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Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil’s in the Details

By Doug Norris, Mary van der Heijde and Hans Leida

For actuaries, long gone are the days when “the three Rs” referred to reading, writing and arithmetic. Within the context of the Patient Protection and Affordable Care Act (ACA), the “three Rs” now mean risk adjustment, transitional reinsurance and risk corridors. These risk mitigation provisions are a critical factor in how premiums are developed, how markets perform, and how the changes from ACA impact carriers.

The risk corridor program is a temporary feature that will apply to individual and small group qualified health plans (QHPs) from 2014 through 2016. The exact definition of which plans will qualify for the risk corridor program is still unknown at the time of this writing; in a proposed final rule published in the Federal Register on June 19, the U.S. Department of Health and Human Services (HHS) states that plans sold exclusively off-exchange could not obtain QHP certification¹. Large group, grandfathered plans, self-funded plans, and non-QHP individual and small group plans will not participate in the risk corridor program.

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Letter from the Editor

By Kurt Wrobel



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After years of debate and predictions, we are finally about to see the arrival of the most significant changes associated with the Patient Protection and Affordable Care Act (ACA). This will be an exciting time for our country, the entire health care industry, and the actuarial profession. As actuaries, we will shortly begin to see the actual data on everything from the relative competitiveness of our premium rates to the accuracy of our participation assumptions.

Of course, these immediate results will just be the beginning. As the claims experience matures from 2013 to 2014, we will begin to see the impact of the financial protection provisions in the ACA—the so-called “3 R’s,” reinsurance, risk corridors, and risk adjustment—on the overall financial results for health insurers. With a relatively low percentage margin, these provisions could have a significant impact on the results of insurers by either providing more payment or by moving premium dollars from one insurer to another. While the final results are uncertain, we can be confident that health actuaries will play a major role in providing guidance and technical support in shaping the ACA.

This expanded edition of *Health Watch* is dedicated to the upcoming implementation of the ACA.

In our cover article, Doug Norris, Mary van der Heijde, and Hans Leida highlight the technical and strategic considerations of the risk corridor provision in the ACA. As with many other aspects of the legislation, the technical details could play an important part in impacting the profitability of a health plan.

We continue this focus on the 3 R’s with two articles that address risk adjustment. Syed Mehmud summarizes his research sponsored by the Health Section into risk adjusters and nontraditional variables. In his article, Syed discusses nontraditional variables that could be predictive in estimating future health care costs, but are not included in risk adjustment models. Jason Siegel furthers this discussion by highlighting specific operational strategies that health plans could deploy to optimize

their risk adjustment performance.

Jeff Rohlinger ties together these technical discussions with specific thoughts on how to prepare for 2015. As Jeff discusses, while we will not have much data to form the basis for our pricing in 2016, we will have new regulation and other factors to consider as we move into the next pricing cycle.

While the commercial market has received considerable focus, the ACA will also have a major impact on the Medicaid market. As Rob Damler discusses, with the new expanded eligibility in the ACA, the Medicaid population will increase significantly and have a much different demographic and risk composition. Sabrina Gibson and Maria Dominiak continue the Medicaid discussion with a technical overview of the impact of the health insurance fee on Medicaid insurers.

David Tuomala provides additional detail on a study sponsored by the Society of Actuaries (SOA) on the cost of the newly insured. While the study received a considerable amount of media interest, David provides additional information on the key data and assumptions that helped underpin the findings in the report.

This edition concludes with a second round of the debate between David Cutler and Grace Marie Turner. In 2010, they had a spirited debate at the SOA health conference and in a follow-up *Health Watch* article, and we wanted to continue this discussion with another round of questions. As with the first discussion, they both provide compelling evidence for their sides and certainly offer up some very interesting perspectives on what they think will happen as we go into 2014. Unlike many political debates, however, we are much more likely to have definitive evidence on the results of ACA in a few years.

In our next *Health Watch*, we are planning to focus on advanced modeling and analytics. If you are doing cutting edge work in this area, we welcome you to submit articles for the next edition. ■

Chairperson's Corner

By J. Patrick Kinney

Welcome to the 73rd issue of *Health Watch*, this time with an editorial focus on the implications of U.S. health care reform. In this month's Chairperson's Corner, I will talk about some of the accomplishments of the Health Section Council (HSC) over the past year. And I encourage any members attending the Society of Actuaries (SOA) Annual Meeting in San Diego to come to the Health Section breakfast on Tuesday morning, where you will have an opportunity to ask questions and interact with section leaders and fellow section members.

Health Section Leads in Member Retention—Again!

A good measure of the Health Section's success in satisfying our members' need for education and professional connection is the percentage of section members who renew their membership each year. I am happy to report that the SOA section renewal statistics for 2013 showed the Health Section leading all 19 SOA sections in this statistic. For the second year in a row, in fact! At 92 percent of members renewing, we exceeded the total SOA section renewal percentage of 85 percent. But wait, there's more! We are the only section in the past five years to achieve 90 percent or greater member retention—and we have done it every year! We have also been growing in total membership, with new members more than offsetting the attrition rate. Thank you to all members of the section for supporting our activities with your dues, your volunteerism, and your continued interest in the Health Section.

The only disappointment in the membership stats is that we have fallen to second place—behind the Financial Reporting Section—in total membership as of August 2013. We need 60 more members to catch back up! You know the benefits of section membership, so encourage your colleagues and students to join the Health Section. Don't make me drop my Financial Reporting membership next year out of a heightened sense of contrived competition!

Health Meeting

As you know, the largest continuing education event for the Section is the SOA Health Meeting, held in June of each year. This year's Health Meeting was held in Baltimore, Maryland. (I didn't get to Fort McHenry or Camden Yards this time, but I did pay my respects to E.A. Poe.) The section council, SOA staff and numerous volunteer session coordinators and speakers worked together to provide an outstanding opportunity for professional education and networking. Major thanks go to our meeting chair Karl Volkmar and vice-chair Valerie Nelson. We came very close to record attendance, and 98 percent of survey respondents rated the meeting as Good to Excellent (with Very Good receiving an outright majority). Over the next few months, the section council and SOA staff will be reviewing the detailed responses on the 98 meeting sessions, in preparation for next year's Health Meeting in San Francisco.

Continuing Education

One of our primary functions is to provide continuing education to section members, other actuaries, and interested parties. In this we have done even more than usual during the past year. Our annual report to the SOA Board at their October meeting includes the following accomplishments:

- The Section provided 85 percent of the content at the SOA Health Meeting.
- We are sponsoring 15 sessions at the October Annual Meeting (that's all the time the SOA can give us).
- We sponsored eight webinars and produced several podcasts for health actuaries on the go.
- We ran Boot Camps each November on rotating topics important to Health actuarial practice.
- Med School for Actuaries remains a popular seminar offered several times per year.

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To join the section, SOA members and non-members can locate a membership form on the Health Section Web page at <http://www.soa.org/health/>

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- Our new Provider Payment Reform Seminar was very highly rated by attendees.
- We launched members-only online access to *Health Affairs*.
- We also opened a LinkedIn subgroup for Health Section members to engage in ongoing discussion.

Add to that the outstanding *Health Watch* issues of the past year and our monthly Health E-News blast email, and I think you will agree that the Health Section continues to provide significant value for your membership dues.

Section Council

We all owe particular thanks to the members of the section council, who contributed so much of their time and effort over the past year to achieve the strong results outlined above. I have enjoyed working with all of them, and I personally have learned so much through having the opportunity to lead the section over the past year. In addition to me, council members whose terms expire this fall include Karl Volkmar, Dewayne Ullsperger, and Tom Handley. Please join me in thanking each of these leaders for their work with the Health Section.

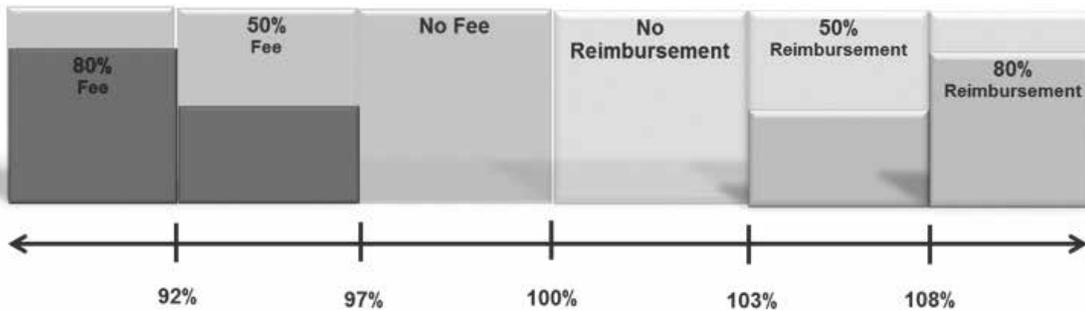
Continuing on the council next year will be Donna Kalin, who steps into the chair position after the Annual Meeting, Andie Christopherson (vice-chair), Valerie Nelson (2014 Health Meeting chair), Greger Vigen, Nancy Hubler, Kara Clark, Olga Jacobs, and Eric Goetsch. Thanks to each of you for your continuing involvement with the Health Section.

Section Elections

Each year the Health Section membership has the opportunity to elect new volunteer leaders as members of the section council. As I write this, the section elections are about to begin. By the time you are reading this in *Health Watch*, we will know who is joining the Health Section Council for the next three years. I am sure those elected will be eager to work alongside Donna, Andie and the other returning HSC members in continuing our tradition of providing strong and substantive professional development for Health actuaries.

As always, if you have ideas for our future success, along with energy and commitment to carry us forward, consider how you might be able to contribute as a volunteer. For more information, please contact Donna Kalin or any member of the Health Section Council. Remember, as I have said often over the last few years, we are the oldest and the best of the 19 SOA sections—and together we will keep it that way! ■

Figure 1: Gain and Loss Sharing under ACA Risk Corridors



On the face of things, the risk corridor program appears rather straightforward (and may appear less complicated than its “three R” brothers—risk adjustment and transitional reinsurance). However, there are some interesting aspects of the formula itself, and there are also some interesting consequences that result from the rule’s language. Our goal is to dispel some common misconceptions, demonstrate some of the less obvious aspects of the risk corridor program, and help you navigate through these next three years.

Why Do We Have Risk Corridors?

By now, you have hopefully completed your 2014 product pricing. Unless you have a vintage DeLorean (with time machine capability), you were likely intimidated by the amount of uncertainty in your pricing assumptions. How many employers will send their employees to the individual market? What percentage of the current uninsured will purchase coverage? How healthy will these individuals be? For those newly covered, how much will pent-up demand affect their utilization? How will my competitors price their products? Will the transitional reinsurance be fully funded?

The list of concerns goes on and on (and could be the subject of its own article). Regardless, it is clear that, despite our best efforts and actuarial principles, there are some significant factors about the future insurance market that we cannot know.

The goal of the risk corridor program is to protect health insurance issuers against this pricing uncertainty of their plans, temporarily dampening gains

and losses in a risk-sharing arrangement between issuers and the federal government. Since the protection is only available for QHPs, it also provides a strong incentive for issuers to participate in the health insurance exchanges set up by the ACA. Lastly, it provides an incentive for issuers to manage their administrative costs optimally.

The program compares “allowable costs” against a “target amount.” Allowable costs are essentially claim costs plus various adjustments, including adjustments for the other two Rs and quality and health information technology costs. The target amount is essentially premium less allowable administrative (non-claim) costs, where the administrative costs include a certain allowance for profit. If the ratio of these amounts is greater than one, then the premium was less than what was required, and if the ratio is less than one, then the premium was more than what was required. Based upon this ratio, plans share with HHS in the fashion shown in Figure 1 above.

The chart in Figure 1 illustrates the basic concept, although we will walk through some case studies later in the article. If a plan’s ratio is within three percentage points of 100 percent, the plan keeps all gains (or losses) for itself. For the next five percentage points, gains (or losses) are shared 50/50 between the plan and the government. Beyond that (either below 92 percent or above 108 percent), the plan keeps 20 percent of gains (or losses), ceding the remaining 80 percent to the government.



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Given the uncertainties in pricing, and the need to both maintain market share and receive approval by state divisions of insurance, there is pressure to keep premiums lower.

However, as we'll see, the "gain" and "loss" percentages shared here are not really what health insurance issuers are used to when they see those words. The formula is complex, and it is important to work through examples to understand it fully. For instance, having a risk corridor ratio of 100 percent does not mean that an issuer broke even—in fact, the issuer could have either gained or lost money, depending on its specific situation.

One consequence of the chart is obvious—the risk corridor program appears to be symmetric, with some plans paying into the program and some plans receiving funds from the program. But is it really? In the final rule HHS states that "[the Congressional Budget Office] did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers."² However, if all of the plans in a market (or even just the most popular ones) end up pricing their products too low and so suffer losses, the government will end up needing to fund this program, and the required funds could be substantial.

Given the uncertainties in pricing, and the need to both maintain market share and receive approval by state divisions of insurance, there is pressure to keep premiums lower. Because state divisions of insurance are typically more likely to question high prices than low prices, the possibility of an asymmetric risk corridor program outcome seems likely. For this provision to be symmetric, the losses would have to exactly balance the gains, which would be more a coincidence than a certainty. HHS did acknowledge this on page 15473 of the Federal Register (released on March 11), noting that the program is not statutorily required to be budget neutral, and that payments will be made regardless of the balance between receipts and payments.³

How Do the Risk Corridors Work?

The ultimate goal of the risk corridor program is to dampen the impact to issuers from having premiums that end up being too high or too low; however, the formula contains a cap on administrative expenses as well as a floor on profit, which

combine to produce interesting results. Here are the official steps involved in a risk corridor calculation:

- Claim costs = Incurred claims + IBNR + payments/receipts from risk adjustment and transitional reinsurance.
- Allowable costs = Claim costs + quality expenses + health care information technology (consistent with the medical loss ratio (MLR) definition).
- Profits = (Premium – allowable costs – non-claim costs), floored at 3 percent of after-tax premium.
- Administrative costs = Non-claim costs – taxes/fees.
- Allowable administrative costs = Taxes/fees + (administrative costs + profit, capped at 20 percent of after-tax premium).
- Target amount = Premium charged – allowable administrative costs.
- Risk corridor ratio = Allowable costs / target amount.

Note that the formula does not compare pricing assumptions with actual experience. All of the values used in the risk corridor calculation are actual experienced values; the formula uses premiums actually charged, and claim and administrative costs actually experienced. It is also important to note that the parameters are set up so as to be aligned with the federal MLR calculation as much as possible. (The risk corridor calculation happens after reinsurance and risk adjustment, but prior to the minimum MLR provision calculations, because any risk corridor payment or receipt is an input to the MLR calculation.) Issuers must submit risk corridor data and calculations by July 31 of the year following the benefit year. The calculations can essentially be done at the issuer level (although there are some subtleties), in order to be consistent with the ACA's single risk pool requirement.

The March 11 publication in the Federal Register⁴ walks through a rudimentary calculation example, which is quite helpful (even though the parameters used in the published example are not particularly realistic). Consider instead this baseline scenario: An issuer has \$350 per member per month (PMPM) in allowable costs (including health care quality and health information technology expenses). In addition, the issuer has \$85 PMPM in non-claim costs

(other than profit margin), \$25 of which are taxes and fees. Let us assume that the issuer has priced its product accurately, including a 5 percent profit margin (as a percentage of total premium, not after-tax premium), and has set its premiums at \$458 PMPM on average. After-tax premiums are therefore \$433 PMPM, with profits at \$23 PMPM and allowable administrative costs at \$108 PMPM (neither factor is subject to the cap/floor here). Therefore, the target amount (premiums less allowable administrative costs) is \$350 PMPM, which is compared with the allowable costs (also \$350 PMPM). The risk corridor ratio is 100 percent (and no payments are made or received), since actual results came out consistent with pricing assumptions. In this baseline scenario, the issuer's priced-for profit margin of 5 percent was actually achieved, and remains at 5 percent after risk corridors.

