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The ACA@5

An Actuarial Retrospective

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Published by the Health Section Council
of the Society of Actuaries

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Prologue

By Jim Toole and Carmen Easterwood

In the years leading up to health reform and the passage of the Patient Protection and Affordable Care Act (ACA) in the United States, it was clear to health actuaries that major changes were urgently needed. The U.S. system of health care finance and delivery was characterized by unequal access to care and high costs, without delivering the corresponding outcomes that might justify such expenditures. In this environment—where no side of the cost-access-quality “iron triangle” was being satisfactorily addressed—in 2009 the Health Section of the Society of Actuaries sponsored an essay contest for actuaries to consider key health policy issues and propose solutions. Health actuaries deal on a day-to-day basis with the intricacies of health care delivery and have a deep understanding of how the nuances of financing affect cost, access, and quality of care.

The 29 essays produced for this contest covered a range of health care issues in which actuaries have interest and expertise and about which they care deeply. Two broad strategic issues were a common thread through all of the essays:

High uninsured rates: In 2007, the Census Bureau estimated that 45 million Americans (approximately 15 percent) were uninsured. This is a major barrier to health care access, and the uninsured are known to forgo necessary health care. This is harmful on both an individual and societal level, as it results in higher rates of morbidity and mortality for the uninsured and in some cases those around them (e.g., someone who cannot afford care for a contagious disease passes it to others). Furthermore, access to care varies greatly across so-

cio-economic groups, and the uninsured are concentrated among low-income and minority households.

Rising costs: Controlling costs is a more intractable issue than extending access. The United States consistently spends more on health care than any other developed country but does not provide proportionately high-quality care. OECD estimates show that in 2009—the year before the ACA was passed—U.S. health care spending topped 16 percent of gross domestic product (GDP). Objectives include reducing spending on unnecessary or ineffective care (estimated to be as high as 30 percent of overall spend) and will involve some form of cost sharing with individuals so that consumers do not become desensitized to its cost.

Actuaries also considered more specific insurance issues that were creating challenges in the

delivery and finance of health care. These included matters such as:

Expensive coverage for small businesses: The employer-based health insurance system was an unintended consequence of post-WWII tax policy, and it was a costly one for smaller employers. Small group health coverage has historically been more expensive due to smaller risk pools, higher per-person administrative costs for the policy, and the business’s lower negotiating power with the insurer.

Non-transportability of coverage: Since the majority of Americans obtain health coverage through their employer, leaving or losing a job also means losing health coverage. Being unemployed or self-employed could mean coverage is unavailable or prohibitively expensive, discouraging entrepreneurship.



Fragmented risk pool: Americans can obtain health coverage through their employers, the individual insurance market, Medicare, Medicaid, or not at all. Those without coverage can be separated into those who cannot afford coverage and those who choose to forgo it. Thus the market is very fragmented, increasing costs and the ability for risk pooling mechanisms to function properly.

In their essays, health actuaries proposed solutions to these and other issues affecting delivery and financing of health care. Their proposals integrated basic insurance principles with the goal of improving cost, access and quality. Some proposed broad-based reforms to health financing, such as:

- Making insurance mandatory
- Making everyone eligible for insurance (i.e., no denials or termination of coverage)
- Linking individuals' health care payments to their ability to pay, such as by subsidizing premiums; and out-of-pocket costs on a sliding scale
- Placing limits on out-of-pocket spending for necessary care
- Increasing risk classification.

Other actuaries addressed the relationship between health care financing and tax policy. Premiums for employer-based insurance are paid with pretax dollars, while premiums on individual policies are not. This is

a disincentive for individuals to obtain coverage and an incentive for employers to provide richer benefits, encouraging unnecessary care. Ideally, the tax code would also integrate with any cost-reduction systems put in place for low-income households.

Some actuaries proposed specific reform schemes, such as creating a public-private system similar to Medicare Advantage for the entire population. Others outlined improvements to the provider reimbursement system, changes in pricing to promote preventive care, and risk adjustment schemes that would shift money toward sicker and more vulnerable individuals.

