Session 93PD, Policy Provisions to Improve the Individual ACA Market

Moderator/Presenter: Joseph P. Slater, FSA, MAAA

Presenters: John Culkin, ASA, MAAA
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Douglas T. Norris, FSA, MAAA
Policy Provisions to Improve the Individual ACA Market

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Session 93

Tuesday June 26, 2018
Active participation in the Society of Actuaries is an important aspect of membership. While the positive contributions of professional societies and associations are well-recognized and encouraged, association activities are vulnerable to close antitrust scrutiny. By their very nature, associations bring together industry competitors and other market participants.

The United States antitrust laws aim to protect consumers by preserving the free economy and prohibiting anti-competitive business practices; they promote competition. There are both state and federal antitrust laws, although state antitrust laws closely follow federal law. The Sherman Act, is the primary U.S. antitrust law pertaining to association activities. The Sherman Act prohibits every contract, combination or conspiracy that places an unreasonable restraint on trade. There are, however, some activities that are illegal under all circumstances, such as price fixing, market allocation and collusive bidding.

There is no safe harbor under the antitrust law for professional association activities. Therefore, association meeting participants should refrain from discussing any activity that could potentially be construed as having an anti-competitive effect. Discussions relating to product or service pricing, market allocations, membership restrictions, product standardization or other conditions on trade could arguably be perceived as a restraint on trade and may expose the SOA and its members to antitrust enforcement procedures.

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- Do not discuss prices for services or products or anything else that might affect prices
- Do not discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
- Do not speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
- Do leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
- Do alert SOA staff and/or legal counsel to any concerning discussions
- Do consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone’s responsibility; however, please seek legal counsel if you have any questions or concerns.
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## Session Objectives

- At the conclusion of the session, attendees will be able to:

<table>
<thead>
<tr>
<th></th>
<th>Explain policy ideas to build a more sustainable and stable individual health insurance market</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Describe how proposed policy provisions would lower premiums and raise the number of insured</td>
</tr>
<tr>
<td>3</td>
<td>Identify the issues that are unfavorably impacting the individual ACA marketplace</td>
</tr>
</tbody>
</table>
Moderator and Panelists

Joe Slater, FSA, MAAA
• Partner and Consulting Actuary
• Axene Health Partners, Charlotte, NC

Douglas T. Norris, FSA, MAAA, PhD
• Principal and Consulting Actuary
• Milliman, Denver, CO

John Culkin, FSA, MAAA
• Consulting Actuary
• Axene Health Partners, Charlotte, NC

Ian G. Duncan, FSA, FIA, FCIA, MAAA, FCA
• Adjunct Associate Professor of Actuarial Statistics, Dept. of Statistics & Applied Probability
• University of California Santa Barbara
Agenda

Session Introduction – Slater
1332 Waivers and What’s Next for Commercial Health Insurance – Norris
How to Save the Individual ACA Market for $14 Billion – Culkin
Creating a Rational Individual Market (and Healthcare System) – Duncan
Q&A and Wrap-Up – Slater, the Panelists, and You
Background

• A Simple Proposal to Save the Individual ACA Market, Health Watch Issue 85, February 2018

• Policy Proposal to Reform Individual ACA Market, Health Section Podcast, April 2018
The Problem with the Individual ACA Market

• Pre-existing conditions are not insurable risks
• Covering pre-existing conditions through the Individual ACA market under community rating rules is not sustainable
Policy Proposal

• Create a Federal high-risk pool
• All premiums priced as if no one in the risk pool has a pre-existing condition
• Members would continue paying premiums to their insurer and use the insurer’s networks and benefit plans
• Member premium and risk would be transferred to the Federal Government
• Increase age rating ratios from 3:1 to 5:1
• Establish care management programs
Modeling - CDPS

• University of California, San Diego Chronic Illness and Disability Payment System

