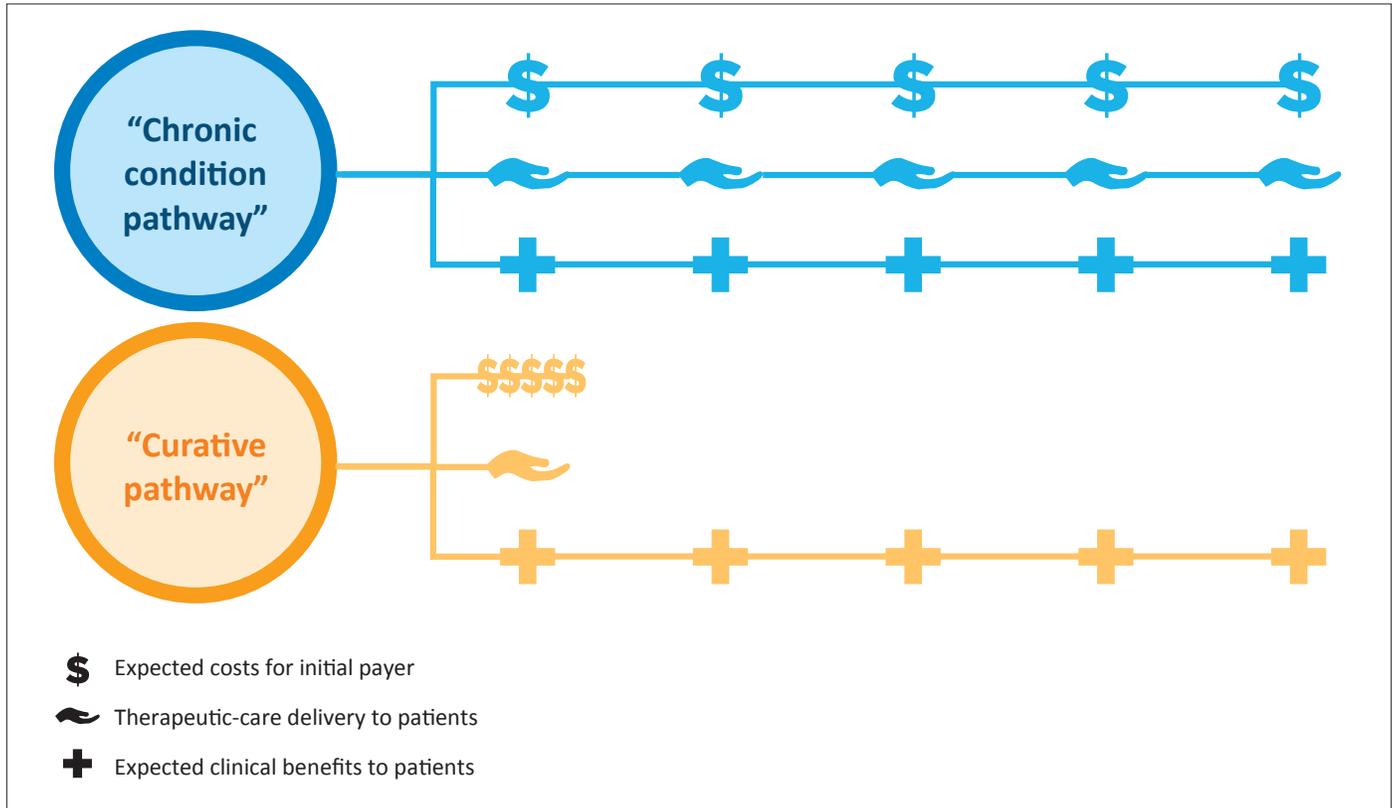
Last October, four actuaries from the U.S. and the U.K. released their latest research report on alternative payment models for high-cost curative therapies, culminating over a year of research and partnership with the Society of Actuaries

(SOA). This short article aims to present the rationale and context for initiating research on this issue and to provide a brief overview of the full report, now available online.¹

CURATIVE THERAPIES VS. TRADITIONAL MAINTENANCE THERAPIES

High-cost curative therapies have begun to enter the market, and more are expected to follow, particularly in the rare-disease space. The pipeline for these high-value therapies is growing, but traditional payment for care—where cost is incurred up front at the time of treatment administration—could strain a payer’s annual budget if these therapies launch at record-setting prices. Many of these therapies have the potential to provide an extended duration of clinical benefit from a single administration or limited treatment duration. Compared to more traditional maintenance (or chronic) therapies, for which funding mechanisms are structured to cover costs incurred at the time the service is delivered, curative therapies show a mismatch between the up-front treatment costs, delivery of care to patients and long-term realization of clinical benefits to patients, as seen in Figure 1.