Some of the issues covered in these essays would go on to be addressed in the ACA of 2010. Remarkably, the following principles anticipated by actuaries were ultimately incorporated into the ACA:

- Individual mandate
- Guaranteed issue (non-deniability of coverage)
- Sliding scale of premium subsidies
- Out-of-pocket spending limits
- Risk adjustment mechanism.

Other issues raised by actuaries were indirectly addressed by the ACA. For example, the ability of health insurers to classify consumers by health risk was severely restricted by the ACA, but the need for risk classification was simultaneously made

much less acute by the individual mandate. This requirement removes some of the adverse selection issues that arise when individuals can choose whether to participate in a risk pool.

In commemoration of the five-year anniversary of the passage of the ACA, the Society of Actuaries has put together a new series of articles on the bill and its implementation. The following essays will review several technical aspects of the ACA, examining how the intent of the regulations compares to reality, and what we can expect to see in the next five years. We expect that actuaries will continue to play a key role in the implementation of the ACA as it evolves and adapts in the future, and to continue thinking and writing about the systemic changes that may still be needed. ■

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The ACA's Medical Loss Ratio Provisions: Looking Back

By Rowen Bell

In the first months following the enactment of the Patient Protection and Affordable Care Act (ACA), one of the most significant statutory provisions drawing the immediate attention of the actuarial community was the newly created Section 2718 of the Public Health Service Act. Titled “Bringing Down the Cost of Health Care Coverage,” Section 2718 created a new requirement, effective as of 2011, where insurers would rebate a portion of premiums for individual and group medical coverage in the event that the insurer were to report a medical loss ratio (MLR) below a certain threshold. As such, although the term “MLR” does not itself appear in Section 2718, the reporting and rebate requirements created therein are usually referred to (in industry circles, at least) as the ACA’s MLR provisions.

While the majority of this article will focus on Section 2718, toward the end we will discuss two other sections of the ACA where MLR calculations play a role. One is Section 1103 of the ACA’s companion bill, the Health Care and Education Reconciliation Act of 2010 (HCERA); it creates a similar MLR threshold and remittance process for Medicare Advantage (MA) plans, effective for

2014. The other is ACA Section 9016, which created ties between the tax benefits enjoyed by some health insurers (primarily, Blue Cross Blue Shield [BCBS] plans) under Section 833 of the Internal Revenue Code and Section 2718 MLR reporting.

SECTION 2718 AND THE ROLE OF STATUTE VERSUS REGULATION

As these words are being written, insurers are getting ready to file their fourth year of federal MLR reports under Sec-

tion 2718 and preparing for their fourth annual cycle of administering rebates of premiums to policyholders based on those federal MLR calculations. When compared with so many of the other facets of the ACA, MLR reporting and rebate administration feels like a mature and well-understood process.

In that light, it’s interesting to step back and look at which portions of the now-familiar construct were actually pre-ordained by the statutory language, and which were the creation of an intensive and consultative regulatory process in 2010 and 2011—a process in which actuarial participation, both nonpartisan (via the American Academy of Actuaries’ MLR Regulation Work Group, which I had the honor of chairing) and partisan (via actuaries directly advising reg-

ulators and participating in insurance industry lobbying efforts), was critical.

If we step back to review the bare statute itself, shorn of the light in which we are now accustomed to interpreting it, here’s what we see:

- Insurers offering individual or group health insurance coverage need to submit, for each “plan year,” a report about “the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.”
- In this report, earned premiums shall be adjusted for payments or receipts relating to the 3Rs, and shall also be adjusted for “Federal and State taxes and licensing or regulatory fees.”



Different regulatory choices could have led to fundamentally different implementations of Section 2718.