Because the goal of the program is to cushion against pricing uncertainties, let us modify our example to see what happens when our issuer prices its product 10 percent higher than what would have been ideal (above and beyond the priced-for profit margin),

and when our issuer prices its product 10 percent lower than what would have been ideal. Does the risk corridor “protect” against these scenarios?

Just to be clear, given all the “profits” floating around: The line labeled “Priced Profit Margin” in Figure 2 is the profit the issuer intended to make. The “Profits” line is the profit amount used in the risk corridor formula after applying the floor. Finally, the last two lines show the approximate profit margins the issuer experiences as a percentage of total premium before and after the impact of the risk corridor program.

In both scenarios shown in Figure 2, the transfer payment between the plan and HHS mitigates the impact of the deviation from pricing assumptions to some degree, but far from completely. In the overpricing scenario, the allowable administrative costs are capped at 20 percent of after-tax premiums, plus taxes and fees. If this cap were not present, then the issuer would be permitted to deduct its entire allowable administrative costs (including the large profit), and there would be no risk corridor payment made.

Figure 2: Risk Corridor Calculation under Mispricing Scenario

	Baseline	10% High	10% Low
Premium Charged	\$458	\$504	\$412
Allowable Costs	\$350	\$350	\$350
Non-claim Costs (other than Priced Profit Margin)	\$85	\$85	\$85
Taxes/Fees	\$25	\$25	\$25
Priced Profit Margin	5%	5%	5%
After-Tax Premium Earned	\$433	\$479	\$387
Profits (in risk corridor formula)	\$23	\$69	\$12*
Allowable Admin Costs	\$108	\$121*	\$97
Target Amount	\$350	\$383	\$315
Risk Corridor Ratio	100.0%	91.4%	110.9%
Risk Corridor Receipt (Payment)	\$0.00	\$(11.42)	\$15.30
Profit Margin Before Risk Corridors	5.0%	13.6%	-5.6%
Profit Margin After Risk Corridors	5.0%	11.4%	-1.8%

*Asterisks denote values impacted by cap/floor. Note: Dollar values are rounded PMPM values. Taxes/fees assumed to be flat amount, and not indexed to premium. Profit margins are percentages of premium charged.

Figure 3: Risk Corridor Calculation under High/Low Admin Cost Scenario

	Baseline	High Admin	Low Admin
Premium Charged	\$458	\$526	\$421
Allowable Costs	\$350	\$350	\$350
Non-claim Costs (other than Priced Profit Margin)	\$85	\$150	\$50
Taxes/Fees	\$25	\$25	\$25
Priced Profit Margin	5%	5%	5%
After-Tax Premium Earned	\$433	\$501	\$396
Profits (in risk corridor formula)	\$23	\$26	\$21
Allowable Admin Costs	\$108	\$125*	\$71
Target Amount	\$350	\$401	\$350
Risk Corridor Ratio	100.0%	87.3%	100.0%
Risk Corridor Receipt (Payment)	\$0.00	\$(25.20)	\$0.00
Profit Margin Before Risk Corridors	5.0%	5.0%	5.0%
Profit Margin After Risk Corridors	5.0%	0.2%	5.0%

*Asterisks denote values impacted by cap/floor. Note: Dollar values are rounded PMPM values. Taxes/fees assumed to be flat amount, and not indexed to premium. Profit margins are percentages of premium charged.

“...the program is also designed to strongly reward administrative efficiency”.

Similarly, in the underpricing scenario, if the profits were not floored (at 3 percent of after-tax premiums), then there would be no risk corridor payment received. This explains why the cap and floor are needed—without them, the program doesn’t make sense (assuming that it is to be based on actual expenses rather than pricing assumptions).

Next, let us examine the impact of an issuer that has higher (or lower) administrative costs than our hypothetical issuer. These are non-claim costs other than health care quality and health information technology (which are both considered allowable costs). The table in Figure 3 compares our baseline scenario with two issuers, each of which has accurately priced its product, but the first has higher administrative costs, and the second has lower administrative costs.

If the issuer manages to keep its administrative costs low (as in the third column in Figure 3), the issuer does not have to share any of these efficiencies with the government. However, if the issuer has high administrative costs (as in the second

column in Figure 3), its allowable administrative costs are capped at 20 percent of after-tax premium earned, plus taxes and fees, and it is required to make a significant risk corridor transfer (approximately 5 percent of premium charged, which in this case is their entire profit margin). Thus, the program is also designed to strongly reward administrative efficiency.

Finally, consider the impact of pricing a plan with a high profit margin as compared to pricing a plan with a low profit margin, assuming accurate pricing elsewhere. The table in Figure 4 on page 9 illustrates this scenario.

The issuer that prices in a large profit margin (as in the second column in Figure 4) ends up hitting the cap on administrative costs, and has to pay back a portion to HHS (in this example, approximately 0.6 percent of premium). On the other hand, the issuer in the third column includes no profit margin (you can see that the premium charged is equal to the allowable costs and the non-claims costs). Despite this, the risk corridor formula builds in a 3 percent profit margin (as percentage of after-tax premium, not total premium) in order to calculate the risk corridor ratio, and the issuer receives a small payment from HHS (although not the entire 3 percent).

Note that if a plan has low enough administrative costs, the issuer can price in a larger profit margin without hitting the 20 percent cap.

What Are Some Key Considerations Related to This Provision?

The final regulations aligned the risk corridor provision with the minimum MLR requirement, such that allowable taxes, fees and quality expenses in the MLR formula are also allowable in the risk corridor calculation. Issuers have been dealing with the MLR formula for a while now, and have found that it is critical to appropriately categorize items that qualify as health quality improvement expenses—items that lead to measurable improve-

ments in patient outcomes or patient safety, prevent readmissions, promote wellness or enhance health information technology. It is also important that issuers are appropriately allocating administrative expenses between their individual, small group and large group business (along with their self-funded and other non-commercial lines of business). Remember that only individual and small group QHPs receive protection from the temporary risk corridor program.

Because risk adjustment payments and transitional reinsurance compensation will feed into the risk corridor calculation, and the risk corridor calculation will adjust the final MLR calculation, it is not a simple exercise to project (and correct for) potential MLR rebate payments in advance. Some plans have taken measures—such as premium holidays or the waiving of cost sharing—in order to avoid the administrative effort (and potential negative publicity) of making MLR refund payments. Beginning in 2014, it will be more difficult to manage MLR liabilities in this fashion, because it will be possible that a plan is sitting at a comfortable MLR, only to have a large risk adjustment receipt or risk corridor correction push them below the minimum MLR requirement.

Issuers may be able to readily model their own risk score, but will find it difficult to model the overall market risk score (which is just as important in the risk adjustment calculation), and the risk adjustment transfer payment feeds into the risk corridor calculation, which populates the MLR formula. This is another place in which the risk corridor mechanism ends up being non-symmetric—after a certain point, an issuer must start disbursing gains to policyholders through MLR rebates. In other words, the issuer’s potential gains are capped, but the downside risk is not (merely dampened), and for very profitable issuers, the risk corridor may essentially have the effect of allocating some gains to the federal government that instead would have been paid to policyholders as rebates. Issuers should already be modeling potential risk adjustment, reinsurance and risk corridor scenarios and how they feed into their MLR, and should be setting up a real-time process to monitor how these provisions are impacting their bottom line.

Figure 4: Risk Corridor Calculation Under High/Low Priced Profit Scenario

	Baseline	High Profit	Low Profit
Premium Charged	\$458	\$483	\$435
Allowable Costs	\$350	\$350	\$350
Non-claim Costs (other than Priced Profit Margin)	\$85	\$85	\$85
Taxes/Fees	\$25	\$25	\$25
Priced Profit Margin	5%	10%	0%
After-Tax Premium Earned	\$433	\$458	\$410
Profits (in risk corridor formula)	\$23	\$48	\$12*
Allowable Admin Costs	\$108	\$117*	\$97
Target Amount	\$350	\$367	\$338
Risk Corridor Ratio	100.0%	95.5%	103.6%
Risk Corridor Receipt (Payment)	\$0.00	\$(2.83)	\$1.08
Profit Margin Before Risk Corridors	5.0%	10.0%	0.0%
Profit Margin After Risk Corridors	5.0%	9.4%	0.2%

*Asterisks denote values impacted by cap/floor. Note: Dollar values are rounded PMPM values. Taxes/fees assumed to be flat amount, and not indexed to premium. Profit margins are percentages of premium charged.

HHS has clarified that it is conscious of the risk corridor program’s non-symmetric nature, and states in the March 1 regulations⁵ that funds will be paid out regardless of the balance between payments and receipts. Some issuers are still worried that if the formula requires a large amount of funding from the government, there may be political pressure to reduce payments to issuers. It does not appear that most issuers are pricing differently as a result of these fears (based upon what has been released publicly so far).

Because of the risk-sharing nature of the program, it could provide an incentive for an issuer to price its plans competitively (with reasonable but aggressive assumptions), and if its price ends up being too low to cover costs, it will share that burden with HHS, while at the same time gaining market share. State divisions of insurance have historically had a focus upon plans with rates that they perceive to be too high; going forward, it will also be important for state divisions of insurance to increase efforts to review rates for being potentially insufficient. To the

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extent that issuers are underpricing in a competitive market, this could also lead to significant rate increases in 2017 when the risk corridor program ends.

It is also important to remember that the risk corridor only applies to QHPs both on and off the exchange. For plans sold on the exchange, this should not be a concern, as QHP certification will happen at that point. However, as mentioned previously, the recent HHS proposed rule suggests that products sold only off exchange will not be eligible for QHP certification (or risk corridor protection).

The ACA presents an exciting, yet uncertain, reality for issuers, who are accustomed to pricing products using an ample amount of relevant, quality data. Ultimately, the risk corridor program is designed as a “bridge over troubled waters” to help protect against this uncertainty. If all goes well, by the time the risk corridor program sunsets in 2017, issuers will finally have the ability to price ACA plans with ACA data. ■

END NOTES

¹ U.S. Department of Health and Human Services (June 19, 2013). Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards (Proposed Rule). Federal Register, Vol. 78, No. 118, 45 CFR Parts 144, 147, 153, 155, and 156, p. 37044.

² U.S. Department of Health and Human Services (March 11, 2013). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 (Final Rule). Federal Register, Vol. 78, No. 47, 45 CFR Parts 153, 155, 156, 157 and 158, p. 15516. Retrieved July 12, 2013, from <http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>.

³ Ibid, p. 15473.

⁴ Ibid, p. 15472.

⁵ Ibid, p. 15473.

SOA 2013

SOCIETY OF ACTUARIES
Annual Meeting & Exhibit

Oct. 20-23, 2013
San Diego Convention Center
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Join with 2,000 actuarial pros to take part in the SOA Annual Meeting—created with input, insight and guidance, by actuaries, for actuaries. More than 100 sessions, on over 100 topics, presented by nearly 300 experts. Hot issues you told us are important to you and your career—and 25+ networking ops.

Plan to take part in these sessions, sponsored by the Health Section:

Trends in Pharmacy

Session 79 Panel Discussion

Tuesday, Oct. 22

8:30 – 9:45 a.m.

This session will provide an overview of current industry trends in prescription drug costs and utilization, and how those trends are impacting overall health care experience.

Pricing Issues in Health Care Reform

Session 91 Panel Discussion

Tuesday, Oct. 22

10:15 – 11:30 a.m.

As the Affordable Care Act (ACA) is implemented, it is critical for all health actuaries to have a solid understanding of the changes ahead. This session will focus on those market reform rules most acutely impacting plan pricing, including the 3Rs.

SOAAnnualMeeting.org

Excerpts from the Health Meeting 2013

By Kristi Bohn and Rebecca Owen



Kristi Bohn, FSA, MAAA, is consulting staff fellow—health at the Society of Actuaries. She can be reached at kbohn@soa.org.



Rebecca Owen, FSA, MAAA, is director, actuarial services Meridian Health Plan in Detroit, Mich. She can be reached at owenfsa@gmail.com.

All in all, the 2013 Health Meeting was one of the best meetings the Society of Actuaries has ever held. The energy was high, and the sessions were informative and timely. In speaking with a couple of board of directors members who practice in other fields and never attended a health meeting before, they were very impressed with the content of the sessions, the amount and quality of volunteer speakers, and the participant interactions both in and out of sessions. We must agree: The health meeting was excellent, and it is because of the many volunteers who step up to coordinate, moderate and present. It is also because of the audience, who listened, asked great questions and kept the energy levels high. Thank you all. Another special word of thanks goes to Karl Volkmar, the meeting's chair, as well as Valerie Nelson, the meeting's vice chair. They did a great job. A reminder to all of you: If you are interested in presenting or moderating for the 2014 Health Meeting, please reach out soon to Valerie Nelson at valerie_nelson@bcbsil.com or Kristi Bohn at kbohn@soa.org. As you read this, the 2014 planning is already well underway.

Below is an overview of four great sessions from the health meeting. While most health meeting presentation materials are available for free on the SOA website, many of the sessions were recorded. The audio from these sessions, linked to the slides, is now available online through purchase at www.soa.org.

Session 32: ASOP 45 Risk Adjustment Deep Dive

Session 32 covered the content of a professionalism standard in a unique way. Approaching excerpted provisions of the standard one by one, the panelists Syed Mehmud and Bill O'Brien commented on how each provision plays a role in a variety of risk adjustment projects. In this way, while the session was very much a conversation about the professionalism standard, it was also fairly technical. Syed and Bill are both co-authors of separate SOA-commissioned studies that involve the evaluation of risk adjustment for different purposes and under different circumstances. They provided great

advice for those of you who are new or experienced with risk adjustment. For example, consistency is a key consideration; the consistency in claims run-out timing or claims coding completeness between you and your competitors is very important when revenue transfers are at stake. Syed explained, "Risk adjustment scores follow a different run-out pattern than claims." They also made an important point about the perceived flaws of the risk adjustment methodology including possible inconsistencies due to user errors, incomplete data or strategic reactions to risk adjustment. Because the system is consistently applied to each party, this normally does not present a material consequence to the final transfer of funds unless there are some biases being actively leveraged by one party. Another piece of great advice: create a pre-conceived expectation of the prevalence and risk score magnitude by condition, and then reconcile your actual results against that expectation to search out possible user errors. Seeking counsel from others is advised in the standard; Bill and Syed mentioned how important clinicians and statisticians have been to them. All in all, this professionalism session was timely, interesting and technically helpful.

Session 52: Actuarial Soundness, the CMS Checklist and Rate Certification Letters as They Relate to Medicaid Managed Care Rate Setting

Session 52 of the spring health meeting focused on the rate-setting process for Medicaid. The scope ranged from a discussion of how CMS views the landscape, as presented by Christopher Truffer, as well as a presentation of the Medicaid Managed Care Strategic Plan from Nicole Kaufmann, the acting technical director of the Center for Medicaid and CHIP Services. It was riveting to hear directly from CMS about what they are planning and what is important to them, since the profession is often receiving this information viewed as it applies to particular state programs.

Rob Damler reviewed the mechanics of the actuarial certification of rates, including a discussion of how the checklist and the 2005 AAA Practice Note



interact, as well as a note that the GAO felt that something more binding on actuaries was needed; the Academy is working on an ASOP to be released for comment in 2014.

Katia Bogush addressed the nuts and bolts of rate setting with a presentation so comprehensive and specific that we have asked her to redo the presentation in a webcast this fall so we can spend more time on this important topic. She gave an excellent compendium of everything a careful actuary needs to keep in mind when working through the checklist, along with enlightening additional information about the process that cannot be put into a dry document. Watch for an announcement about this webcast.

