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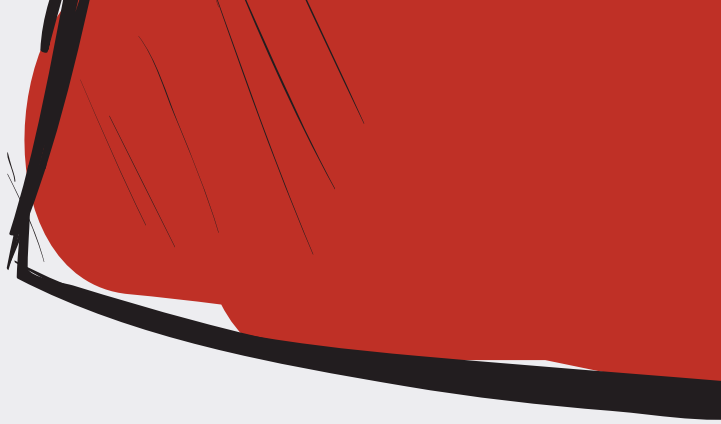

THE ACA COST PREDICTABILITY QUESTION

Will the exchange populations have sufficient cost predictability to allow insurance organizations to participate in the ACA Exchange Program?

By Kurt J. Wrobel

With the tremendous interest in the Affordable Care Act (ACA) exchanges, many policymakers and pundits are looking for signs of their success or failure with everything from emerging demographic and diagnosis information to the proposed rate increases from different health plans. Although this information is insufficient at this point to make a final determination, these metrics ultimately point to the fundamental policy question to determine the ACA exchange's success:

Will the exchange populations have sufficient cost predictability to allow insurance organizations to participate in the program?

While over the next two years we will see emerging information in the form of premium increases, enrollment, and payment for the risk protections to help answer this question, the ultimate determinant will be seen when insurance companies file their rates in mid-2016 for the 2017 calendar year. As I will highlight, because these rates will not include several important risk protections currently imbedded in the ACA, these rates and the insurers' willingness to participate in the exchanges will become one of the most important evaluations of the success of the program and will answer the cost predictability question.

THE FIRST THREE YEARS—THE COST DISCOVERY PHASE OF THE PROGRAM

Consistent with the stated policy in the ACA, the Centers for Medicare & Medicaid Services (CMS) have provided insurance organizations with substantial financial protections in return for taking risk on a new population without the underwriting controls that traditionally have been used in the industry. These provisions provide protection for health plans that attract high-cost claimants (reinsurance), sicker-than-average individuals (risk adjustment), and incorrectly estimating the cost of the exchange population (risk corridors). After the initial three years of the program, only the self-financing risk adjustment program will continue to be implemented. In this program, health plans reallocate money among themselves based on the relative risk attracted to each health plan.

The intent of this policy is to allow insurance companies the opportunity to better understand the underlying cost of this population and ensure rates can be developed without the reinsurance or risk corridor protections that will sunset after the 2016 calendar year.

As one would expect in this period of cost discovery, the initial filed rates for the 2014 calendar have varied substantially. Although several factors have played a part in this variation, the most important

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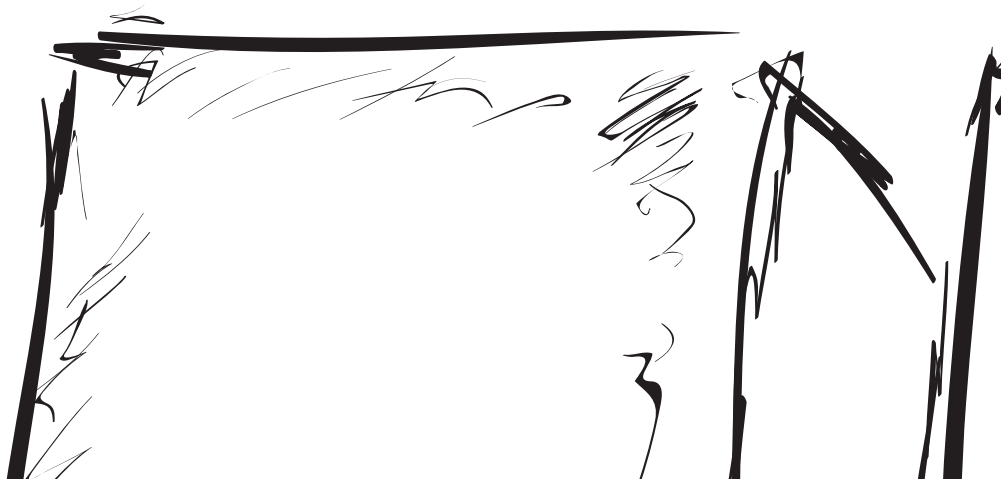


variables have been the extent actuaries have assumed different morbidity assumptions for this population and the risk tolerance of the particular insurance company. Because so many variables can impact this ultimate result, the rates have predictably varied widely.