- The report would show how the adjusted earned premiums are split between three major categories: “reimbursement for clinical services provided to enrollees,” “activities that improve health care quality,” and “all other non-claim costs.”
- For purposes of determining whether rebates might be owed, the relevant MLR ratio involves earned premiums adjusted for the 3Rs and for taxes and fees in the denominator, and the sum of reimbursement for clinical services and amounts spent on quality-improving activities in the numerator.
- Rebates are to be provided “with respect to each plan year” and “to each enrollee under such coverage, on a pro rata basis.”
- For purposes of determining whether rebates might be owed, the MLR as determined above is to be compared against an MLR threshold of either 80% or 85%, depending in some fashion (see discussion below) on whether the individual or small group markets are involved.
- There is no discussion in the statute about the level of granularity at which these MLR calculations are to be made. However, the statute does provide that a state could by regulation impose a higher MLR threshold than the standard 80%/85%, and does give the Department of Health and Human Services (HHS) the ability to downwardly

adjust the 80% threshold for a particular state to address concerns about the stability of the individual market in that state. These references suggest that MLR calculations would, at the least, be state-specific.

- If the MLR is below the threshold, then the amount of rebates owed is equal to the adjusted earned premiums multiplied by the difference between the applicable MLR threshold and the reported MLR (which, arithmetically, treats the rebates as though they were a claim—the rebates are the additional amount of claims that the insurer would have needed in order to report an MLR equal to the threshold).
- Starting in 2014, for rebate calculation purposes the MLR is to be determined using three-year average values, rather than one-year values.
- The National Association of Insurance Commissioners (NAIC) was given a specific role to develop technical recommendations, subject to the certification of HHS, about how to define the methodologies for these MLR calculations. Particular mention was made that the methodologies ought to consider “the special circumstances of smaller plans, different types of plans, and newer plans.”

As this recitation demonstrates, certain aspects of today’s federal MLR construct—the fact that the federal MLR would differ from the traditional ra-

tio of incurred claims to earned premiums, or the fact that expenses on quality-improving activities would be highlighted for special treatment—are inherent in the statute, while others—the concept of credibility adjustments, or the separation of an insurer’s book of business into state/market cells for rebate purposes—are the pure product of the regulatory process. This highlights the notion that different regulatory choices could have led to fundamentally different implementations of Section 2718.

To that end, I wanted to take the opportunity as we look backwards on the first five years of the ACA to talk about two very plausible interpretations of the MLR statute that weren’t made—two of the many paths not taken, in the process of breathing life into the statutory MLR provisions via the issuance of implementing regulations.

The first topic relates to when the 80% MLR threshold applies for rebate purposes versus when the 85% threshold applies. Of course, it is well known that the 80% threshold applies to coverage in the individual and small group markets while the 85% threshold applies to coverage in the large group market. One might think I’m

mad to suggest that this could have been a debatable point.

However, the statutory language is far from clear-cut. What the statute actually says is that the 80% threshold pertains “with respect to a *health insurance issuer* offering coverage in the small group market or the individual market” (emphasis added). It does not say, for instance, that the 80% threshold pertains “with respect to *coverage offered* in the small group market or the individual market by a health insurance issuer”—which would be a far more natural way of tying the threshold to the type of coverage. Instead, by focusing the sentence around the word “issuer” the enacted language leaves open an alternate, and arguably more natural, interpretation: Namely, that the MLR threshold is supposed to be an attribute of the issuer based on the markets in which it chooses to participate, rather than an attribute of the market.

Moreover, one can imagine reasons why the framers might have wanted to structure the MLR statute in such a way—to incent issuers to offer products in the more highly regulated individual and small group markets. Under this alternate, issuer-centric reading of Section 2718, an issuer that only

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participates in the large group market in a given state would use the 85% threshold—whereas, an issuer that elected to participate in the individual and/or small group markets in that state would get to apply the 80% threshold across all of its business in that state, *including its large group business*. This could serve as a strong incentive for an issuer with a profitable large group block in a particular state to participate in that state's individual or small group markets—and encouraging broad participation in those markets by issuers was, surely, a legislative objective.