Figure 1
Incurred Costs, Therapeutic Administration and Clinical Benefits: Chronic vs. Curative Timeline



Reprinted from Didier Serre, Joanne Buckle, Anne Jackson and Jessica Naber, Evaluating payment models for high-cost curative therapies, Society of Actuaries, October 2018, <https://www.soa.org/research-reports/2018/high-cost-curative-therapies/>. Copyright © 2018 Society of Actuaries.

PAYMENT MODELS CONSIDERED AS ALTERNATIVES TO PAYING FOR THE THERAPY UP FRONT

We believe that alternative payment models should take into account the risks to payers, manufacturers and third-party entities and should attempt to mitigate or share these risks. Several approaches are selected for consideration as potential alternative payment models for high-cost curative therapies. These include approaches found in the literature such as industry pooling, multiyear insurance contracts, financial bonds, annuity payments and health currency.

Our study also looks at how models can incorporate selected conditions for payment to mitigate various risks. Two key risks included in the study are membership turnover and efficacy of the curative therapy. In an environment where members can switch insurers, there is a risk that the entity paying for the curative therapy up front does not realize the expected financial benefits associated with the cure, a phenomenon known as the free-rider problem. Similarly, there is a risk that the curative therapy will not be effective or will be less effective than anticipated. Our study assesses the effect of implementing conditions for payment related to turnover or drug failure.

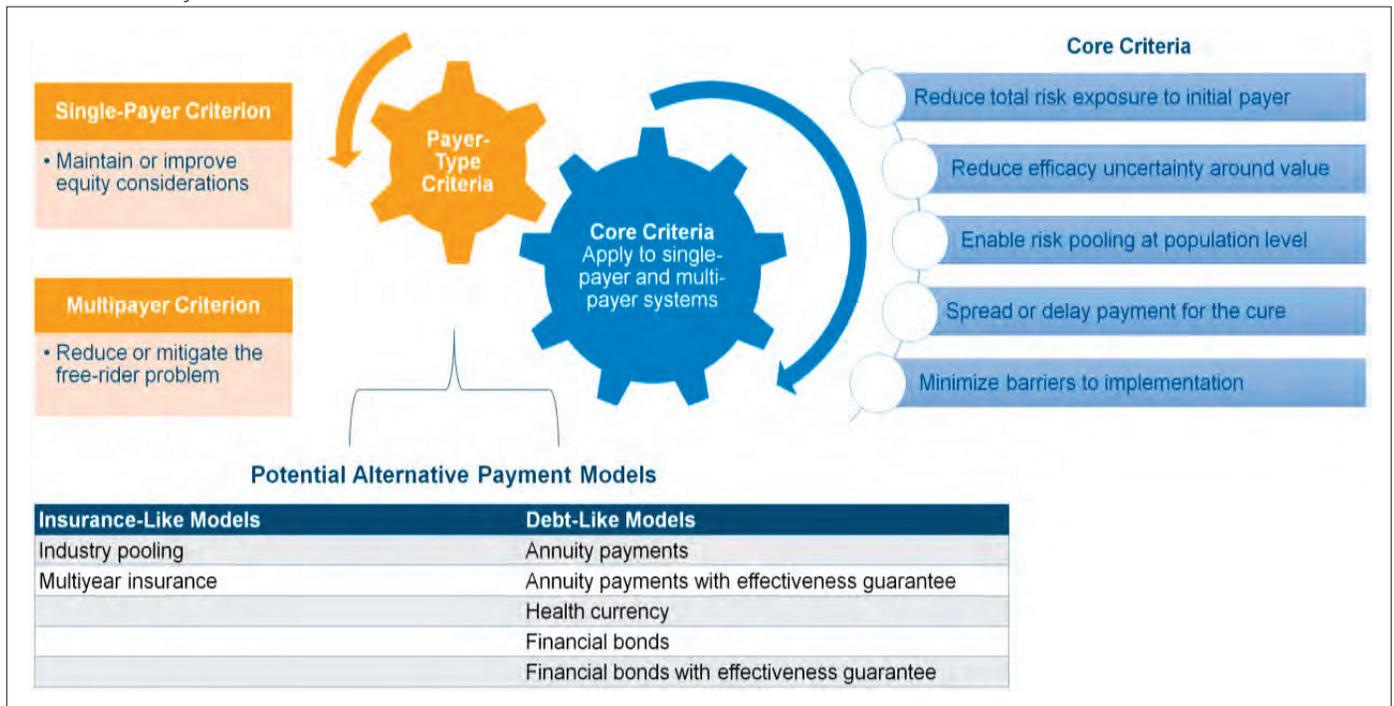
In general, the research focus is on the extent to which each of the proposed payment models can diversify, mitigate or eliminate financial risk after the decision to fund a therapy has been made.