• Used for risk adjusting capitation payments for Medicaid beneficiaries

• 58 possible conditions based on ICD9 and ICD10 codes

• 19 child conditions and 21 used to model the high risk pool

<table>
<thead>
<tr>
<th>CDPS Condition Category</th>
<th>Child Conditions</th>
<th>Adult Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematological, extra high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Renal, extra high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer, very high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pulmonary, very high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hematological, very high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Renal, very high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Infectious, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>AIDS, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gastro, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pulmonary, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cardiovascular, very high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Metabolic, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hematological, medium</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Infectious, medium</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Central Nervous System, medium</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes, type 1 high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Central Nervous System, high</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>HIV, medium</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Renal, medium</td>
<td>x</td>
<td>✓</td>
</tr>
<tr>
<td>Cardiovascular, medium</td>
<td>x</td>
<td>✓</td>
</tr>
<tr>
<td>Skeletal, medium</td>
<td>x</td>
<td>✓</td>
</tr>
</tbody>
</table>
Modeling – Identifying Pre-Existing Conditions

- Base Data – AHP’s propriety experience database – Individual ACA experience includes more than 2.5 million member months.
- Known Pre-Existing Conditions – Members that were eligible in both 2014 and 2015, and were flagged with the same condition in both years.
- Undisclosed Pre-Existing Conditions – Members that were only eligible in 2015, and were flagged with the same condition in both their first month of eligibility, and the remainder of the year.
- Members With No Pre-Existing Conditions – All other members were grouped together.
Monte Carlo Simulations were used to simulate the Individual ACA population in each state.

Condition Cost and Probability Distribution – based on 2015 Individual ACA experience in AHP’s propriety experience database for each age band.

<table>
<thead>
<tr>
<th>Age Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
</tr>
<tr>
<td>18-25</td>
</tr>
<tr>
<td>26-34</td>
</tr>
<tr>
<td>35-44</td>
</tr>
<tr>
<td>45-54</td>
</tr>
<tr>
<td>55-64</td>
</tr>
<tr>
<td>65+</td>
</tr>
</tbody>
</table>
Modeling – Calibration and Simulation (Continued)

- Age Distribution – 2015 or 2017 Marketplace Open Enrollment Public Use File
- Individual ACA Population – State Billable Member Months listed in Appendix A to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year
- Statewide Cost – Average PMPM Claims reported in the 2015 Paid Claims Cost by State Report
Modeling Results – Overall Savings

- High Risk Pool Claims Cost – $14.3B
- High Risk Pool Program Expense (est. 5% of program cost) – $0.7B
- High Risk Pool Member Premium – $1.8B
- Net Program Costs – $13.1B
Age Curve Calibration

- Resetting the age curve from 3:1 to 5:1 significantly decreases required premiums for younger and healthier members

<table>
<thead>
<tr>
<th>Age Band</th>
<th>With Pre-Ex and 3:1</th>
<th>Without Pre-Ex and 3:1</th>
<th>Without Pre-Ex and 5:1</th>
<th>% Change*</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>$220.10</td>
<td>$176.01</td>
<td>$125.28</td>
<td>-43.1%</td>
</tr>
<tr>
<td>18-25</td>
<td>$275.87</td>
<td>$220.61</td>
<td>$157.11</td>
<td>-43.0%</td>
</tr>
<tr>
<td>26-34</td>
<td>$318.49</td>
<td>$254.69</td>
<td>$202.10</td>
<td>-36.5%</td>
</tr>
<tr>
<td>35-44</td>
<td>$362.48</td>
<td>$289.87</td>
<td>$252.18</td>
<td>-30.4%</td>
</tr>
<tr>
<td>45-54</td>
<td>$496.93</td>
<td>$397.40</td>
<td>$405.25</td>
<td>-18.5%</td>
</tr>
<tr>
<td>55-64</td>
<td>$747.12</td>
<td>$597.47</td>
<td>$690.07</td>
<td>-7.6%</td>
</tr>
<tr>
<td>65+</td>
<td>$845.80</td>
<td>$676.38</td>
<td>$802.40</td>
<td>-5.1%</td>
</tr>
<tr>
<td>Average</td>
<td>$468.49</td>
<td>$371.66</td>
<td>$371.66</td>
<td>-20.7%</td>
</tr>
</tbody>
</table>