As much sense as this interpretation of the statute may make in a vacuum, it is pretty clear that, at the time of enactment, nobody in government believed that this is how Section 2718 was intended to operate. Although some of the comment letters to the government's April 2010 request for information (RFI) on Section 2718 pointed out that having the MLR threshold be an attribute of the issuer rather than of the market was a very plausible interpretation of the statute, it was already quite clear within the RFI document itself that the government believed the intent was for a market-based threshold—and all of the subsequent development of regulations assumed that implicitly. Readers are welcome to draw their own parallels between this situation and the controversy, brewing furiously as of this writing, over whether tax subsidies apply with respect to a federally-facilitated exchange.

There were a number of key areas in which regulators made important and intelligent decisions to create something highly operational out of the statutory language.

The second path not taken involves how to wrap one's head around the specific reference in the first sentence of Section 2718 to "loss adjustment expenses (or change in contract reserves)."

Many people in industry believed that the intent behind these words' inclusion in the statute was for both loss adjustment expense (LAE) and the change in contract reserves to be included in the numerator of the federal MLR. And on technical grounds, there are sound reasons why you might want to include both amounts when defining an MLR used to determine premium rebates.

Taking the latter concept first: In the pre-ACA individual market, products were typically priced to achieve a particular lifetime loss ratio, and it was quite common for an issuer to expect to see radically different loss ratios at different policy durations, in light of the intersection of the impact of medical underwriting at policy issuance and the issuer's renewal rate increase strategy. Many issuers would hold contract reserves in order to achieve a more level emergence of expected profit by policy duration over the lifecycle of a policy, rather than front-load profits into the

earlier durations where the effect of underwriting was still dampening morbidity. In this context, if the annual change in contract reserves was not taken into account in the federal MLR calculation, then an issuer with a relatively new block of individual insurance might find itself obliged in a particular year to rebate premiums that were intended to fund contract reserves. In addition to seeming unfair on general principles, this in particular could have served as a significant disincentive for issuers to keep offering new policies in the individual market during the period between enactment and 2014.

The argument for why one might want to include LAE in a rebate-oriented MLR calculation is perhaps more subtle, and has two main thrusts. One thrust is maintaining equity across "different types of plans" (a relevant consideration under the statute). Here the key observation is that the per member per month (PMPM) cost of claims adjudication for a health insurance policy is more or less independent of that policy's actuarial value (AV), because the issuer adjudicates all health care services including those for which the issuer's responsibility is zero due to member cost-sharing features of the pol-

icy. As a result, if you look just at the ratio of claims to premiums, low-AV policies will naturally experience lower ratios than high-AV policies, because the fixed PMPM cost of claims adjudication represents more in percentage-of-premium terms for low-AV policies than it does for high-AV policies. This phenomenon would make low-AV policies more likely to require rebates and thereby less attractive to issuers. Having the ability to include LAE in the numerator of the federal MLR would be one way of making the playing field more level between high-AV and low-AV plans. The other thrust is also an equity play, but between different types of health insurance issuers. All else being equal, issuers employing capitated or staff models will report higher claims and lower amounts of LAE than issuers employing other managed care models. Allowing all issuers to calculate rebates based on the ratio of claims + LAE to premiums would avoid tipping the playing field in one particular direction.

Divining the real statutory intent, however, was clouded by two aspects of the statute's construction. The first was the awkward parentheses in the phrase "loss adjustment expenses (or change in contract reserves)"—awkward because when one sees the phrase "A (or B)" one typically expects that A and B are either synonyms, or mutually exclusive concepts—but neither is true here. This created doubt in some minds as to whether the framers really understood what they were trying to say when they wrote this sentence. The second was

the fact that the remaining text in Section 2718 uses completely different jargon than what is used in the first sentence: For instance, the first sentence talks about “incurred loss (or incurred claims)” while the remainder of the section talks about “reimbursement for clinical services.” As a result, there was no explicit reference to either LAE or the change in contract reserves in the portion of Section 2718 that discussed how rebates would be calculated.