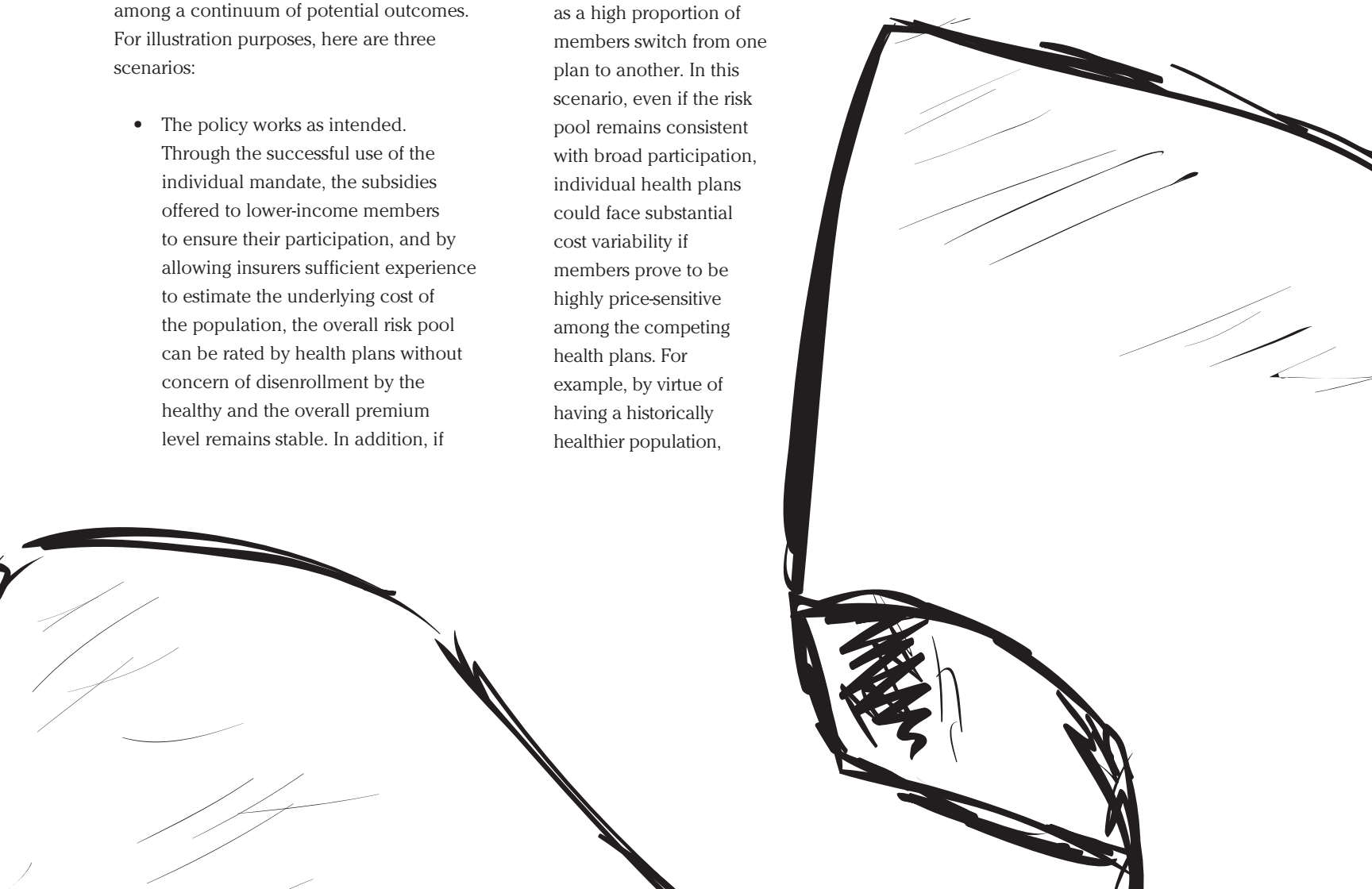
POTENTIAL OUTCOMES AFTER THE COST DISCOVERY PERIOD