* Percent change compares to "Without Pre-Ex and 5:1" to "With Pre-Ex and 3:1" columns

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Limitations

• Assumes the risk of the population stays the same, although lower premiums should attract a healthier population
• Does not assume any savings to the APTC due to premium reduction
• Assumes the number of high-risk individuals in the risk pool stays the same because these members are already incentivized under current ACA rules
ACA Finances
The ACA is a Problem for Consumers

Table 1: Increases in Lowest Marketplace Silver and Gold Premiums by State, 2017–2018

<table>
<thead>
<tr>
<th>State</th>
<th>State Average Lowest Silver Premium</th>
<th>State Average Lowest Gold Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Average</td>
<td>$342</td>
<td>$444</td>
</tr>
</tbody>
</table>

THE ACA IS A PROBLEM FOR CONSUMERS

Recent Changes in the Law Aren’t Helping

- The combined effect of eliminating the individual-mandate penalties and expanding short-term limited-duration policies would increase 2019 ACA-compliant nongroup insurance premiums 18.3 percent on average in the 45 states (including the District of Columbia) that do not prohibit or limit short-term plans.

- Federal government spending in 2019 will be an estimated 9.3 percent higher than under prior law, owing to the combined effect of expanding short-term limited-duration policies, eliminating the individual-mandate penalties, and other recent policy changes. This increase in federal spending is lower than the overall increase in premiums because of cost reductions caused by decreases in enrollment.

ACA IS REALLY MEDICAID EXPANSION

Medicaid accounts for 55% of the 2018 projected cost.

Average spending per enrollee: $6,200.
Actual Cost of Insurance Subsidies has been consistently lower than projections, although still significant.

ACSA EXCHANGES FALL SHORT

Commercial Exchange enrollment falls short of projections; subsidy per enrollee is also lower than projected ($4,200 in 2016 although projected to be $6,400 in 2018).
THE ACA IS NOT CONTAINING SPENDING

THE ACA IS NOT CONTAINING SPENDING

ACA IS COSTLY BUT NOT THE BIGGEST PROBLEM

ACA IS COSTLY BUT NOT THE BIGGEST PROBLEM

2014-7 Data
Medicare $672.1 billion\(^1\)  ($11,000 per beneficiary 2014\(^2\) )
Medicaid $565.5 billion ($6,400 per beneficiary 2014\(^3\) )
Private health insurance $1,123.4 billion. ($6,169 per beneficiary 2017\(^4\) )
   Tax subsidy estimated at $260 billion per year\(^5\) (2017).
   Tax subsidy per “member” $1,600 per year \(^6\).

MANY PROBLEMS OF THE CURRENT FINANCING SYSTEM

• Unequal subsidies between classes of persons;
• Mis-aligned incentives and distortion;
• Substantial Government control and direction:
  • Plan designs
  • Unit costs (reimbursement)
  • Cost-shifting;
• Attempts to equalize reimbursement (Risk Adjustment) doesn’t work very well and creates perverse incentives.
• Gaps in coverage (e.g. switching employment).
Creating A Rational System
CREATING A RATIONAL SYSTEM

A number of plans have been advanced that would achieve two goals:

• Return control of healthcare to members and their providers; and
• Equalize subsidies between individuals and classes of insureds.
Recently, policy makers have taken up this charge as well. Most notably, President Bush’s 2008 budget proposed to replace the ESI exclusion with an individual deduction of $7,500 for individuals holding health insurance.

PRIOR PROPOSALS

John McCain (presidential candidate, 2008) 8

In short, the McCain plan of 2008 was the most radical, free-market-focused platform championed by either a presidential contender or advanced in high-profile legislation in recent decades. It’s also the best. In the future, reform that works needs to incorporate a big portion of McCain’s bold manifesto.