In the end, regulators split the baby, allowing the change in contract reserves to be included in the numerator of the federal MLR calculation, but not allowing LAE to be included. Obviously if LAE had been included, then reported federal MLRs would have been much higher, and rebates would have been significantly less likely. Interestingly, the November 2009 draft of Section 2718 did not include the “loss adjustment expenses (or change in contract reserves)” language, and instead used rebate thresholds of 75%/80% instead of 80%/85%—and, furthermore, that language was added to the draft bill at the same time that the thresholds were increased to 80%/85%, in December 2009. This anecdotal piece of legislative history certainly lends credence to the notion that somebody involved in the development of the statute had once envisioned that LAE would be included in the MLR numerator; but in the end, that’s not the way the cookie crumbled.



KEY REGULATORY CHOICES IN IMPLEMENTING SECTION 2718

Notwithstanding the discussion above about possible alternative interpretations of the statute, it is clear that there were a number of key areas in which regulators made important and intelligent decisions to create something highly operational out of the statutory language. I will highlight six such areas.

“Plan Year”

As noted earlier, the statute talks about having issuers submit an MLR report for each “plan year” and having issuers provide premium rebates “with respect to each plan year.”

The use of the term “plan year” as the temporal unit was of some initial concern among industry circles because, if taken literally, it could lead to a regime where the issuer is continually submitting MLR reports and administering rebates—one report for every cohort of policies sharing the same policy anniversary date. Such a regime could also have

been confusing for consumers: imagine a person with a March anniversary contract from a particular issuer getting a rebate while his neighbor with an April anniversary contract from the same issuer did not get a rebate, because the two policies were in different cohorts, reporting different MLRs to federal regulators.

Instead, the regulators took a very pragmatic view, deeming that for purposes of Section 2718 the term “plan year” meant “calendar year,” notwithstanding the fact that “plan year” was given a different meaning in other ACA provisions. This had the considerable practical advantage of aligning the annual MLR reporting to federal regulators with issuers’ annual financial reporting to state regulators, and making MLR reporting and rebate administration a once-per-year event for issuers.

It also had the curious effect of making Section 2718 a retroactive provision of the law, in the following limited sense. The statute said that rebates would

be owed for plan years starting January 1, 2011 or later. By deeming that plan year equals calendar year for this purpose, the implication was that all of an issuer’s premiums earned in 2011 would be potentially subject to rebates. Some of those 2011 earned premiums pertained to policy years that started prior to the ACA’s enactment, e.g., the January and February 2011 premiums for a contract effective March 1, 2010; while some other premiums earned in 2011 pertained to policy years that started post-enactment but where rates were set pre-enactment. As a result, an issuer’s ability to adjust its pricing in order to achieve the 80%/85% MLR thresholds for calendar year 2011 was somewhat limited by the fact that, by the time the ACA was enacted (let alone by the time the technical details of MLR calculations were hashed out), it had already set its premiums for a material fraction of its calendar year 2011 business. This phenomenon is one of the reasons why total rebates paid out in mid-2012 based on calendar year 2011 experience were much higher than those for subsequent years.

“Reimbursement for Clinical Services”

As discussed above, while the first sentence of Section 2718 used the familiar language “incurred claims,” the later and more substantive portions of the section instead used a term, “reimbursement for clinical services provided to enrollees,” that was not heretofore part of standard industry jargon.

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Once again, regulators took a pragmatic approach, deeming that “reimbursement for clinical services” and “incurred claims” were synonyms, but then making a few modifications from traditional statutory accounting definitions of incurred claims. One such modification I alluded to above, namely the inclusion of the change in contract reserves as part of reimbursement for clinical services.