Session 64: Medicaid Coverage of Medicare Beneficiaries—Dual Eligibles under the ACA

Session 64 was another Medicaid session, this time looking at the dual eligibles (dual eligibles are those who are covered under both the Medicare and Medicaid programs). Two actuarial speakers, Tom Carlson and Shelly Brandel, delivered a professional and interesting presentation on how rates are developed for the demonstration programs. These demonstration programs seek to integrate

care between the state and federal programs. Shelly discussed the process for rate setting, as well as the motivation and the mechanics behind the proposals. Tom discussed details on demonstration proposals in four states: Ohio, Massachusetts, California and Illinois.

In addition to these very useful, topical and excellent presentations, the redoubtable Pam Parker from the Minnesota Department of Human Services gave us a rousing and exciting overview of the dual-eligible population, how they have interacted with the system, ways to address their specific issues, the state and federal perspective, what was at stake, where the programs were headed, possible pitfalls, along with her perspective after decades of inspired and diligent work in this area.

Session 98: The Impact of ACA on Entrepreneurs

A session at the end of the meeting featured Dr. Robert Graboyes, a health care advisor at the National Federation of Independent Business (NFIB) and a health economics professor at Virginia Commonwealth University, University of Virginia, George Mason University and George Washington University. NFIB is a lobbying firm

CONTINUED ON PAGE 14

for small businesses and entrepreneurs. When at your local strip mall, you might find an NFIB logo displayed on a storefront. Graboyes has not been an admirer of the Affordable Care Act and is often quoted in the popular press as such. In particular, he is cautiously pessimistic about how the Affordable Care Act will affect small businesses' health care premiums in the future, stating "no one knows." While admitting that some businesses' net premiums will be lower, and noting that the small business tax credits that are newly available could help, a major concern is that entrepreneurs do not like uncertainty. And most small employers are uncertain as to where their premiums will land over the next few years.

According to Graboyes, most small business owners lack the experience and interest to become or hire human resources experts. He stated that many would rather pay an employee more money and allow that employee to purchase an individual product, especially now that they know that all of their employees can obtain insurance. He said small employers were worried that employees may blame the employer for aspects of reform that are beyond the control of the employer. He also pointed out that small employers are worried that the Internal Revenue Service (IRS) may not agree with their determination to not offer health insurance directly. As an example, he reported that couples who own separate small businesses, or heavily invest in their children's businesses, are worried about the possibility that years in the future, certain overzealous IRS employees will inconsistently determine that certain business ventures must be joined when determining employee counts, thus implying massive hindsight penalties for those who failed to offer their employees health insurance for years. He noted that some small businesses are proactively becoming smaller in order to avoid having to offer health insurance by outsourcing or spinning off certain functions such as payroll, accounting, sales and technology. Graboyes pointed out that even large

public institutions, such as community colleges, are unexpectedly negatively affected by the Affordable Care Act; for example, many adjunct professors are seeing their hours and thus pay cut so that their college or university can continue to avoid offering them health insurance.

When asked whether brand new entrepreneurs might emerge because they know that they will have guaranteed access to health insurance starting in 2014, Graboyes said that this is a possibility, but there have been no research studies to verify and quantify this effect, and the overall question of affordability at the individual business level is still an issue. He suggested that a study of this possible new entrepreneurial resource through measurement of pre-ACA efforts in states such as Massachusetts, New York, Vermont and New Jersey would be valuable.

Graboyes pointed out that the study commissioned earlier this year by the Society of Actuaries on modeling the possible underlying claims cost changes of the insurance markets was, in his view, the only credible resource he has yet read on the long run compositional changes anticipated due to the complex and numerous insurance rule changes contained within the Affordable Care Act. However, he pointed out that the degree of uncertainty around the underlying forces is not known and was not studied. Further, the premium effects on any given individual or small business are still uncertain, and if there is one thing entrepreneurs do not like, it is uncertainty. ■

Diary of a Health Care Reform Actuary

APRIL 2013, ANY DAY – ANY TOWN, USA

By Olga Jacobs

- 12 a.m. Sleeping soundly and dreaming of sipping wine in Tuscany.
- 1 a.m. Wake up in a cold sweat. Had nightmare that I missed the April 30 deadline for submitting FFE QHP Templates and was fired.
- 2 a.m. Sleeping soundly and dreaming of eating gelato in Florence.
- 3 a.m. Wake up in terror. Had nightmare that I forgot to account for guaranteed issue in proposed rates for individual exchange rate filings. Sold 1 million policies. Crowned as actuarial hero. Stripped of crown when Finance reported loss ratio of 1,000 percent.
- 4 a.m. Sleeping soundly and dreaming of hiking in the Alps.
- 5 a.m. Wake up in terror. Had nightmare that I told Products that AV de minimis was +/- 20 percent, not +/-2 percent. All product submissions rejected. No benefit plan receives QHP certification. Fired (again!).
- 6 a.m. Wake up. Just the alarm this time!
- 7 a.m. Drink three doppio espresso macchiatos from Starbucks.
- 8 a.m. Check email. See 20 emails from “do not reply@cms.hhs.gov.” All 20 of the Unified Rate Review Templates I submitted yesterday were rejected. All failed due to invalid date format. Everyone at work knows ... thanks to my wisdom of designating 85 submitters and validators.
- 10 a.m. Meeting with Exchange IT Project Management Team. They want a list of every single report that Actuarial would produce effective Jan. 1, 2014 with exchange experience.
- 11 a.m. Still laughing at IT’s request.
- 12 p.m. Tasked with running the Minimum Value Calculator on every unique benefit plan sold to large groups. There are 6,000 plans. Due today.
- 1 p.m. Attend REGTAP meeting on QHP Certification. Zone out after the 75th caller explains their very, very specific template upload problem ... which is the same as the other 74 previous callers.
- 2 p.m. Starving. Eat nutritious lunch of 2 handfuls of almonds and a Diet Coke.
- 3 p.m. HHS releases 762 pages of proposed regulations related to FFE.
- 3:01 p.m. Senior management calls to express disappointment that my analysis of the 762 pages is not already completed.



- 4 p.m. Get hit in head with foul ball coming down third base line at Little League game. Wasn’t watching due to reading IRS Contraception Guidelines on iPhone. Find out my son was at bat!
- 5 p.m. Call actuary at state department of insurance and explain URRT submission.
- 6 p.m. Have dinner with the family. Entertain (OK, OK ... bore) them with scenarios of employer dumping into the individual exchange.
- 7 p.m. Call and email every health actuary I know to see if they can present at SOA Health Meeting. Getting turned down by everyone as they are “too busy with health care reform.” Special place in heaven for those who said yes.
- 8 p.m. Read *The Jobs Almanac* to see if I can find a better career than an actuary. Can’t.
- 9 p.m. Read FAQ #75. Get the answer on cost sharing reductions that I was hoping for. Direct IT how to pay claims for members in cost sharing reduced plans on non-EHB benefits.
- 10 p.m. Read FAQ #76. No longer have the answer of cost sharing reduction that I wanted. Neglect to tell IT.
- 11 p.m. Watch *Game of Thrones*. Come to conclusion implementing the Affordable Care Act would be much simpler if my name was Daenerys Targaryen and I had a dragon. ■



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Nontraditional Variables in Health Care Risk Adjustment

By Syed M. Mehmud



Syed M. Mehmud, ASA, MAAA, FCA, is director and senior consulting actuary at Wakely Consulting Group in Englewood, Colo. He can be reached at syedm@wakelyconsulting.com.

Note: This article is intended to introduce a recently concluded research project (Mehmud, 2013) with the same title. The research was funded by the Health Section of the Society of Actuaries. The report, in its entirety, is available at: <http://www.soa.org/Research/Research-Projects/Health/research-2013-nontrad-var-health-risk.aspx>.

Recognizing the importance of fortifying risk adjustment programs against selection based on nontraditional variables, the Society of Actuaries' Health Section sponsored an in-depth study into the relationship of nontraditional variables with health costs. The results of this research demonstrate that it is important to adjust the traditional risk adjustment model in order to recognize nontraditional variables. While this article does not go into the detailed results of the study, it introduces the key concepts and provides the context and motivation for this research. I encourage you to read the full report, a Web link for which is provided on this page.

The Affordable Care Act (ACA) includes the mechanism of risk adjustment in commercial small group and individual markets in order to further the policy goals of premium stabilization, mitigating incentives for issuers of health care coverage policies (issuers) to avoid unhealthy members, and to remove any advantages or disadvantages for plans inside health care exchanges compared to plans outside of such exchanges. The importance of risk adjustment to these policy goals cannot be overemphasized, and details such as the variables that are included in the risk assessment formula affect the extent to which the program is successful in meeting these goals.

Risk adjustment models have included variables such as demographic (i.e., age and gender) and clinical markers based either on ICD-9 diagnosis codes and/or pharmacy codes such as the National Drug Codes (NDCs). Literature points to other variables such as geography, body mass index (BMI), education and income that also explain the variation in health care cost—but have hitherto not been included in risk adjustment programs mainly

because such variables are not typically found in claim data, or that their use may or may not be permissible given legal or privacy-related concerns. If these nontraditional variables explain meaningful variation in cost beyond traditional risk adjustment models—then this may provide incentives for issuers to select certain members. If such incentives lead to selection that affects the financial performance of issuers—then the policy goals of the risk adjustment program may be undermined.

Issuers of health care policies will price their 2014 products assuming that the purchasers will be an “average risk.” As the phrase implies, an average risk is an individual who is expected to cost the same as the average of all of the individuals in that age cohort in a market. Around June of 2015, an issuer will receive a payment if purchasers were actually higher than average risk, or have to make a payment if they were lower than an average risk. In this manner an issuer can price to an average risk year over year, which promotes premium stabilization, and not have to worry about who takes up coverage since revenue is adjusted after the benefit year. This process mitigates the incentive for risk selection.

Like most actuarial exercises, risk adjustment is not perfect. In this case, the imperfections, if not properly understood and addressed, may undermine the policy goals of the ACA risk adjustment program. What happens when a risk adjustment mechanism does not adequately remove the incentive for selection? Health actuaries are well aware of the so-called “death spiral” that may occur when an issuer experiences significant ongoing adverse selection. Can that happen even in a risk-adjusted market?

The way it can potentially happen is if the risk adjustment mechanism does not adequately compensate an issuer for the assumed risk. For example, consider the hypothetical case of a chronic disease such as diabetes. A risk adjustment model such as the Department of Health and Human Services' ACA condition category model (HHS model) assigns a risk weight to this condition. The

risk weight is about 1.3 for adults in a 2014 platinum plan. This implies that a person with diabetes is expected to cost about 1.3 times more than an average person without diabetes in the same demographic cohort and metallic plan. This is an average expectation, but in reality, individuals with a specific health care condition have costs that are typically distributed across a spectrum from low to high cost. There will be individuals with diabetes who will not cost much more than an average individual without the condition, and there will be those who will cost much more than 1.3 times the cost of an average individual without diabetes. If there were ways to identify these two different theoretical sub-groups of individuals, then a strong incentive for selection would persist even after the revenue is risk adjusted.

There are two distinct stakeholder perspectives on the issue, as follows.

1. Issuer Perspective: Understanding the impact of nontraditional variables is as much about avoiding losses as it is about creating gain. The ACA risk adjustment is intended to be a zero-sum exercise, but if incentives for selection via nontraditional variables persist and are utilized only by a few participants, then participants not using them will be at a disadvantage. Conversely, if the variables are used similarly across the marketplace, then the potential for adverse effect on a given issuer would be greatly mitigated.

2. Policy Perspective: It is important to understand the impact of nontraditional variables and to consider these in any update of a risk adjustment methodology so that policy goals are preserved.

The report tests the potential of nontraditional variables to explain claim cost variation above and beyond traditional risk adjustment. The non-traditional variables were grouped into one of five categories:

1. Demographic: While traditional models utilize age and gender, the report examines models that include ethnicity, years of education, smoking status, occupation or industry, and family size.



2. Economic: Income is an important variable considered in the research. Cost-sharing subsidies are based on income levels in health care reform, which in turn impacts the ACA risk models via an assumed induced utilization.

3. Lifestyle: Variables include whether the person was advised to restrict high fat/cholesterol foods, usually had a lot of energy, whether health had limited social activities, or was advised to exercise more.

4. Psychological Outlook: Variables such as whether a person considered their mental health status to be good, fair or poor; or felt calm or peaceful, etc.

5. Physical Outlook: Perception and attitudes toward personal health may drive medical cost, and variables such as whether perceived health status was poor, difficulty in walking three blocks, or whether the person feels that ills can be overcome without medical help are analyzed in the report.

“The ACA risk adjustment is intended to be a zero-sum exercise, but if incentives for selection via nontraditional variables persist and are utilized only by a few participants, then participants not using them will be at a disadvantage.”

CONTINUED ON PAGE 18

You may already be thinking (correctly I might add) that variables such as those described above are not typically found in claim data. Data from the Medical Expenditure Panel Survey (MEPS)¹ was used in the research. This data is collected through a survey-based approach, complemented to a limited extent by physician records and transactional claim data. There are important limitations of this data that are described in the report. For purposes of this research it was an ideal dataset that contained a plethora of person-level characteristics along with medical conditions, pharmaceutical utilization and cost variables. The dataset includes over 1,500 person-level variables that were winnowed down to 200 based on (a) whether a variable could be causally related to health care costs, and (b) whether the variable could conceivably be used to attract a certain membership (i.e., whether it could be actionable). This list was further cut down to around 33 variables based on the relative importance of these variables.

This brings us neatly to the crux of the research that describes how we determine the relative importance of nontraditional variables. While socioeconomic variables have received a lot of interest in terms of their relation to health care cost, we do not have a conceptual framework to measure their economic value to an entity such as a health plan, nor crucially do we have a framework to measure their economic value in a risk-adjusted environment.

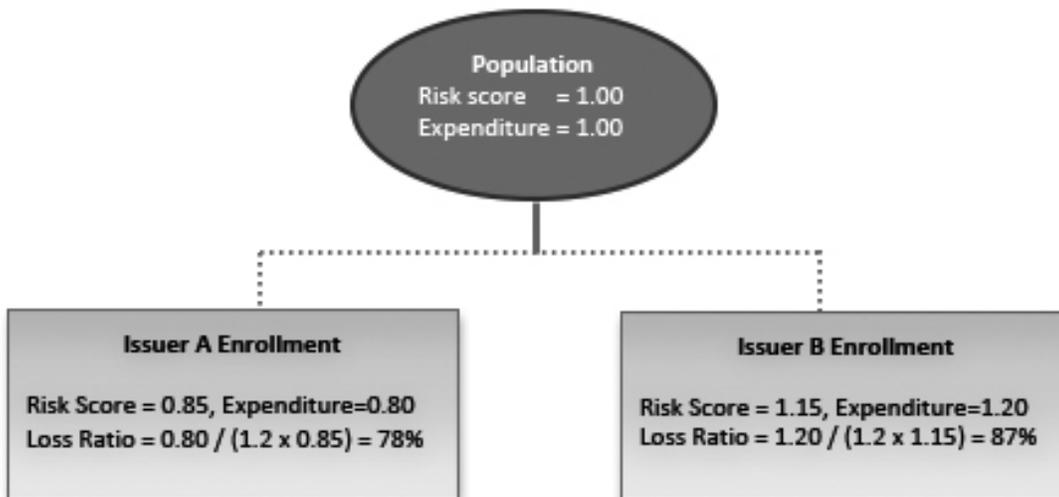
The research report describes the development of a new conceptual framework that allows us to quantify the economic value of a nontraditional variable, and consistently compare this value across many other variables. The report develops a new measure (Loss Ratio Advantage or LRA) to help quantify the potential of a nontraditional variable to affect a risk adjustment program.

The LRA indicates the difference in loss ratios between an issuer (i.e., Issuer A) that is able to select the more profitable 50 percent of the market based on a nontraditional variable and another issuer (i.e., Issuer B) that enrolls the remaining 50 percent. In this manner the influence of a nontraditional variable can be directly linked to financial performance. This research shows that financial performance is the correct perspective with which to study the performance of nontraditional variables and not, for example, statistical performance.