Following this initial period of substantial risk protections and cost discovery, the key question that will drive the 2017 rates will be cost predictability. At this point, assuming no further policy changes, the ACA will become largely an actuarial question of cost predictability driven by the experience over the preceding 2.5 years. The final answer to this question will be among a continuum of potential outcomes. For illustration purposes, here are three scenarios:

- The policy works as intended. Through the successful use of the individual mandate, the subsidies offered to lower-income members to ensure their participation, and by allowing insurers sufficient experience to estimate the underlying cost of the population, the overall risk pool can be rated by health plans without concern of disenrollment by the healthy and the overall premium level remains stable. In addition, if any adverse selection does occur at the plan level, the risk adjustment mechanism provides a trusted reallocation of payments to ensure an equitable payment for insurers with healthier or sicker members.

- The broader risk pool is compromised as younger and healthier members disenroll in the face of rate increases. The resulting cumulative anti-selection produces a downward spiral. This could make adequate rate increases more difficult to predict. In this scenario, several insurers may choose to exit the market.

- Individual health plans face substantial cost variability as a high proportion of members switch from one plan to another. In this scenario, even if the risk pool remains consistent with broad participation, individual health plans could face substantial cost variability if members prove to be highly price-sensitive among the competing health plans. For example, by virtue of having a historically healthier population,



a health plan could develop a very competitive rate across the spectrum of plans and receive a disproportionate percentage of sicker members. Although not inherently problematic assuming adequate risk adjustment payments from other health plans, this population shift introduces additional uncertainty and would require an accurate risk adjustment mechanism to reallocate dollars among the health plans. In addition, this constant shifting among plans by members will limit a health plan's ability to impact the provision of care through medical management activities where more than a single year is necessary to improve outcomes and costs. Similar to the problems described earlier, the challenges with constant member turnover could limit insurer participation.

AT THIS POINT, WE SIMPLY DO NOT HAVE ENOUGH INFORMATION TO MAKE A JUDGMENT ON THE FINAL SUCCESS OF THE ACA EXCHANGES.

WHAT TO LOOK FOR IN THE DATA

At this point, we simply do not have enough information to make a judgment on the final success of the ACA exchanges. This, of course, will change over time as more information and data become available. Several keys will be important to look for over time regarding the cost predictability question.

- **Disenrollment of the young and healthy.** Although the initial demographics have been collected, the most important cohort will be those individuals who are implicitly subsidizing the broader exchange pool—younger and healthy members. If these individuals leave the pool in response to rate increases, this could be the first sign of a downward spiral, and it will challenge the ability of insurers to adequately rate and predict the cost of the exchange population.

- **The overall health status of the exchange population.** To the extent that the premiums will ultimately reflect the cost of the exchange population after the risk protections are eliminated, a more costly exchange population will lead to higher premiums and a greater chance that healthier members will leave the pool in response to rate

increases. A wide variety of data sources will provide insight into this population, including the extent of the reinsurance and risk corridor payments.

- **Risk-adjusted payments among the insurers.** Because the risk adjustment program is designed to simply reallocate payments among the insurers, if we see large payments among health plans, they will face additional uncertainty in estimating their final revenue payments and matching these payments to newly emerging costs.

- **Substantial enrollment changes in response to rate changes.** If the exchange populations at the individual health plan level change substantially in both total enrollment and relative risk in response to rate changes, this will contribute to the challenge in estimating costs and limit medical management activities.

- **Rate increases among those insurers who have attracted the highest proportion of membership.** While many have focused on the rate increases among all insurers, a better measure for the potential morbidity of this population will be increases for those health plans that have attracted the bulk of the membership—particularly those health plans that have attracted the sickest members in the market. In many cases, the health plans requesting low or negative increases are attempting to simply become competitive after receiving little enrollment in the initial year.

For the remainder of this year, we will see the states and insurance companies release information regarding their rate increases for 2015, while the enrollment results will be released by the states and CMS early next year. The most compelling information regarding the cost of the risk protections will likely be released in the middle of 2015 by CMS.

In short, the next two years will provide a stream of emerging data to help insurance companies make more reasoned decisions about their exchange rates and participation in 2017 after two important risk protections—reinsurance and risk corridors—are removed from the program. Assuming no further policy changes, the 2017 rate filings will provide the most definitive proof of whether the cost predictability challenge has been achieved by the ACA. A

Kurt J. Wrobel, FSA, MAAA, is chief actuary at Geisinger Health Plan in Danville, Pennsylvania. He can be reached at *kjwrobel@thehealthplan.com.*