THE MCCAIN PLAN

1. Employer-provided Health insurance is taxable income; offset by:
2. Refundable tax credit of $2,500/individual; $5,000 per family.
3. Available to employees/uninsured/Medicaid beneficiaries.
4. Policies could be purchased from the insurer or on an exchange.
5. Policies “owned” by member, hence portable.
6. Health savings accounts with enhanced tax-deductible contributions.
7. True national market ("across state lines.")
8. True underwriting and pricing (age/sex/condition).

PRACTICAL EXAMPLE

1. Employee earns $100,000/year; 35% Federal tax bracket.
2. Employer contributes $10,000/year towards health insurance.
3. Employer increases compensation by amount of reduced insurance cost.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CURRENT</th>
<th>FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Healthcare cost</td>
<td>$10,000</td>
<td>$0</td>
</tr>
<tr>
<td>Employer Tax deduction</td>
<td>($10,000)</td>
<td>$0</td>
</tr>
<tr>
<td>Employee Compensation</td>
<td>$10,000 tax free compensation</td>
<td>$5,000 refundable tax credit</td>
</tr>
<tr>
<td>Employee compensation</td>
<td>$6,500 (net of tax)</td>
<td></td>
</tr>
</tbody>
</table>
ADVANTAGES

1. Removes Government control and restores the market.
2. Removes the third-party payer issue and replaces with individual control.
3. Competition: Private exchanges and competing insurers.
4. Removes the incentive for tax-free high value plans.
5. Removes the distortions of the ACA (old subsidized by the young).
6. Opens commercial plans to Medicaid beneficiaries.
7. Improves labor-market flexibility.
ISSUES TO BE ADDRESSED:

1. The tax deduction should probably be age-adjusted.
2. Need high-risk pools for individuals with pre-existing conditions.
3. Transfers between carriers without exclusions.
4. Up to the States whether they will provide additional subsidies for Medicaid beneficiaries (e.g. the Healthy Indiana plan).
5. State regulation of insurers and policies.
6. No mandate. (more on this in a moment)
WHAT WILL INSURANCE LOOK LIKE (example 1)

https://www.youtube.com/watch?v=K_Rkahsi7c8
WHAT WILL INSURANCE LOOK LIKE (example 2)

https://www.youtube.com/watch?v=nnGWqyAYDYY
WHAT WILL INSURANCE LOOK LIKE (example 3)

Not limited to Auto Insurance

https://www.youtube.com/watch?v=D5iu8u0aVWs
WHAT WILL INSURANCE LOOK LIKE (example 4)

https://www.youtube.com/watch?v=Om3MeiTtLfo
It is significant that you can change behavior in auto insurance (and benefit from a “fair price”) but not in health insurance.
THANK YOU!
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What’s Already Going On? (1332 Waivers, Federal Overtures)

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2018 SOA Health Meeting

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Let’s Define Some Terms
1332 Waivers: What are the rules?
1332 Waivers: State by State (as of May 9, 2018)

1332 Waivers: What can be done?

Reinsurance Pool – by Diagnosis
Reinsurance Pool – by Cost
Changes to mandate requirements
Changes to eligibility requirements
Changes to metallic levels
Changes to APTCs and CSRs
Changes to Exchange mechanics
Changes to cost sharing limits
...and more!
Commercial Health Care: What’s Next?

SOA Health Section initiative

Anthology of white papers

The Actuary magazine web exclusive

Demographic Restrictions – What’s the Controversy?

http://www.theactuarymagazine.org/the-old-and-the-beautiful/
Demographic Restrictions – “A” is for “ASOP”

http://www.theactuarmagazine.org/the-old-and-the-beautiful/
Demographic Restrictions – What’s the Right Balance?

http://www.theactuarmagazine.org/the-old-and-the-beautiful/
Demographic Restrictions – The Times, Are They A-Changin’?

http://www.theactuariymagazine.org/the-old-and-the-beautiful/
Comments/Complaints/Compliments/Cookies:

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