Let me state that one more time, given the importance of the point and how much effort was involved in arriving at this conclusion! Accuracy is not the correct lens through which to value the contribution of socioeconomic variables. Bias in terms of risk-adjusted cost is the key that unlocks the door to understanding the potential incentives to use such information.

The graphic on page 19 illustrates (albeit in a simplified way) the core concept of the LRA measure. Issuer A is able to select 50 percent of the market that has the lowest *risk-adjusted expenditure* based on a nontraditional variable. Issuer B enrolls the remaining 50 percent. Assuming Issuer A's risk score is 0.85 and expenditures are actually 0.80 of average while Insurer B's risk score is 1.15 and expenditures are actually 1.20, then allowing 20 percent for administration and margin, the loss ratio may be calculated as the ratio of expenditure to risk-adjusted revenue. For example, for issuer A, this becomes $[\text{expenditure}=0.80] / ([\text{premium}=1.2] \times [\text{risk score}=0.85])$ or 78% while loss ratio for insurer B is $1.20 / 1.2 \times 1.15 = 87\%$. This calculation produces a difference in loss ratio of 9 percent between the two issuers. This is the LRA. In this case, it exceeds typical profit margins, and is therefore a very significant result from a business perspective.





The calculations in the graphic are simplified, and the calculations used in the research report more closely resemble the risk adjustment methodology under the ACA.

I invite you to read the report, which develops the framework in more detail, including addressing questions such as:

- 1) What is the relationship between a nontraditional variable and total health costs?
- 2) Is this relationship statistically significant?
- 3) Does the relationship persist after we risk adjust costs and is it still significant?
- 4) How do we quantify the potential and incentive for using such a variable in a risk-adjusted environment?
- 5) Lastly, how can we adjust the risk assessment methodologies to remove such an incentive and thus further the policy goals of a risk adjustment program?

The findings of the report are too lengthy to include here, but to provide a general flavor—variables such as geography and education are more important within the demographic category. Income also has a relatively high LRA measure, and so do a few lifestyle variables such as feeling energetic or attitudes toward having health care insurance or seeing a provider when sick. Issuer A (who within the LRA framework is assumed to be able to use a nontraditional variable to attract a more favorable mix of enrollees) prefers persons who are generally in good mental condition, even after risk adjustment is taken into account. A strong effect was measured for variables that described physical limitations due to pain or other health conditions, with issuer A attracting those who did not have such limitations.

The research report was written keeping in mind both the issuer and policy perspectives, and I hope that the information contained in it is constructive toward the goal of strengthening risk adjustment programs. The report is not to be interpreted as a “cookbook” in terms of how to strategize marketing activities or any other selection effort. Nor should the results be relied upon by policymakers to adjust risk adjustment programs without checking to see if the results hold when data for a specific application is considered. While this study used a specific data source and risk adjustment model, results for an issuer or policymaker will vary by the data, model and methodology that are used.

The most important outcome of this work is the conceptual framework and high-level conclusions rather than specific numbers. I hope that this work is extended by other researchers, and applied toward risk adjustment programs in order to improve them and mitigate selection incentives that may otherwise persist. Finally, I would love to hear any feedback, questions or comments regarding the report.

I would like to take a moment to thank the Society of Actuaries’ Health Section for their funding and support of this important project and to the extremely capable actuaries and experts who volunteered their time to serve on the project oversight group through the course of this project. ■

END NOTES

¹On the Web: <http://meps.ahrq.gov/mepsweb/index.jsp>.



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Strategies for Leveraging the ACA Risk Adjuster

By Jason Siegel

Traditionally, commercial health plans have had to monitor a small number of key activities in order to ensure satisfactory financial performance. These include such factors as underwriting, provider reimbursement contracting and medical management. When the major provisions of the Patient Protection and Affordable Care Act (ACA) go into effect in 2014, there will be another powerful metric that plans will need to manage: risk score. The risk adjustment mechanism implemented by the ACA will likely have a material impact on the financial results of many insurance companies, it exposes carriers to new types of risks, and in some cases can turn business strategies that were once viable upside down.

Smaller carriers, in particular, will be more exposed to these risks because their populations and risk scores are more volatile than those of large firms. And because risk scores will be compared between plans, many carriers will find that a great deal of coding effort is required just to avoid losing ground to competitors. This article outlines the issues that plans will need to consider going forward in order to manage the risk adjuster.

Comparison to Medicare

Risk adjustment has been an integral part of Medicare Advantage for many years and has evolved over time.¹ However, there are several important differences between the HHS-HCC risk adjustment model that will be used in the commercial market and the CMS-HCC model used in Medicare Advantage, largely driven by the differing philosophies and intents of the two mechanisms.

First, Medicare Advantage is at its heart a capitation arrangement where the federal government pays health plans to provide Medicare benefits to individuals who choose a private plan instead of the standard plan offered by the government. In Medicare Advantage, the risk adjuster is a mechanism to ensure that the amount of that capitation appropriately reflects the underlying health status of the enrolled population. In contrast, the commercial

risk adjuster is not designed to create subsidies to commercial plans in aggregate (although other portions of the ACA will do that). Rather, its purpose is to reduce the incentive for carriers to cherry-pick the most profitable business and to protect plans from uncertainties resulting from the prohibition of medical underwriting. Under the commercial risk adjustment model, the risk adjustment transfers sum to a “net zero” among all carriers. To achieve this, the reimbursements under the commercial model will be set using an intricate formula involving the average risk scores of all the carriers in the market (along with other factors such as geographic and age factors), whereas under the Medicare risk adjustment model the primary determinant of each plan’s level of reimbursement is the diagnoses it alone submits.

Second, the commercial risk adjustment model is concurrent, as opposed to the Medicare Advantage model, which is prospective. This means that the risk score calculated for each member is based on diagnoses from the same year as the associated revenue. In the Medicare model, risk scores are based on diagnosis codes from the prior year. The result is that commercial plans will have a much shorter window for identifying any potential diagnoses not in their claim data and ensuring those diagnoses are appropriately reflected in the additional allowable data submitted to the U.S. Department of Health and Human Services (HHS).

Third, the risk scores used in Medicare Advantage represent a measure of each member’s health status only. In contrast, under the HHS-HCC model risk scores will represent a combination of the member’s health status and choice of benefit plan. Hence, if a member changes from, say, a bronze to a silver plan, and nothing else changes, that member’s risk score will increase. The risk settlement calculation will then normalize the average risk score calculated for each entity based on its average plan richness (among other factors) compared to the state average. The result is that to the extent the actual benefit relativities of a



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CONTINUED ON PAGE 22

In the past, health plans that have been able to do well at medical underwriting have traditionally kept their premium rates the most competitive and have experienced the best margins compared to plans without a disciplined selection process.

carrier's benefit plans differ from those of the hypothetical plans used to calibrate the risk score model, carriers will be exposed to risks regarding the mix of plans members select. That is to say, it may be advantageous to promote plans of certain metallic levels (e.g., platinum, gold, etc.) over other plans solely because of unintended impacts from the risk settlement methodology.

Finally, Medicare Advantage covers an older population with inherently more medical conditions than exist under most commercial plans. Models designed to predict missing diagnoses in a commercial population must be more targeted and discriminating to assure administrative expenses aren't wasted pursuing nonexistent conditions.

Why Current Strategies Won't Work

In the past, health plans that have been able to do well at medical underwriting have traditionally kept their premium rates the most competitive and have experienced the best margins compared to plans without a disciplined selection process. Depending on exactly how the risk adjustment model is applied to their populations, these plans could potentially be at a disadvantage relative to the rest of the industry. Preliminary research on the HHS-HCC risk adjuster suggests that for members with certain conditions the model may create transfer payments that exceed the expected additional costs typically associated with those conditions. Given the interactions of the risk score with other rating factors and the new populations expected to take up coverage in the commercial insurance market, it is not yet clear to what extent this will occur in practice.

If it does occur, this effect may be compounded since premium is used as the basis of the risk settlement calculation instead of expected claims. In fact, the payments a carrier with a low retention load will make into the risk adjustment pool will be further leveraged because the settlement amounts will be based on the state average premium instead of the plan's own premium. Because the transfer pay-

ments incorporate the entire premium rate and not just claims, insurers with lower than average retention loads will inordinately benefit from receiving transfers compared to insurers with high retention loads.

In addition, these effects may be further compounded in the individual market since the ACA also provides reinsurance recoveries for certain large claims, yet the risk adjustment and reinsurance calculations do not interact with one another. This design can cause total reimbursements for costly members to partially double count large claims. Of course, this issue is temporary in nature, since the federal reinsurance program is only slated to last three years.

There are many strategies commercial health plans are implementing in response to the introduction of risk adjustment and the other ACA provisions. For example, some plans are keeping members out of the risk adjustment pool through the use of grandfathered plans as these plans are not subject to risk adjustment. Some are renewing plans near the end of 2013 to delay subjecting those members to the risk adjuster for nearly a full year. However these are short-term strategies. Farsighted carriers will need to focus on improving diagnosis coding, thinking through membership mix issues, and managing the care of their members to truly be competitive in the future health care market.

Coding

When health plans discuss coding they are referring to their ability to ensure that all relevant diagnoses for a member are included in their data and that these diagnoses include the most severe form of each condition appropriately attributable to the member. Medicare Advantage plans have typically increased risk scores by 1 to 2 percent a year through progressively better coding, and in response the Centers for Medicare and Medicaid Services (CMS) have instituted adjustments to account for this effect. A study performed by the U.S. Government Accountability Office (GAO)

estimated that, due to coding differences, Medicare Advantage risk scores were between 4.8 and 7.1 percent higher in 2010 than they would have been had the same members been enrolled in fee-for-service Medicare.

There are multiple reasons why proper coding may not occur in practice, including:

- Communication difficulties
- Incorrect lab procedures that are due to a lack of knowledge on the clinician's part
- Nonspecific presentation of the disease of the member
- Level of experience of the coder
- Paper trail errors.²

Each of these reasons presents plans and providers with its own difficulties in identifying and resolving problems.

Perhaps the most important causes of improper coding involve the human element. Full elaboration of a member's diagnoses is often not needed by a physician to get reimbursed for services. Hence, misdiagnosis or a lack of a diagnosis could occur on purpose. For example, Rost, Smith, Matthews and Guise completed research in which 382 physicians were surveyed regarding their coding practices and found that 50.3 percent of the physicians reported using a different code for a patient being seen for major depression; 30 percent of the total physicians admitted deliberately misdiagnosing the condition.³ The research showed that physicians intentionally substitute diagnosis codes that are not accurate for a variety of reasons, including the physician trying to avoid problems with reimbursement and concerns for the patient being able to obtain future health insurance or other benefits.

The ACA prohibition on underwriting may mitigate this eventually, but that will take time and provider education. This is cause for concern because under the ACA risk adjustment program if physicians are deliberately not providing diagnosis codes for members, the health plans will incur the expenses of

having less healthy members without the benefits of receiving the risk score adjustment and future potential payment from the risk adjustment model. There are different strategies health plans can potentially use to improve their coding abilities. Chronic medical conditions are one example of low-hanging fruit. These conditions are sometimes poorly coded because other diagnoses could be part of a physician visit, instead of the underlying condition. However, these conditions might be identified using longitudinal data, and they offer additional opportunities for care management of the member on the part of the plan.

National drug codes (NDCs), which are used to identify unique drugs by name and strength, have also proven to be a powerful marker for member conditions. Because there are numerous drugs commonly used for specific clinical conditions, they might be an indicator of diagnoses missing from the member's data. Coding systems such as the diagnosis-related groups (DRGs) and current procedural terminology (CPTs) also provide opportunities as potential markers that can be used to identify conditions a member might have.

In addition, analyzing the frequency of office visits, specialists' visits, and the use of lab work can all lead to potential future improvements in identifying under-coded members by looking at their data for indications that a diagnosis code may be missing. Even looking for conditions that tend to run in a family may catch instances in which one family member shows up with a condition, and another family member with the same condition is missing the corresponding diagnosis code in the data. Educating providers on best coding practices and their impact on the health plan's financial results (and potentially physician reimbursement) is often a key element in a company's strategy for improving coding. In fact, provider-owned plans may have an advantage in this area as they will have all the chart data readily available and have the most direct incentives to provide accurate and

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complete codes. Insurance companies, on the other hand, will need to build models to identify members with a high probability of missing diagnoses and then complete chart reviews for those members. Insurance companies may also need to design risk-sharing mechanisms to align financial incentives between the plan and provider.

Finally, health plans will need to consider their methods of data warehousing and data processing in order to ensure that all the necessary elements are captured to calculate a complete risk score (and to support those risk scores during annual audits) or identify missing diagnoses. For example, in some cases simple differences in programming might ensure lab results are not only obtained but may be accessed and reviewed easily, potentially providing valuable information. Or members changing plans midyear may cause diagnoses not to be linked across

the plans in the data warehouse, resulting in risk scores that are lower than they should be.

Member Mix

The complexities and likely imperfections in the commercial risk adjuster create additional opportunities and risks as health plans evaluate the impact of enrolling a different membership mix than the rest of the market. One way in which this has been exhibited in Medicare Advantage is with respect to special needs plans (SNPs). Some carriers have proven adept at identifying arbitrage opportunities in the Medicare risk adjustment model, including situations in which the risk adjustment reimbursement for a certain set of conditions results in reimbursements higher than the actual claim burden of the individuals. Time will tell whether or not commercial plans are able to design competitive benefit packages aimed at high-needs populations. Of course, by introducing these plans carriers would take on the risk that changes to the risk adjuster in future years will make once profitable populations unsustainable.

A member's choice of benefit plans is another area in which the risk adjuster potentially turns traditional thought upside down. The standard belief has always been that to the extent members are able to select between plans the sickest will gravitate toward the richer plans, and the healthiest to the leaner plans, to their own benefit. This type of anti-selection has always been to the disadvantage of the health plan. However, the risk adjustment model explicitly builds in the impact of each member's plan design when calculating risk scores, so this is not necessarily the case any longer. Rather, health plans will need to understand how their risk scores vary because of members choosing different benefit plans, and whether this slope is steeper or flatter than the actual benefit variation between benefit plans. This is an area in particular in which the commercial risk adjuster may not be accurate given that it was calibrated using one set of hypothetical plan designs, whereas carriers in the market sell plans with widely varying benefit parameters and associated benefit slopes.



Finally, health plans will need to analyze the impact of demographics. The ACA requires a great deal of age compression (3:1) and forbids the use of gender as a rating variable. Presumably, through the risk adjuster, plans are made whole if they enroll a more or less costly demographic mix than the rest of the market. Nevertheless, to the extent the demographic claim slope experienced by a health plan is different than that underlying the data used to calibrate the HHS-HCC model, additional risks will be created with respect to demographic mix.

Care Management

To really harness the power of improved coding and help members with chronic conditions, coding initiatives should be paired with care management protocols. If a health plan can manage care well, the costs associated with the member having a medical condition will decrease while the payment received through the risk adjuster will remain the same and the quality of care will go up. Predictive models capable of identifying missing diagnoses can result in a strategic advantage in terms of care management because potentially costly members can be identified earlier. Several external vendors can provide prior prescription drug data for new members, which could be used to identify care management opportunities from day one.

Conclusion

The timeline that health plans face in adapting to a risk-adjusted environment is daunting. The risk adjustment settlement amounts for benefit year 2014 aren't expected to be known until June 2015, whereas many states will likely require that 2016 premium rates be filed before that information is available. This means that health plans won't have solid data backing up this calculation until filing 2017 rates. Furthermore, health plans generally accrue and track financial performance at least quarterly, and publish annual statement exhibits shortly after year-end. They will need to certify accruals near the start of 2015, likely well in advance of the first reports on risk adjustment settlements.