STUDY CRITERIA USED TO EVALUATE ALTERNATIVE PAYMENT MODELS

Alternative payment models for high-cost curative therapies are discussed in the literature, but no systematic review has been performed to support a comparison across a variety of payment models. The purpose of the report is to evaluate the models that could be instituted in the real world to pay for these high-value and high-cost curative therapies, using a common set of assumptions and evaluation framework. From the literature, we identify a list of seven evaluation criteria—five core criteria that apply to all payer systems and two additional criteria that are payer-specific (Figure 2).

For each payment model, the study measures the 10-year net present value (NPV) of the total expected financial exposure to the initial payer—that is, the NPV of the difference between revenues and expenses over that period. The NPV includes the

Figure 2
Framework: Payment Models and Evaluation Criteria



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treatment cost of the curative therapy and the expected costs for the patient after treatment, offset by the annual premium and other incoming revenue. This research aims to highlight the strengths and weaknesses of each payment approach across several payer perspectives.

HOW THE SMALL BUDGET IMPACT OF CURATIVE THERAPIES COULD BECOME A BIGGER FINANCIAL ISSUE

Collectively, rare diseases lose their rarity. As more therapies and therapy-indication combinations are approved over time, the payer's aggregate cost exposure may become more significant and may pose financial risks to both smaller and larger payers. As more therapies are approved, the aggregate exposure will likely increase and the need for alternative payment models may come into sharper focus.

ALTERNATIVE PAYMENT MODELS FOR MORE PREVALENT DISEASE AREAS

The illustrative scenarios we present in our study focus on payment mechanisms for curative therapies for rare diseases. This is because rare diseases may be more likely to experience record-breaking prices for curative therapies, given the smaller treatment populations. Yet most of the payment approaches we explore in this report may be valid in more prevalent disease areas as well.

CHALLENGES FOR SINGLE-PAYER AND MULTIPAYER SYSTEMS AND HOW THEY DIFFER

The decision by payers to enter into an alternative payment arrangement to fund a one-time, high-cost curative therapy depends on many factors, with financial risks unique to each health payer.

In a single-payer environment, the majority of the cost of health care is the responsibility of one entity. In a multipayer environment, the cost of health care may be shared by more than one payer, including but not limited to private payers (e.g., insurance companies, self-insured employers) and government-funded programs (e.g., Medicare, state Medicaid agencies). Over a patient's lifetime, he or she will likely receive health coverage from multiple sources or insurers. The ability to capture future financial offsets associated with the curative therapy is a key risk in a multipayer landscape. In a single-payer system, the full duration of clinical benefits is expected to accrue to the entity funding the curative therapy. This represents a simplistic approach as there are still intergenerational concerns to address in such systems.

In our research, we use the National Health Service (NHS) in England and experience in the United States as proxies for

analyzing payment considerations relevant to single-payer entities and multipayer systems, respectively.

CONCLUSION

Overall, there is no single payment model that satisfies all the evaluation criteria, and some of the payment models would not be practical for all payers or may have barriers to implementation. Fundamentally, our study demonstrates that there is no one-size-fits-all approach to the payment of high-cost curative therapies. It is important that payment models be tailored to address or mitigate the risks specific to each payer's characteristics. ■

This report was commissioned by the SOA as part of its efforts to expand the boundaries of the actuarial profession. It also received funding from the REX pool. We wish to thank the SOA for recognizing the importance of research in advancing the role of actuaries within the insurance as well as the health economics space.



Joanne Buckle, FIA, is principal and consulting actuary at Milliman Inc. in London. She can be reached at joanne.buckle@milliman.com.



Didier Serre, ASA, MSc, is an associate at Analysis Group, Montreal. He can be reached at didier.serre@analysisgroup.com.



Anne Jackson, FSA, MAAA, is principal and consulting actuary at Milliman Inc. in Indianapolis. She can be reached at anne.jackson@milliman.com.



Jessica Naber, FSA, MAAA, is consulting actuary at Milliman Inc. in Indianapolis. She can be reached at jessica.naber@milliman.com.

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