Other important modifications related to situations where regulators wanted to forestall the possibility that administrative expenses could be transformed into claims by bundling them within amounts paid to third-party vendors for certain types of outsourced services. In the end, important supplemental technical guidance was offered by HHS via a series of question & answer documents—technically, an example of something called “sub-regulatory guidance,” as it did not go through the normal federal rulemaking process. Of particular interest in this regard was Q&A #20 from February 2012, which established a four-prong test under which an issuer’s payments to a clinical risk-bearing entity would be deemed to be incurred claims for MLR purposes. Ultimately, each issuer has needed to go through a process to evaluate whether there are items the issuer routinely included in incurred claims but that need to be excluded from the federal MLR numerator; however, those excluded amounts have generally not been material.

Granularity

Insurance is, at its core, a risk-pooling mechanism. When

thinking about a scheme where a portion of premiums collected may be refunded to policyholders based on experience, the level of granularity at which those calculations are made is of paramount importance. There is an entire spectrum of possible choices for MLR granularity, from the policyholder level at the one extreme, to the holding company level at the other. Where ought regulators draw the line?

This was clearly one of the more serious questions faced during the regulatory process. As noted above, the statute provides a couple of tiny clues regarding intent: First, by saying that MLR reports are to be submitted by each health insurance issuer (i.e., by each regulated legal entity rather than by a holding company); and second, by noting that a state could impose MLR thresholds higher than the federal 80%/85% standard, which seems to require state-specific MLR reporting. When you couple this with the statutory interpretation that the MLR threshold is market-specific, you get pretty quickly to a conclusion that a logical minimum granularity level would involve distinct combinations of legal entity, state, and market.

One could certainly imagine going more granular than entity/state/market; for example, one could require separate MLR reporting and rebate calculations for on-exchange versus off-exchange products, or for different metallic tiers, or for different product filings. One could also imagine going less granular, particularly in

the large group market, where industry lobbied for greater latitude to mix business across states and entities in recognition of prevailing industry practices (a typical example cited by industry involved a large national account where nationwide PPO coverage is offered by one legal entity, HMO coverage is offered in various cities by various other affiliated legal entities, and premiums are socialized across the entire case). But, different granularity levels create trade-offs: Rebates based on lower granularity levels could threaten the notion of insurance as risk-pooling, while higher granularity in calculating rebates may lead to undesirable opportunities for cross-subsidization.

In the end, entity/state/market is where the regulators ended up. A minor exception was put in place to allow commingling across entities in the not-uncommon situation where an HMO legal entity writes in-network coverage while an affiliated PPO entity writes the corresponding out-of-area coverage.

While reasonable on paper, this framework nevertheless created a number of administrative challenges for issuers, particularly with respect to the precise definitions of how to determine the “state” and “market” for each policy. Some insurers had previously built their financial reporting systems around a very different notion of geography than the one adopted in the federal MLR regulation, which was based on the state in which the contract was issued and delivered. Other insurers did not

have clear delineation of small group versus large group in their financial reporting systems—and even if they did, the insurer’s definition of the boundary between small versus large was generally aligned with state-level definitions that differed from the federal definition applicable for MLR purposes. Insurers typically found themselves needing to ask many of their group customers for supplemental information about employee counts in order to determine whether the group ought to be considered “small” or “large” for federal MLR reporting.

Credibility Adjustments

Historically, health insurers have borne full exposure in both directions to the impact of random variation of actual experience relative to pricing assumptions. If morbidity was lower than expected due to statistical fluctuation, the insurer enjoyed better-than-expected gains; and, conversely, the insurer experienced worse-than-expected gains if statistical fluctuation led to higher morbidity.

The imposition of rebate requirements fundamentally changed that equation. It remains the case that insurers are exposed to the downside from statistical fluctuation; however, the upside from statistical fluctuation may now accrue to the benefit of policyholders rather than insurers, via increased rebates. And since the potential impact that statistical fluctuation has on the MLR of a block of business decreases as the size of the block increases, left unchecked this phenomenon

could create a sustained competitive advantage for larger issuers over smaller issuers.