Furthermore, many techniques that plans will want to make a part of their strategic toolboxes, such as controlling membership mix and identifying members who will benefit from managed care protocols, will require building analytics and other infrastructure up front, resulting in additional time pressures. While these challenges are real, they bring corresponding opportunities to health plans that are the most agile and proactive when it comes to tracking their own data and seeking out available external data sources that can be used to develop benchmarks. State hospital databases, all-payer databases, state simulation studies, and aggregations of employer group data are all examples of data sources that companies are looking at to make these estimates.

Finally, risk adjustment models tend to be relatively more complex than other financial models that businesses use on a daily basis. Companies will need to build teams that combine the analytic skills required to extract information from these models with the business savvy to identify and communicate these opportunities and challenges across the organization. This is a prime area of study in which actuaries can contribute meaningful insights. ■

END NOTES

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What Is Available in 2014 for 2015 Individual Health Insurance Rate Filings

By Jeff Rohlinger



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As 2013 comes to an end, it surely is a good time to prepare for the individual health insurance market that will exist in 2015. For federally funded exchanges, the deadline is April 30, 2014 for submitting the 2015 rates and, as was the case when rating for the 2014 market, you will have very little meaningful experience with which to understand the morbidity of your current population.

Much uncertainty was prevalent when individual carriers were pricing products for 2014. Uncertainty in pricing assumptions will be just as critical an issue when pricing for 2015. Following are four considerations in pricing for your appropriate 2015 rating level.

1. Regulatory Environment for 2015

Recent regulatory guidance during the summer of 2013 certainly altered scenarios that actuaries were anticipating, most notably being the delay of the employer penalty provision until a 2015 effective date. Impacts are expected to vary by state and service area depending upon type of exchange, Medicaid expansion and employer profile.¹

After we complete our 2015 rate filings, you could expect a similar pattern of subsequent regulations occurring during the 2014 calendar year. This regulatory uncertainty should be carefully considered by each insurer as they undertake their pricing for 2015. Barring regulatory delays, there are several scheduled developments for 2015 described in the Affordable Care Act:

- **Increase in the individual mandate penalty.** The law says that the maximum 2014 penalty that individuals who do not purchase a plan with Essential Health benefits must pay is 1 percent of their annual income (or a flat amount of \$95, whichever is larger). In 2015, it's mandated to increase to 2 percent (or a flat amount of \$325, whichever is larger).² (It's important to note that this applies to individuals who have not been granted an exemption from the exchange.)
- **Decreased significance of the reinsurance program.** The reinsurance program is only certain

to be in place for 2014 through 2016, with the program decreasing in scope each year. In 2014, the reinsurance payments are based on expected reinsurance collections of \$10 billion. In 2015, the reinsurance collections will be reduced to \$6 billion. Resulting reinsurance payments to nongrandfathered individual health insurance plans will be reduced accordingly.³

- **Introduction of the Basic Health Plan.** Slated to go into effect in 2014, its implementation has been delayed until 2015. The Basic Health Plan allows interested states to offer coverage for enrollees from 139 to 200 percent of federal poverty level (FPL). The federal government will make payments to the participating states for 95 percent of the federal subsidy payments these enrollees would have received from the federal government. In return, states will have the "flexibility to define benefits, cost-sharing, delivery systems and procurement strategies to provide a potential bridge between those on Medicaid and those with subsidized QHP coverage."⁴

These provisions are effective according to federal purview. However, it will be critical to understand the corresponding state regulatory framework. For 2014, states were largely reacting to the deadlines required for implementation of the law. In contrast, for 2015, it can be expected that states will have more opportunity to follow up with their own state-specific policies. Emerging regulations for each state can largely be anticipated by understanding what states did during their 2013 sessions. For example, what kind of decisions did states yield due to time and/or operational constraints? In other states, those that chose minimal involvement in the Affordable Care Act, what are their options available for continuing this path in future years?

State decisions for 2015 can be very significant. Examples include:

- 1) Will your state become a state-based exchange in 2015?
- 2) Will your exchange move to an active purchaser model?
- 3) Will your state opt for changes in qualified health plan (QHP) certification such as allowable rat-

ing factors, state-administered risk adjustment or network adequacy requirements?

Two recommended websites for keeping track of state-specific legislation would be from the National Conference of State Legislatures (<http://www.ncsl.org/issues-research/health/health-reform-database-2011-2013-state-legislation.aspx>)⁵ and the State Reform(u)m (<https://www.statereform.org/>).⁶

2. Employer Impact

It will be helpful to understand how the small and large employers react, by type of industry, to the Affordable Care Act as 2014 begins. As you price for 2015, you will be able to see the emerging dynamics for varied segments of the employer marketplace. There are many ways to analyze the marketplace. Some possible ways would be to look at: (1) whether it's a small employer or large employer, (2) type of industry, and (3) those currently offering coverage (or not).

EMPLOYER SIZE

Employer surveys clearly indicate that the larger the employer, the more likely it is to offer insurance. Indeed, in the 2012 Kaiser Employer Survey, the results showed that 47 percent of employees in companies with fewer than 200 employees were covered, while 62 percent of employees were covered if working for a company with more than 200 employees.⁷ In addition to these survey results, employers with fewer than 50 employees do not face a penalty for not offering insurance. As a result, these market and regulatory forces would create a significant likelihood that an employee of a small employer would be more likely to be without employer-sponsored insurance, and so more likely to be subject to the individual mandate.

TYPE OF INDUSTRY

Employers competing against one another in their respective industries are likely to have similar business models. This likely would include similarities in what kind of insurance, if any, they provide for their employees. For example, "firms with more



high-wage workers are more likely to offer coverage to their employees than those with more low-wage employees."⁸ Lining up industries with similar wage structures can provide a basis for anticipating whether an employer will provide employer-sponsored coverage or not.

CURRENTLY OFFERING COVERAGE OR NOT

Another type of employer to look at is those that currently offer health insurance as part of their compensation to their employees. Dropping insurance would mean disrupting their employees' current access to the health care system. On the other hand, you would have to consider what would induce an employer to now begin offering employer-sponsored coverage. Will the introduction of the Small Business Health Options Program (SHOP) be able to do so?

You can observe employer health care strategies by similar characteristics such as these, in order to project how employer reactions will follow for 2015. Questions to ask could be: Are there leaders in certain significant segments that have demonstrated significant success or problems with their health insurance strategy? If so, will others in their indus-

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try follow those employers that have demonstrated success?

3. Individual Economic Impact

Following is a brief overview of the coverage decisions that each and every person must answer for themselves and their family:

- Do you have employer- or government-sponsored coverage that fulfills your requirement for minimum essential coverage?
- If not, then decide if you will have insurance coverage or not.
 - If you will not have coverage, then these are two options:
 - Can you get an exemption from the exchange, or
 - Will you pay the individual mandate penalty?
 - If you will have coverage, then:
 - Determine if you are eligible for premium and/or cost-sharing subsidies, and
 - Make your preferred purchasing decision.

There are not “typical” answers to these questions; rather there are a myriad of possible answers pertaining to each individual’s circumstances. The

answers will be different based on many unique factors (such as state of residence, household earnings and family size).

Of course, someone’s preferred purchasing decision will be largely based on how the Affordable Care Act impacts them in their unique circumstances. There are many different ways to understand what will be common economic drivers for people’s purchasing decisions.

If someone does not have affordable employer-sponsored or government-sponsored insurance, they have a couple of options to address their health insurance coverage for 2014: (1) Go without health insurance coverage; (2) Medicaid or CHIP coverage; or (3) commercial individual health insurance.

For those who choose to go without health insurance, two ways to go about this would be to get an exemption from coverage, or else to pay the individual mandate. Exemptions from coverage are obtained from the exchange in one’s state and are available for several circumstances such as hardship or religious beliefs. A hardship exemption is based on such considerations as demonstrating an inability to access affordable health insurance (based on lowest cost bronze plan available) or unexpected events such as homelessness or death of a close family member.⁹

Otherwise, if you wish to pay the individual mandate penalty, you can forgo health insurance as well. The 2014 penalty would be based on a formula that considers household income as well as family size. For a family of four, one recent Congressional Research Service article estimated a 2014 penalty of \$285 if household income is between about \$20,000 and about \$50,000. The penalty rises for household incomes beyond this \$50,000 threshold to be based on 1 percent of “applicable income.” In this case, the penalty could be expected to be around \$1,000 for a family of four that is at approximately \$120,000 of household income.²

For Medicaid and CHIP programs, eligibility varies by state. In all states, it will depend on household income, but income thresholds for each program will vary by state. Additionally, states may be able



to apply Medicaid eligibility of an individual toward premium and cost-sharing assistance to make coverage available in the commercial insurance market.¹⁰

Another aspect of the purchasing decision is whether an individual could choose to purchase commercial health insurance, either on or off the exchange. If the coverage is purchased on the exchange, one can qualify for premium tax credits or cost-sharing reduction subsidies. The amount of subsidy available depends on household income and the premium they would have paid for the second lowest cost silver plan available to them. Household income is determined according to the FPL, which is a function of family size.

4. Overview of Data in 2014 to Help with 2015

Individual health insurance will introduce several new means of sharing revenue and expenses between issuers and the applicable government entity, some at the benefit plan level and some at the issuer level. It will be critical to have an understanding of each of these programs in order to correctly interpret emerging experience. For examples at the benefit plan level, there are Medicaid wrap plans and cost-sharing reduction plans that have issuer plan liability as a subset of the total plan liability.

Medicaid “wrap” plans are coordinated coverage provided to Medicaid-eligible members, in part by a QHP and in part by the state Medicaid agency, allowable if the applicable state receives a section 1115 demonstration waiver. A state may pay the premium of an individual’s QHP coverage if they believe it to be an effective way to meet Medicaid cost-sharing and premium assistance responsibilities, and then provide the balance of its Medicaid cost-sharing responsibilities.¹⁰

Similarly, cost-sharing reduction plans are coordinated coverage provided to members with household incomes up to 250 percent FPL. An eligible member may purchase a “variation” of a silver plan provided in the exchange by a QHP. This variation has reduced cost sharing for the member from the applicable silver plan.

In both cases, the health plan issuer is responsible only for the benefits of the QHP, while the state or federal government is responsible for the balance of the benefits of the plan. It will be imperative to understand which portion of the total coverage provided is the responsibility of which entity.

Also, at the issuer level, there are the 3Rs (risk adjustment, reinsurance and risk corridor) to consider, which were created to stabilize member premiums, particularly in the early years. It’s not clear what data would be available to help for 2015 pricing by early 2014. Some states may have state average risk scores, which would be helpful in understanding the impact that risk adjustment will have on your financial results. Other sources of information that may be available and useful in early 2014 could be early indications of risk score diagnosis categories or unexpected high claim results that may result in a greater impact of the reinsurance program than expected. Understanding emerging administrative costs in early 2013 can be helpful for understanding what risk corridor results will be for 2014. The March 1, 2013 release of the HHS Notice of Benefit and Payment Parameters for 2014 provides the background of the mechanics of the 3Rs.

As with any new process, it will be critical to evaluate data quality to understand what should or should not be used in order to project to the future. Due to the complexity and scope of new individual health insurance program requirements, you will want to establish methods to verify the internal consistency and reasonableness of any internally generated data results with external data (for example, the exchange-related 820 Payment report). You will want to determine which reported results are most reliable for use in preparing 2015 pricing.

Perhaps the most reliable source of information available at the outset of 2014 will be enrollment information. Open enrollment begins in October 2013 and ends March 2014. With the enrollment information that you do have, you can get an early estimate for which subpopulations are choosing to purchase coverage and which are not. You may not have any credible claims experience, but at least you will be able to get a fairly clear idea of the effective-

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ness of your marketing efforts, and be able to react with product decisions for 2015.

With the lack of any credible experience available for understanding the reasonableness of your 2014 plan pricing assumptions, perhaps evidence of pent-up demand may be available. First, it is helpful to understand what, if any, delays in access to care that newly insured members may be facing in early 2014. Delays can happen for various reasons such as in implementing new member enrollment into exchange or off-exchange plans, or due to a lack of access to primary care. Of course, if you are aware of primary care shortage in the early stages of 2014, this would be an indication that there could be pent-up demand. Even with adequate primary care, it is still valuable to compare utilization patterns in early 2014 with utilization patterns from past Januarys and Februarys.

Conclusions

In summary, there are several things actuaries can do to prepare for pricing in 2015. Anticipate regulatory action to come at the federal and state level by paying attention to what regulators are doing in early 2014. Evaluate the emerging employer health insurance strategies that will impact your individual health insurance market. Try to gain an early understanding of the purchasing decisions of the emerging individual health insurance market. The population of the individual health insurance market will be very different in 2015 than it is now, but at least you will be able to observe in early 2014 the beginning trends compelled by the Affordable Care Act. ■

END NOTES

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- ² "Individual Mandate and Related Information Requirements under ACA." Mulvey, Chaikind of Congressional Research Service, July 2, 2012.
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- ⁴ "The Role of the Basic Health Program in the Coverage Continuum." Bachrach, Dutton et al. Kaiser Family Foundation Focus on Health Reform, March 2012.
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- ¹⁰ "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes and Premiums and Cost Sharing." Federal Register, July 15, 2013.

Medicaid Expansion under the Affordable Care Act

By Rob Damler



On June 28, 2012, the Supreme Court rendered an opinion on the constitutionality of the Affordable Care Act (ACA). One major outcome of the Supreme Court's decision was to give states the ability to opt out of the Medicaid expansion while not jeopardizing current federal funding levels for existing Medicaid programs. The original text of the ACA would have taken federal Medicaid support away from those states that did not expand its enrollment eligibility, but the Supreme Court decision ruled that the ACA violated the prohibition of federal coercion upon states. As of July 2013, 23 states plus the District of Columbia are moving forward with Medicaid expansion, 21 states are not moving forward, and six states are still debating the option.¹ The impact on existing state Medicaid programs will vary by state, regardless of whether or not a state chooses to expand enrollment in 2014.

The ACA expanded Medicaid eligibility to 133 percent of the federal poverty level (FPL) for parent and childless adult populations. However, the eligibility level is often referred to as 138 percent because of a 5 percent income disregard. The expansion will significantly change the population demographics of the current Medicaid program. Table 1 illustrates the fiscal year 2009 enrollment distribution by general eligibility groupings.²

Table 1: 2009 Medicaid Enrollment by Eligibility Group

Eligibility Group	Enrollees (millions)
Aged	6.1
Disabled	9.5
Adults	16.2
Children	30.7
Total	62.5

The current Adult population includes primarily individuals who are eligible either as pregnant women or parents/caretakers of children. Most state Medicaid programs will cover pregnant women up to 185 percent FPL; however, many states limit the parent's eligibility to 20 to 50 percent FPL. A few states provide coverage to childless adults through section 1115 demonstration waivers or other waiver programs. Medicaid expansion will primarily extend eligibility to parents and childless adults. Table 2 on page 32 summarizes the number of individuals who meet the new Medicaid eligibility threshold. We have separately illustrated the populations by current insurance status—either uninsured or currently insured.³



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“... The introduction of the parents and childless adult populations will have a significant impact on the demographic profile of the current Medicaid population.”

Table 2: Individuals Newly Medicaid Eligible under ACA Provisions (as of 2010)

Eligibility Group	Uninsured (millions)	Currently Insured (millions)
Parents	6.7	3.5
Childless Adults	14.9	9.2
Total	21.6	12.7

The introduction of the parents and childless adult populations will have a significant impact on the demographic profile of the current Medicaid population. Based on self-reported health status, the currently uninsured adult population, in aggregate, may have a lower risk profile than the current parent population. Table 3 illustrates a relative morbidity distribution based on self-reported health status of the current Medicaid parent population and the uninsured parent and childless adult populations. The relative morbidity is shown in relation to a commercially insured adult member. The relative morbidity was developed by fitting the commercially insured reported health status information from the current population survey to the Milliman Individual Underwriting Guidelines.

Table 3: Relative Morbidity Comparison of Adult Populations

Health Status	Relative Morbidity	Employer Sponsored	Medicaid—Parents Only	Uninsured
Excellent/ Very Good	0.60	70%	47%	55%
Good	1.30	23%	32%	32%
Fair/Poor	4.10	7%	21%	13%
Composite Morbidity		1.00	1.56	1.28

Source: Kaiser Family Foundation, 2011 (see note 3); health status distribution by population only.

While the overall uninsured population has a relative morbidity lower than the current Medicaid parent population, the expected average morbidity is 28 percent greater than the average commercial insurance morbidity. Further, the percentage of the population reporting fair or poor health status varies significantly by income level. Table 4 compares the percentage of the population that reports fair or poor health status by federal poverty level. The populations include those that are fully insured, receiving public health care, or are uninsured.⁴

Table 4: Population Report Fair/Poor Health Status by FPL

Federal Poverty Level	Fair/Poor Health Status
Below 100%	20.9%
100% – 199%	15.2%
200% – 399%	8.3%
400% +	4.3%

Medicaid expansion provides eligibility for the parent and childless adult populations up to 133 percent FPL. If a state does not expand Medicaid, a person may receive federally subsidized health insurance through the health insurance exchanges if their income is between 100 and 400 percent of the federal poverty level. With the higher morbidity of the population in the lower income levels, the exchange-based population’s relative morbidity may increase under a no Medicaid expansion scenario. In a state that does not expand the Medicaid program, the population between 100 and 133 percent FPL will not be eligible for Medicaid but will be eligible for the advanced premium tax credits and cost-sharing subsidies in the exchange.

In the states that expand Medicaid eligibility, the state Medicaid programs will face various issues related to the new population base.

- **Eligibility Changes:** Under the ACA, many of the current Medicaid-eligible populations will have different eligibility rules regarding income and



assets. Income will be converted to a Modified Adjusted Gross Income (MAGI) standard for all states. Medicaid eligibility for the children, parent and childless adult populations will no longer have an asset test. In addition, the Medicaid program will receive referrals from the health insurance exchanges. All of these eligibility changes may create enrollment delays as individuals are navigating the new eligibility rules.

During the first year of the program, it was observed that individuals incurred overall health care costs 20 percent greater during the first three months of enrollment in the program, with hospital inpatient and outpatient services 20 to 40 percent higher. Pharmacy expenditures tended not to be greater during the earlier months of enrollment; however, the pharmacy expenditures increased after six months of enrollment.⁶

- **Presumptive Eligibility:** Many current Medicaid programs provide presumptive eligibility for pregnant women. Presumptive eligibility provides immediate coverage based on the individual meeting certain criteria. Under the ACA, presumptive eligibility is expanded beyond the pregnant women population. Hospitals may provide presumptive eligibility for individuals who meet certain eligibility criteria. The expansion of the presumptive eligibility provision may increase the average health care costs for the Medicaid populations since individuals will be receiving eligibility at the point of care.⁵
- **Pent-up Demand for Services:** Individuals who are currently uninsured may have pent-up demand for health care services. In 2008, the state of Indiana implemented a Medicaid expansion program: the Healthy Indiana Plan. The Healthy Indiana Plan provided expanded Medicaid eligibility for parents and childless adults through an 1115 waiver.
- **Access to Providers:** On a national basis, the average physician reimbursement rate under the Medicaid program is approximately 60 percent of the Medicare reimbursement rate. Physician reimbursement varies significantly on a state-by-state basis. The ACA provides for increased physician reimbursement to qualifying primary care physicians for evaluation and management services during calendar years 2013 and 2014. While this provides for short-term enhanced funding to primary care physicians, the long-term funding issue remains for physicians under Medicaid. The newly eligible population may encounter issues related to physician access, especially as the newly eligible population ramps up into the system and more people seek care.
- **Take-up Rates:** Outreach by the state, the exchange and others will impact the percentage of those newly eligible for coverage who actually enroll. The current Medicaid program illustrates

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that not all of those eligible for coverage choose to engage in the process. We know those with higher perceived needs will be more likely to sign up for coverage, and those who actually seek care will likely be assisted in the enrollment process by their providers. This leads to a less healthy enrolled risk pool than what the survey data on all uninsured would lead one to believe.

- **Welcome Mat Effect:** It is anticipated that significant publicity will occur in late 2013 and early 2014 regarding enrollment into Medicaid, health insurance exchanges and employer-sponsored insurance plans. This may encourage those currently eligible for Medicaid but not enrolled to enroll in the program. The impact of this population may lower the average cost per person if these individuals are lower-cost healthier lives, although the aggregate spending will increase with greater enrollment.

For the six states that are still debating legislatively or in discussions with the Centers for Medicare & Medicaid Services (CMS) regarding the Medicaid expansion, it may be expected that the expansion may not be able to be implemented with an effective date of Jan. 1, 2014. Under the delayed expansion scenario, individuals may temporarily qualify for the subsidies offered through health care exchanges and then subsequently qualify for the Medicaid program. If a state implements a midyear expansion, the integration of the population that qualified for the health care exchanges will create pricing issues for both calendar year 2014 and 2015 as population eligibility shifts during these periods. During the next several years, the Medicaid expansion population will change the face of the current Medicaid program. The Medicaid program will reflect more parents and adults, with enrollment potentially growing to the levels of the children population. The enrollment growth will put pressure on the demand for health care services and access to providers. Many states may turn to enroll-

ment into risk-based managed care programs. With or without the expansion, state Medicaid programs will need to determine how to integrate eligibility data and information with the health care exchanges. The Medicaid program will continue to evolve as the option to expand coverage has been given to the state legislators, governors and state Medicaid agencies to decide. ■

END NOTES

- ¹ "Analyzing the Impact of State Medicaid Expansion Decisions." Kaiser Commission on Medicaid and the Uninsured, Issue Brief, July 2013.
- ² *Statehealthfacts.org*, FY 2009 Medicaid enrollees by enrollment group.
- ³ "The Uninsured: A Primer—Key Facts about Americans without Health Insurance." October 2011. The Henry J. Kaiser Family Foundation.
- ⁴ Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey, *Health, United States, 2011*, Table 56.
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- ⁶ "Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured." Milliman Health Reform Briefing Paper, Rob Damler, FSA, MAAA.

The Health Insurance Providers Fee and Medicaid Managed Care Capitation Rates

By Sabrina Gibson and Maria Dominiak

What Is the Health Insurance Providers Fee?

Section 9010 of the Affordable Care Act (ACA) created the Health Insurance Providers Fee—sometimes called the Health Insurer Fee—as one source of funding for the ACA provisions. The Health Insurance Providers Fee (fee) is an excise tax by the federal government on entities in the United States that provide health insurance. Notable exclusions are self-insured employers, government entities and certain non-profit corporations. The Internal Revenue Service issued proposed regulations for the fee on March 4, 2013 and final regulations are expected to be released soon.

The fee is a fixed amount each year (\$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, etc.) as defined in the regulation which in aggregate is to be collected across entities to which the fee applies. The amount each entity pays is developed by calculating the entity's percentage of its previous year's net premiums written as a percentage of every entity's previous year's net premiums written. For each entity, the Internal Revenue Service (IRS) will exclude 100 percent of the first \$25 million of net premiums written and 50 percent of the next \$25 million of net premiums written when calculating the entity's total net premiums written.

The fee is due by the date specified by the secretary of the Treasury, but no later than Sept. 30 each year. The fee paid in the year is the fee for that calendar year (fee year). Invoices will be sent to each entity no later than Aug. 31 of the fee year. The actual amount each entity will pay will not be known until the date the invoice is received.

An important characteristic of the fee is that it is not tax deductible to the entity.

Managed Medicaid Issues Related to the Fee

Medicaid managed care capitation rate setting is governed by the Code of Federal Regulations—42 CFR 438.6(c). This regulation requires that Medicaid managed care capitation rates be actuarially sound. The Centers for Medicare and Medicaid Services (CMS) provide oversight to ensure that this regulation is followed and has developed some guidance for actuarially sound rate development through a rate-setting checklist. In response to the checklist, the American Academy of Actuaries (AAA) released a Health Practice Note that provides guidance on following the checklist. The AAA is in the process of developing an actuarial standard of practice (ASOP) to provide actuaries with more binding guidance for setting Medicaid managed care rates.



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“A recent twist to accounting for the fee is that the NAIC is proposing that MCOs expense the fee in the year before the payment is due.”

Through the regulations and guidance described above, the Medicaid rate-setting actuaries have developed a practice of including fees and taxes in actuarially sound capitation rate development. CMS allows premium taxes to be included in the Medicaid managed capitation rate and the states to receive federally matching funds, as long as the premium tax is “broad based.” This practice has served to include fees and taxes in the capitation rates with little risk to the managed care organizations (MCOs), while maximizing federal matching funds in the state. Many times the tax is a flat percent of revenue, so the capitation rates can be grossed up to reflect the tax on a prospective basis with no risk at all to the MCOs or the states. The Health Insurance Providers Fee, however, is not like most state premium taxes, so requires additional considerations.

Additionally, states historically have developed fees and taxes for Medicaid premiums as a way to maximize federal revenues by drawing down federal Medicaid funds to pay for taxes that are ultimately transferred to general revenues. Certifying actuaries have included these taxes as part of the capitation rates with full state approval, since they designed the tax for just that purpose. The fee is not a state tax and will instead go to the federal government, so the state, in this case, is transferring state funds to the federal government tax coffers instead of the other way around. States may be more reluctant to fund this tax given that it provides them with no funding advantage. Actuaries must determine how to treat the tax to ensure the rates are actuarially sound.

Several characteristics of the fee create problems when trying to build the fee into Medicaid managed care rates on a prospective basis as follows:

- The fee is not a percent of premium like most taxes on Medicaid managed care revenue, and it is an unknown amount for the majority of the fee year, so it cannot be readily built into the Medicaid capitation rates.

- The fee is for a calendar year whereas most Medicaid managed care rates are for fiscal years that span more than one calendar year.
- The fee paid in a fee year is calculated off of the prior year’s premiums, so there are questions about which capitation rates are associated with the payment.
- The fee is paid in September of the year even though it is for the entire fee year. If the expected amount of the fee is paid in equal distributions in the capitation rates throughout the calendar year, the aggregate fee amount must be paid by the MCOs before they have received the entire amount of payment in their rates. Additionally, if the fee is paid in the capitation rates through the year, the states are prefunding the expense before the amount is paid back to the federal government, so the state does not benefit from holding the funds until they are due.
- The amount each MCO is required to pay is a set dollar amount for all of its net premiums written and is not broken out by state; therefore, for national plans, there is not a clean way to determine how much of the MCO’s total payment should be allocated to each of its Medicaid programs.
- The fee amount will vary by dollar amount and as a percent of revenue for each MCO in the state.
- The fee is not tax deductible to the MCO, so just paying the MCO the amount to cover the fee does not cover the MCO’s cost of the fee. Also, each MCO may pay a different corporate tax rate, so the amount needed to cover the MCO’s cost will vary by each MCO.

A recent twist to accounting for the fee is that the NAIC is proposing that MCOs expense the fee in the year before the payment is due. This could create additional accounting issues for MCOs, since states may not agree to pre-paying the fee in the capitation rates that far in advance. This requirement could also cause states to suffer a double hit to their already stretched budgets in the first year of expensing the



fee, since they may pay two years of fees in one year.

Options for Including the Fee in Capitation Rates

Usually in managed Medicaid capitation rate development, fees and taxes are included in the rate payments prospectively in such a way that there is no risk to the state or the MCO related to these items. Given that the fee varies by MCO and the actual amount of the fee will not be known until August of the fee year, normal methods for including taxes and fees in the capitation rates prospectively and without risk do not work for this fee.

Some potential options for including the fee in the capitation rates are:

- Pay the fee as a pass-through to the MCOs.
- Include an estimate of the fee in the capitation rates then true-up once the actual amount is known. The estimate could be paid with the capitation rates or it could be a withhold amount that is paid when the true-up occurs.

- Include an estimate of the fee in the capitation rates with no true-up.

The first two options dramatically reduce or eliminate the payment risk to the state and the MCOs; however, they will need to be designed in a way acceptable to CMS. The third option does not remove payment risk for either the state or the MCO. All three options will require CMS approval for including the fee in the Medicaid managed care capitation rates, but there is no guidance at this time.

The first two options may also provide the states with more flexibility in choosing the fiscal year in which to fund the fee payments. Each state should consult with their accounting department to clarify how the payments will be expensed.

For accounting purposes, the MCOs must book a payable for the fee beginning Jan. 1 of the fee year. The MCOs will want the expected payment from the state established in a way that will allow them to also book a receivable to offset the payable so this will not impact the MCOs' earnings. The methods above may make this a little more challenging, so the state should work with the MCOs to determine if there is language that can be included in the contracts to reduce the impact of an accounting mismatch.

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Tax Deductibility Issue

An important characteristic of this fee for rate setting is that it is not tax deductible. Therefore, if the full amount of the tax is reflected in the rate, the fee amount should be grossed up to reflect the tax amount that the MCO will pay on the fee. The tax amount can vary by MCO, which is another consideration in the development of the capitation rates and the pass-through payments.

Summary

The Code of Federal Regulations—42 CFR 438.6(c)—requires that Medicaid managed care capitation rates be actuarially sound. The AAA Health Practice Council Practice Note on the Actuarial Certification of Rates for Medicaid Managed Care Programs defines actuarially sound rates as including “any state mandated assessments and taxes”; therefore, industry practice has determined that rates are only actuarially sound if fees and taxes are included in the rate development. Actuaries along with CMS guidance will determine the industry practice for this new federal tax.

The fee is unlike most taxes included in Medicaid capitation rates, since the amount of the tax will not be known at the time capitation rates are developed and the amount can vary dramatically by MCO. Including an estimated amount for the fee in the capitation rates without future adjustments to true-up the actual amounts places risk on the MCOs and the state, so implementing a methodology for paying the fee that includes a true-up approach to make the fee more of a pass-through payment reduces the risk of mispricing this component of the capitation rates.

The options described above may meet CMS approval for including the fee in the Medicaid managed care capitation rates, but CMS ultimately will need to approve any method used. They had not issued guidance for including the fee in Medicaid managed care capitation rates at the time this article was written. ■

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Frequently Asked Questions about the Cost of the Future Newly Insured under the Affordable Care Act (ACA) SOA Study—And Other Things You Might Not Know by Just Reading the Executive Summary

By David Tuomala

In March 2013, the Society of Actuaries released a modeling study titled “Cost of the Future Newly Insured under the Affordable Care Act (ACA).” This study garnered quite a bit of media and political attention when it was released, but much of that coverage focused on the high-level findings, particularly those summarized in the executive summary. In the intervening months, I have had the opportunity to present the findings of this study to a number of audiences and also to participate in several question-and-answer sessions with various interested actuarial groups. In this article, I will cover some of the most frequently asked questions about the findings and methodology used for this modeling study, as well as highlight some of the more interesting findings that might not be evident without a deeper reading of the entire report.

Question: *In some states, the enrollment in certain subpopulations prior to the ACA is very different from what is reported by other sources. What data source was used for this study and why might it be different from other sources?*

This study was performed using The Lewin Group’s Health Benefit Simulation Model (HBSM) which is a micro-simulation model of the U.S. health care system that has been used for over 20 years to model the likely effects of different health reform proposals on the enrollment and cost of care. Because we need to model the entire health care system, this model requires a data source that includes information about the currently uninsured population. The HBSM uses data from the Current Population Survey (CPS), which provides detailed demographic and source-of-coverage information. This data is coupled with data from the Medical Expenditure Panel Survey (MEPS), which includes similar demographic data as well as detailed cost of medical care data. Over time, we have found these two sources to be the best comprehensive sources of data that cover all populations of interest. The CPS data has the added advantage of being done

consistently at a state level that allows for more granular analysis.

Two subpopulations that are often identified as different from the CPS results are Medicaid and the uninsured. When comparing the results from other data sources, it is important to understand how membership was counted (each month or at a particular point in time), which is the most common reason for differences. In most cases, other sources of data are not available consistently in all states, or are only available for certain populations (e.g., Medicaid), which makes them difficult to use for this type of modeling. An in-depth discussion of all potential data sources and their feasibility for this type of modeling was outside the scope of this study.

That said, it is important to point out that the timing for the data pull was based on 2008 to 2010 CPS data that we pooled together to increase the sample size at the state level. Because the data for the uninsured was based on 2008 to 2010 proportions, when the uninsured rate was somewhat higher than it is right now in many states, this means that some of the states’ claims costs may be higher than what were modeled given a strengthening economy (the composite effect of the uninsured subpopulation generally helped to offset or mitigate the other compositional changes anticipated).

Question: *What definition of “cost” was used in this study?*

In the HBSM, health care costs are developed from the MEPS data. Our focus for this report was the change in morbidity of the underlying populations as members moved between coverage choices and from uninsured to insured status as a result of the provisions of ACA. Health care cost for this purpose was the equivalent of allowed charge as measured by the MEPS data. This should be distinguished from other



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potential cost measures such as premium, which could include other elements such as administrative expenses, taxes, financial assistance to issuers from risk mitigation programs, and premium subsidies available to individuals.

Question: *Did you model the “pent-up demand” for health care services in the newly insured population?*

Our results are presented on a fully implemented basis after the compositional changes have stabilized (the model does not attempt to predict 2014 claims cost though 2014 was used as a static reference year), so we do not explicitly attempt to model the phase-in of enrollment or the ramp-up of utilization and expense over time. From this perspective, we did not attempt to analyze the effect of pent-up demand for health care services.

However, for members who were formerly uninsured, we modeled their future expense levels using currently insured members with similar characteristics. We expect the cost of the uninsured to eventually increase to the level of currently insured members, so while we do not attempt to model the pattern of pent-up demand leading to higher costs in the first few months of enrollment, we do model claims at an ultimate level consistent with an insured population.

Question: *In the report, detailed results were provided for Wisconsin and results for other states were summarized. Why was Wisconsin chosen?*

In order to keep the size of the report manageable, we were only able to provide detail and discussion in the body of the report for a single state. Wisconsin was chosen as a good example because several members of the project oversight group (POG) were familiar with the market in that state. It was also determined to be a suitable example because it had a more “typical” pre-ACA regulatory environment where individual product pricing and regulation were neither overly restrictive nor overly loose.

Detailed data tables were provided for all states plus the District of Columbia for many of the detailed tables presented in the body of the report. The readers are left to draw their own conclusions regarding the state-level details for the other states, although the considerations would be similar to Wisconsin.

Question: *Some media coverage has criticized the report for not considering the impact of subsidies for low-income populations under ACA. Did the report consider the impact of individual ACA subsidies?*

Our modeling approach considered the impact of subsidies in terms of choice of coverage and whether a particular individual chooses to purchase indi-

vidual coverage or to remain uninsured. This study used two different approaches to model member-level choices of coverage. One approach is price elasticity where the net cost of coverage pre-ACA is compared to the net cost of coverage post-ACA. The second approach uses a utility method to also include the perceived value or utility of having insurance coverage rather than not having coverage. In both approaches, we factored in the reduced cost of coverage under ACA for those individuals who are eligible for subsidies.

While it is true that we did not illustrate the net cost of coverage after subsidies in our exhibits, we did explicitly account for the availability of these subsidies in modeling member-level choice of coverage. The focus of this report was on the most difficult assumptions that issuers faced in pricing under a swiftly changing environment: the effect of membership composition shifts and consequent morbidity shift caused by the ACA. Even focusing the study on this targeted modeling took well over nine months to accomplish.

Question: *The report focuses on the individual market, and only briefly touches on the impact on the large and small group markets. Why did the report focus on the individual market rather than other market segments? Are the results included in the detailed tables for the group market appropriate for estimating the impact on those populations?*

In order to keep the size of the report manageable, we needed to focus on the segment of the market that we thought would be most interesting and useful for the actuarial profession and other interested parties. The POG felt that the individual market was where the most significant impact of the provisions of ACA would be felt, and where the least current research was available. In particular, the change in morbidity in the individual market was believed to be the most critical change, and that was where we focused our attention for the report.

While not the focus of the report, the results for other subpopulations are valid and can be used to estimate the impact of ACA on those populations.

Question: *Did you model the impact of different coverage choices among the metallic benefit options? Did you include the effect of increased Essential Health Benefit (EHB) requirements for individual plans post-ACA?*

Because the focus of this study was on the change in morbidity of the different populations affected by ACA, we did not model the impact of benefit choice at the metallic benefit levels required by ACA. Costs were modeled at the allowed level, so member cost-sharing features were not factored in. For premium calculations pre- and post-ACA, we assumed the same benefit design in calculating the change in premium before and after ACA, so the change in premium level was driven by the ACA rating provisions and the morbidity of the population, rather than changes in plan design or covered benefits.

It should be further noted that the cost measures presented in this study are intended to reflect the change in morbidity only, and do not consider many other factors that could affect final premium rates. These include changes in covered benefits as a result of EHB requirements, network differences, competition, transparency, minimum actuarial values to satisfy metallic benefit level, additional taxes and fees, temporary reinsurance program recoveries, and premium and cost-sharing subsidies for low-income members.

Question: *The state-level results summarized in the report vary a great deal from state to state. Within a particular state, how much variation can we expect from the values included in the study?*

It is not possible to put exact parameters around the expected variation, or to establish a reasonable expectation of variability in this type of modeling. We can only state what assumptions we used and show a range of sensitivity to different levels or types of assumptions, which are included in the detailed Excel table outputs included with the report. Because many of the provisions of ACA have never been applied historically, we have no way of know-

ing in advance how much variation we might see when actual enrollment occurs. It is safe to say that there is a very wide range of possible outcomes, depending on the level of assumptions chosen and who actually enrolls in the individual market post-ACA. We would encourage the readers to use judgment in applying the results of this report to their particular situations. Other modeling approaches or assumption sets may yield different results.

The SOA's modeling study was uniformly and consistently sourced, and assumptions and methods were uniformly and consistently applied throughout the model, so it is very important to point out that one of the key findings—that the ACA will have remarkably different influences on morbidity from state to state—was a new and unique insight at the time, and had received little to no attention before the study was released. While a lot of the reasons for this variation have to do with state differences such as age, income levels and health costs, a lot of the variation also is due to states having remarkably different starting points in their current individual markets. Some actuaries found that the gathering of the initial source data into one single place in itself helped them understand variability better, and that the modeling of 50 states plus the District of Columbia in itself created some interesting and enlightening correlations to think about.

Question: *What are the most commonly overlooked findings of this study?*

Many of the common questions addressed above are actually covered in some detail in the body or appendices of the report. I would encourage users of the report to read the report in its entirety and also to review the accompanying Excel tables. While much attention has been paid to the baseline differences by state that are summarized in the executive summary of the report, there is a lot of interesting detail that can easily be overlooked. While the body of the report discusses the findings for Wisconsin only, there is a great deal of detail included in the accompanying Excel tables for each of the 50 states.

In addition to the baseline assumption set results, the Excel tables provide results under five sets of alternative assumptions, including: no Medicaid expansion, no ACA subsidies, and three sets of assumptions using variations of a utility methodology rather than price elasticity. In particular, the expected variation in enrollment and morbidity for the no Medicaid expansion scenario will be important in states that have decided to not implement the Medicaid expansion under ACA.

For all users, it is important to understand the enrollment and cost results for the various subpopulations that build up to the post-ACA individual population and whether those results are reasonable for a particular plan or market. Adjustments can and should be made to fit the specific circumstances of a particular user. ■

On The Research Front

CHECK OUT NEW REPORT AND MODELS: SIMULATING HEALTH BEHAVIOR

In this report and accompanying models, the author, Alan Mills, explores how to develop agent-based simulation models of the many dimensions of health behavior, in order to help solve health system problems. It is organized into six parts, Health Behavior, Classification of Agents and Behaviors, Health Behavior Facts, Health Behavior Theory, Methods and Tools, Filling the Gaps. At the end of each chapter there are exercises and solutions to help the reader better understand the material. Also included are three models exploring aspects of health behavior. <http://www.soa.org/Research/Research-Projects/Health/Simulating-Health-Behavior-A-Guide-to-Solving.aspx>

2013 GROUP TERM LIFE MORTALITY AND MORBIDITY STUDY INCLUDES PIVOT TABLES

The Group Life Insurance Experience Committee of the Society of Actuaries has completed the 2013 Group Term Life Mortality and Morbidity Study Report. Data were solicited from insurers regarding Group Term Life Insurance policies in force anytime during the study period of 2007 to 2009. Benefits included are: Death, Disability Waiver of Premium ("Waiver" or "Disability"), and Accidental Death and Dismemberment ("AD&D"). The 2013 Study includes three pivot tables--Individually Billed, Self-Administered and AD&D--which will enable companies to perform their own analysis to supplement the findings of this report.

<http://www.soa.org/Research/Experience-Study/Group-Life/2013-group-term-life-experience-study.aspx>

REPORT POSTED: NONTRADITIONAL VARIABLES IN HEALTHCARE RISK ADJUSTMENT

This report presents the results of an in-depth study into the relationship of nontraditional variables for risk adjustment with health costs using the Medical Expenditure Panel Survey (MEPS) data. This data is unique in that it includes a large number of individual characteristics (from BMI to whether a person has difficulty enjoying hobbies) together with healthcare claim data. The results of this research demonstrate that it is important to adjust the traditional risk adjustment model in order to recognize nontraditional variables. The report develops a new measure (Loss Ratio Advantage or LRA) to help quantify the potential of a nontraditional variable to affect a risk adjustment program. <http://www.soa.org/Research/Research-Projects/health/research-2013-nontrad-var-health-risk.aspx>

NEW GROUP LTD BENEFIT OFFSET STUDY

This study of group long-term disability (LTD) benefit offsets is a follow-up study to one conducted in 2008. As with the earlier study, the 2012 study investigates the percentages of LTD claimants who are receiving disability benefits from sources that offset their LTD benefits, the level of these offset benefits relative to pre-disability earned income and how they are affected by several factors. In addition, the 2012 study investigates the distribution of Social Security approval dates by duration of disablement.

<http://www.soa.org/Research/Research-Projects/disability/research-2013-group-ltd-offset-update.aspx>

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The ACA—Two Policy Experts' Perspectives

With Kurt Wrobel



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With the upcoming deployment of the most important aspects of health care reform, we are fortunate to have two well-known policy experts respond to our questions on the legislation. Grace-Marie Turner and David Cutler participated in a debate at the SOA health conference in 2010 and this interview serves as an extension to that initial debate. While they have different views, they each provide a very articulate support of their policy positions.

As we enter into the most important phase of the Affordable Care Act (ACA), have you been surprised by any particular aspects of its implementation?

Grace-Marie: Unfortunately, the ACA is unfolding with the implementation problems, delays, economic distortions and rising costs that my colleagues and I had predicted.

What has surprised me is the determination of the law's supporters to continue to press forward in spite of the harm it clearly is doing to the most vulnerable Americans. A few examples: People with lower incomes are finding their hours slashed to part time by employers threatened with fines for not complying with the ACA's temporarily postponed employer mandate. Seniors without retiree supplemental insurance or the means to purchase Medi-Gap insurance are at risk of losing access to Medicare Advantage health plans that provide them with comprehensive health benefits. People on Medicaid today will be forced to compete with millions more people being added to the program for appointments with the limited number of doctors who can afford to treat Medicaid recipients. People with pre-existing conditions have been shut out of the ACA's temporary high-risk insurance program because of cost overruns. Families risk losing their health plans at work because of a glitch in the law that allows employers to escape penalties if they provide coverage that is affordable only to the employee. It would seem to me that the administration would do more than it has to protect those who are most at risk of being harmed by the law.

David: I am surprised by how smoothly things have gone overall. The programs that were supposed to start have started, exchanges are being set up, and

there have been more favorable surprises than negative ones.

All new programs come with unforeseen challenges and benefits. At one point, Part D was considered a troubled program because of implementation glitches. But Part D is now seen as a major success. The same will be true of the ACA.

The glitches are well known, and the administration did not handle some of them well. But look at the successes: state exchanges are being set up, half the states are expanding Medicaid, average premiums are coming in below expected costs, local groups are gearing up for outreach, and medical cost trends are below forecast.

The issue of the reduced rate of cost increases is particularly interesting to me. Recall one of the conservative arguments about Obamacare—that it would increase medical spending and explode the deficit. Alas, the reverse has happened. So, conservatives need a new argument. Their new argument is, "it started before Obama so it couldn't have been the ACA". It is true that the cost slowdown started in the mid-2000s. But if one looks at the data, as I did, the relative slowdown in the mid-2000s is somewhat easy to explain by income growth. The one that is harder to explain is the post-ACA slowdown as the economy has been recovering.

Looking at the data shows that the ACA is a big part of this. Remember the hospital payment increase reductions that were going to ruin care for Medicare beneficiaries? They happened, with no apparent adverse effects. Recall the Medicare Advantage payment reductions that were going to toss people out of Medicare Advantage? They happened too, and Medicare Advantage enrollment continued to increase. Those two factors together are about 10 percent of the cost slowdown. In addition, there are savings from the reduction in hospital-acquired conditions and reduction in readmission rates—driven by ACA-enacted policies penalizing those events—that have materially affected the Medicare bottom line. At this point, Obamacare deniers have the feel of climate change deniers: lone voices arguing against a sea of science.



One calculation is fascinating. The actuaries in the Centers for Medicare and Medicaid Services have continually reduced their forecast of future medical spending since the Affordable Care Act was enacted. Their latest estimate shows that medical costs will be sufficiently lower in 2016 (after the recovery has entirely occurred) that the typical family will pay \$2,500 less for health care every year. That is exactly what the President has promised people.

Considering both the short and long term, what aspects of ACA will have the greatest benefit? What aspects have the potential to be damaging?

Grace-Marie: There is no question that there were serious problems in our health sector that needed to be addressed before the ACA was enacted in 2010. But the ACA is a complex, interacting system and it is not possible to pick and choose good and bad aspects of the law. It is a Rube Goldberg contraption that cannot be saved and will likely be dismantled piece by piece.

When my colleagues and I wrote our book, *Why ObamaCare Is Wrong for America* (Broadside/HarperCollins, 2011), we anticipated many of the disruptions that have unfolded in the three-plus years since the law was enacted—the rise in costs for health insurance, the dislocations in the labor market, doctors leaving and selling their practices, and the extraordinary difficulty of creating the massive bureaucracies needed to redesign one-sixth of the economy, for starters.

We also anticipated that the law would become more unpopular as it neared implementation with individuals facing the individual mandate and with businesses facing the employer mandate and its onerous reporting requirements. The administration recently has acknowledged by its actions that many of these warnings were valid. For example, the administration has delayed for a year (in contradiction to the language in the statute) the reporting requirements and fines associated with the employer mandate.

And in a 606-page regulation issued late on July 5, the administration announced that income and employment verification in the state-run exchanges in 2014 will be waived. This announcement is another indication of the difficulty, and perhaps impossibility, of such a massive bureaucratic undertaking. The administration acknowledged the difficulty of getting verification systems up and running, saying “large amount of systems development on both the federal and state side ... cannot occur in time for October 1, 2013.” Therefore, income verification “is not feasible for implementation for the first year of operations.” The administration will, instead, rely on an honor system for reporting.

Meanwhile, public support for the law is dropping, leading Congress to begin action to delay the most unpopular features of the law, including the individual mandate that requires most Americans to obtain qualified health insurance or pay a “tax.”

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David: The success of health reform hinges almost entirely on two issues: (1) do people get coverage early next year; and (2) what happens to cost trends in health care?

If people get coverage, the cost of insurance in the exchanges will be affordable, subsidies will be modest, and the economic benefits of insurance coverage—reduced job lock, fewer people applying for disability insurance as a means to get health insurance, reduced presenteeism and absenteeism—will be substantial. I wrote extensively about this on the New York Times Economix blog page, where I relay the economic benefits of having greater coverage. For these benefits to occur, we do not need everyone to be covered, but we need most people to be covered most of the time.

The second aspect of success is a continued moderation of health cost increases. As health costs increase, wages of middle income families stagnate, employers seek to leave more workers uninsured, and governments either run deficits or cut essential services. Over time, the most important aspect of health care is whether we make it more efficient or

not—which means cutting spending and improving the quality of care.

Some people have argued that additional social subsidies could impact the incentive for people to work while others have argued that because workers will not be locked into their jobs through employer sponsored health care that they will have a greater opportunity to leave and either start new businesses or take more satisfying jobs. How do you think ACA will impact the incentives in the labor market?

Grace-Marie: The subsidies for the portable health insurance provided through the ACA exchanges are not free: they come from higher taxes and larger deficit spending. Spending therefore is shifted from the private to the public sector. As a result, there will be fewer opportunities in the private sector and fewer opportunities to start new businesses until the economy recovers more strongly.

Chris Conover of Duke University explains that “every dollar going into the U.S. Treasury to finance this expansion is a dollar taken out of the private economy.” And he adds that “Every additional dollar of new taxes shrinks the economy.... That dollar would have been spent (i.e., ‘created’ or supported jobs) anyway: the [ACA] expansion simply transfers the decision about how to spend that money to Washington, D.C.”

But the impact is not neutral. “Currently every added dollar of federal taxes essentially shrinks the economy by 44 cents,” Conover adds. “Thus, if we convert this to jobs, we will lose 144 jobs for every 100 health sector-related jobs that are induced by expansion.”

Young people have been hit particularly hard by the faltering labor market, at least partially induced by the ACA. Most young people need jobs even more than they need health insurance, yet the law provides strong incentives for employers to refrain from hiring entry-level and lower-skilled workers, to put full-time employees on part time, and even to release full-time workers to keep their total workforce under 50 so as not to trigger the employer mandate.



A recent Gallup poll had found that 41 percent of small businesses surveyed had frozen hiring because of the health law. One in five said they already have reduced the number of employees in their business “as a specific result of the Affordable Care Act.” Large employers are also carefully navigating the complexities and ongoing uncertainties of “Obamacare.”

Even though the reporting requirements and fines for the employer mandate have been delayed until 2015, that will not change the hiring practices of employers. The ACA will continue to exert downward pressure on job creation until the employer mandate is repealed entirely.

An extension of the delay of the employer mandate is likely, since the 2014 congressional elections would come at a time that the current delay will be set to expire, putting members who voted for the law at risk with voters.

David: I have analyzed the economics of the Affordable Care Act in some detail: http://economix.blogs.nytimes.com/2013/08/07/the-economics-of-the-affordable-care-act/?_r=0. Let me make several points about it.

1. The doom-and-gloom crowd has been proven wrong. Many of the adverse effects predicted of the ACA were also predicted for Massachusetts, when it passed its precursor to the ACA. In fact, every single one of these predictions have been proven wrong, as studies shown in the intervening years attest. Job growth has been robust in Massachusetts, full-time employment has increased, and employer-provided health insurance has risen.
2. The benefits of the Affordable Care Act are substantial and well documented. These benefits include reduced “job lock” (people locked into a job for health insurance, which they fear they cannot get elsewhere); fewer people applying for disability insurance as a way to get stable health insurance; and reduced rates of absenteeism/presenteeism as people receive better primary and preventive care. The latter effect alone has been estimated to cost the economy over \$200 billion annually.

3. As noted earlier, the single biggest effect will be saving money for employers. A number of studies show that employment is sensitive to the rate of health care cost increases.

Overall, while there is the potential for some adverse effects from the ACA, the benefits are so substantial as to outweigh any potential harm.

As actuaries, we get close to the details of the act and one that we have seen is the mandate to only allow a 3 to 1 rating differential based on a member’s age. This rating restriction has the effect of increasing costs for young men and reducing the cost for older people. Do you think this rating restriction will have a significant impact on the potential for young men to purchase insurance?

Grace-Marie: About two-thirds of the uninsured are under age 40. Because they are generally healthier and are less likely to be major users of health services, their premium contributions are needed to help keep insurance costs down for everyone else.

Yet the incentive structures in the law work at cross-purposes with this goal and could well undermine its success. The former director of the Congressional Budget Office, Douglas Holtz-Eakin, found in a study published earlier this year for the American Action Forum that, “Across all markets, the ACA will dramatically increase the cost of insurance for the young and healthy individuals and small employers.” He found that “the ACA regulations lead to a 149 percent average increase in the cost of insurance for this population.”

The survey also showed that fewer than half of young people will sign up for insurance if premiums rise by 30 percent.

Ezekiel Emanuel, a key architect of the president’s health plan, writes that he is worried that young people will be “bewildered,” and they may “forgo purchasing health insurance and opt to pay a penalty instead.”

The fact that the administration has been working so hard to convince sports heroes to help promote enrollment in the ACA insurance shows the significant concern about reaching this group.



That certainly will be an attractive option for many since the penalty starts at just \$95 the first year.

But if young people don't sign up, the insurance pools are likely to be composed primarily of people who have high health costs. This could cause a "death spiral" where many more older, sicker people are enrolled, causing health insurance premiums to rise to cover their medical costs, thereby driving even more young people out of the market.

And there is yet another disincentive for young people to enroll in coverage: Because of the guaranteed issue provision, they can wait to sign up for coverage until after they get sick or injured since the law requires health insurance companies to sell insurance to anyone who applies.

A study using a different survey method published this year by the American Academy of Actuaries' *Contingencies* magazine found that because of the 3-1 rating provision, "premiums for younger, healthier individuals could increase by more than 40 percent." The premium increase for young men will be much more than for young women because gender variations are not allowed.

The fact that the administration has been working so hard to convince sports heroes to help promote enrollment in the ACA insurance shows the significant concern about reaching this group.

David: I don't think it will have a huge impact because it will be offset by the subsidies. Many young men have relatively low incomes. Thus, the premium they face will not be the full amount, but rather the amount net of the subsidy. Put another way, the ACA has limits on the share of income that people will pay for health insurance. These limits are sufficiently low that the price will not be a prohibitive factor in determining whether to buy coverage or not.

David, you have suggested that we may have entered into a period of structural change in the health care delivery system. As suggested by your research, considering the impact of less expensive technology, better incentives among providers, and increased out-of-pocket expenditure, the trend rate for health insurance expenditure has decreased dramatically over the past three years. How do you think this spending slowdown will impact the success of ACA? What will happen to overall costs after the implementation of ACA?

David: The spending slowdown is fundamental to the ACA. If the implementation comes in under budget, it makes everything much easier. If it is over budget because of rising health costs, the reaction will be very severe.

The ACA will have several effects on spending. There will be a one-time bump in spending in 2014 as people get insurance. Insured people use more care than uninsured people (that's why we want them to have insurance). The bump will not be huge, but it will be noticeable.

Over time, I expect the growth of costs to continue to moderate. As cited earlier, I have explained my predictions in some detail, but can summarize them briefly. Between 1960 and 2011, real, per capita health care cost increases have exceeded the rate of GDP growth by about 2.5 percentage points annually. Much of this was the creation of Medicare

and Medicaid; take that out and the residual is 1.5 percentage points or so. Economists estimate that the technological component of this is about 1.0 percentage points, so many forecasts have medical care spending increasing by about 1.5 percentage points above GDP annually, declining to about 1.0 percentage points above GDP over time.

Now consider how much waste there is in medical care. Consensus estimates suggest that the waste is about one-third of medical spending. Some think it is higher; others less high. But take one-third. The ACA puts us on a path to eliminate this waste. Imagine that we eliminate 20 percent of medical spending over the next decade. Note that this isn't a reduction of 20 percent of spending, but a slower growth rate that amounts to 20 percent lower spending than currently forecast. Reducing spending growth by 20 percent over 10 years is a reduction of about 2.0 percentage points annually. Allow for a somewhat longer transition and the reduction in growth is about 1.5 percentage points annually.

Note that the 1.5 percent growth reduction is about the same as the excess of medical care cost increases over GDP growth. So, my prediction is that the ACA will contribute to holding health care at the same percentage of GDP over the next 10 to 20 years. That would be a very substantial savings. I should note that the recent slowdown is consistent with this; since the recession ended, health spending has increased about the rate of GDP growth, right along the line of this forecast.

David, you have written about the potential for changing provider payment systems to improve their economic incentives to practice more efficient care, including a recent article on bundled payments. Among the programs in ACA, which program do you think has the greatest potential to improve provider incentives? Why?

David: There are many debates about this, and the truth is that we don't know. Remember—we don't need all of the programs to work, we just need some of them to. Put it another way: Success is defined by fostering a moderation in the growth of spending. Anything that promotes moderation is a winner.

In my mind, I classify the programs in three groups. First are the ones that seek to make consumers more cost conscious. These include the creation of exchanges, where consumers can shop across plans, and the Cadillac tax, which will increase cost sharing for some people. Second are the ones that change provider payments. These include the Accountable Care Organization program, the bundled payment program, and the various other programs run through the Center for Medicare and Medicaid Innovation. Third are the provisions that seek to make the system more efficient. These include steps to reduce administrative expenses, sharing government data with the private sector, and reducing insurer administrative expenses. People argue strenuously about which of these programs is most important. The ACA adopts them all.

David, Grace-Marie Turner has written in the *Wall Street Journal* that implementation of ACA will require people to fill out complex and difficult to understand forms in order to purchase health insurance. Do you think this will become an issue in the implementation of ACA?

David: It was never an issue in Massachusetts. And recall that this was supposed to be a hindrance to Part D as well, where seniors were encouraged to go online and shop for prescription drug plans. Neither one was a fatal flaw.

The real question is whether people want health insurance, in which case this will be a minor inconvenience, or whether they do not, in which case this could be a big hassle. I find it ironic that people who trust individuals so much somehow think that people are incapable of working through a small hassle to get a product they want.

Grace-Marie, considering the early reports on the state exchanges, do you have an early read on how competitive the markets will be on the exchange?

Grace-Marie: Fifteen states and the District of Columbia are planning to run their own health

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exchanges. In some markets with developed managed care systems such as California, many choices will be available, although applicants may be surprised at the limited networks of physicians and hospitals available to them. But even there, Aetna, UnitedHealthcare and Cigna all have said they are leaving the state's exchange, called Covered California.

In New Hampshire, only one health plan, Anthem BlueCross BlueShield, is participating in the ACA exchange, giving applicants the choice only of different price points among standardized Bronze, Silver, Gold and Platinum plans. In Mississippi, two-thirds of counties will not have any health plans participating in the exchanges.

Connecticut, Maryland, Rhode Island and Washington state are examples of states that have been working exceptionally hard to create their own exchanges, but they are struggling. "It is highly complex, it's unprecedented and it's not going to be smooth," Kevin Counihan, chief executive of Connecticut's exchange, Access Health CT, said recently. Although states are promising to provide new marketplaces for individuals to compare and buy health insurance plans, most are being forced to scale back plans to meet the bare minimum of requirements to get certified to open enrollment. Even among those states trying hard to meet deadlines, some will fail, leaving the federal government little time to set up back-up federal exchanges.

There has been even more uncertainty in the 34 states where the federal government is creating exchanges since the Department of Health and Human Services released little information in advance. There also is growing concern about security of the information that "Navigators" will be gathering to help people apply for subsidies—including home addresses, Social Security numbers, employers, income, names and ages of children, and even health status.

Grace-Marie, David Cutler has written about the potential for changing provider payment systems to improve their economic incentives to

practice more efficient care, including a recent article on bundled payments. Among the programs in ACA, do you think a particular program has the promise to improve provider incentives?

Grace-Marie: There is no question that Medicare's current fee-for-service payment system encourages over-use of health services and that new incentives are needed to promote more efficient, economical care delivery. The ACA's accountable care organizations, medical homes and more comprehensive payment models are all very attractive in concept. But similar experiments over the past decade have failed to show measurable savings. The move toward "bundled payments" to encourage "hospitals, physicians, post-acute facilities, and other providers as applicable to work together to improve health outcomes and lower costs," according to the Centers for Medicare & Medicaid, is really a new name for managed care.

These experiments all will fail unless the one thing we haven't tried on a large scale is tested: consumer engagement. We must move away from tinkering with the byzantine payment regulations that dictate how Medicare pays hospitals, doctors and other providers of medical services and build a new system on the successful Part D model.

Part D works differently from traditional Medicare: It offers seniors a choice of plans that are competing with each other to offer the most comprehensive selection of drugs at the lowest price. Seniors have shown they are smart shoppers and have driven down the cost of the program. Overall, the cost of the Part D benefit to the federal government is 43 percent under budget projections.

Just after Congress created Part D in 2003, the Medicare trustees estimated that Medicare beneficiaries would pay an average of \$61 a month for their drug benefit by 2013. Instead, the average premium has remained consistent at about \$30—about where it was when the program began. During the same period of time, premiums for Medicare Part B, which covers doctors' visits and other outpatient care, have increased from an average of \$89 in 2006 to \$105 in 2013.

The difference is consumer choice, competition and market pricing. Medicare modernization plans have been introduced in Congress based on the Part D model, giving seniors a choice of competing plans and a guarantee that the Medicare subsidy will cover the full cost of a basic plan, while giving seniors the option of staying in traditional Medicare. This is a very different path forward than a rule-driven grab-bag of options in which the government is still in charge of doling out incentive subsidies.

Grace-Marie, David Cutler has suggested that we may have entered into a period of structural change in the health care delivery system. As suggested by his research, considering the impact of less expensive technology, better incentives among providers, and increased out-of-pocket expenditure, the trend rate for health insurance expenditure has decreased dramatically over the past three years. If you believe in this structural change, how do you think this spending slowdown will impact the success of ACA?

Grace-Marie: There is no question that the ACA has stimulated major structural changes in the health care delivery system. The industry is consolidating, hospitals are buying doctors' practices, and health insurers are trying to squeeze more generous health benefits into plans with tighter medical loss ratios.

The recent slowdown in the growth of national health expenditures has occurred before the major provisions of the ACA go into effect, and the slowdown began even before President Obama was elected. Therefore it is difficult for proponents of the ACA to claim a cause and effect.

Avik Roy of the Manhattan Institute explains two factors that are primarily responsible for the slowdown: "Whatever you think of Obamacare, however, there are two far more convincing reasons why health spending has slowed," he writes. "The first is the Great Recession, which has slowed health spending around the world. The second is

that Americans are now much more responsible for their own health spending, a development that has made them more frugal."

Roy writes that, "Overall, growth in health spending in the developed world has declined since the onset of the Great Recession, and that's the most obvious explanation for why health spending growth has declined in the U.S. since 2008." He says that on a relative and absolute basis, "U.S. health spending growth rate has increased in 2010 and 2011, relative to 2009."

Prof. Cutler is correct that another likely factor in the spending slowdown is the fact that Americans are paying more directly for the cost of their own health care and coverage in the form of higher deductibles and premiums.

The real test of the ACA will be with the American people. Then-candidate Obama promised in 2008: "I will sign a universal health care bill into law by the end of my first term as President that will cover every American and cut the cost of a typical family's premium by up to \$2,500 a year." Costs have soared by more than \$3,000 instead, and the CBO estimates that approximately 30 million people will remain uninsured after the law takes full effect.

The ACA is trying to do too much, too fast, with too much bureaucracy and disruption. Major changes are likely so that health reform better comports with our market-based economy and consumers' desire for more and better choices of affordable coverage. ■

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