Recognizing this, the regulators adopted a mechanism known as the credibility adjustment, in an effort to address “the special circumstances of small plans” as required by the statute. In the MLR regulation, the credibility adjustment takes the form of an additional amount that the issuer gets to add to the numerator of an MLR calculation, based on the size of the entity/state/market pool as well as on the average deductible level within that pool. Equivalently, one could think of the credibility adjustment as being a reduction in the applicable MLR threshold; for instance, if the credibility adjustment for a particular issuer’s small group pool in a particular state is 3%, then in effect the MLR threshold for that particular pool is not 80%, but rather $80\% - 3\% = 77\%$.

An analogous credibility adjustment had existed for some time in the regulatory Medicare Supplement refund calculation (which is based on cumulative lifetime loss ratios). In the commercial MLR context, the Academy work group that I chaired played a role in raising the concept with regulators, based on some statistical fluctuation modeling that actuaries from one major insurer (Humana) serving on the work group had done using their company’s own experience and brought to the work group’s broader attention. The Academy was certainly not in a position to vouch for the technical accuracy of those calculations or the applicability of the underlying

company-specific dataset to the industry as a whole, but we did feel like the concept was meritorious and that the results of the company’s modeling were worth sharing with regulators for illustrative purposes. Ultimately, the NAIC commissioned an actuarial report from Milliman, using a similar methodology applied to a broader industry dataset in Milliman’s possession, and that report formed the basis for the credibility adjustment in the MLR regulation.

While there was widespread recognition that some form of credibility adjustment was technically appropriate, there was considerable disagreement as to how large the adjustments ought to be. The issue at hand (quoting from the preamble to the federal regulation) was how to “equitably balance the consumers’ interest in requiring plans that should pay rebates to pay rebates against the issuers’ interest in minimizing the risk of paying rebates as a result of chance variations.” The regulators selected an approach where the theoretical chance of a “false positive”—payment of rebates due to random chance even though the unobservable “true underlying MLR” was equal to the stated threshold before credibility adjustment—was 1 in 4; industry had advocated for larger credibility adjustments intended to reduce the chance of such a false positive to 1 in 10.

Treatment of Taxes

As noted above, the statute specifically states that for rebate calculation purposes, the MLR shall be calculated after

removing “Federal and state taxes and regulatory fees” from premiums.

Qualitatively, there are several distinct types of taxes/fees that could fall under the auspices of “Federal and state taxes and regulatory fees,” such as:

1. State premium taxes
2. Income taxes (both federal and state)
3. New federal taxes and fees created by the ACA, e.g., health insurer fee, exchange fees
4. Regulatory assessments, e.g., high-risk pool assessments
5. Other general federal and/or state taxes, e.g., payroll taxes.

On policy grounds, there are two distinct reasons why it makes perfect sense, in the context of an MLR calculation used to determine rebates, to exclude many types of taxes from the denominator.

The first reason relates to achieving equity across different types of issuers. Some issuers are exempt from federal income taxes, while most are not, and others may pay federal income taxes as a reduced tax rate (see subsequent discussion about ACA Section 9016). There may also be reasons why the rates of certain non-income taxes, such as premium taxes and the ACA health insurer fee, differ among distinct classes of issuers. If all issuers were held to the same MLR thresholds, and the MLR calculation didn’t adjust for these types of tax differences, then the issuers with

more preferential tax treatment would get a competitive advantage, because they wouldn’t need to fund (as much) taxes out of the retained portion of premiums. Allowing these taxes to be excluded from the MLR denominator makes it more equitable to apply a single common MLR threshold for rebate purposes to all types of issuers across all geographies.

The second reason relates to thinking about where the MLR thresholds ought to be set. Presumably, the legislative decision to set the thresholds at 80%/85% was based at least in part on issuers’ historically reported experience. To the extent that the ACA created a number of new taxes and fees that issuers would need to incorporate into their rate structure, it was reasonable for the framers of the statute to expect that, under the traditional claims-over-premiums definition of MLR, post-ACA MLRs would be lower than pre-ACA MLRs due to these new taxes and fees. Rather than attempt to anticipate the impact of those fees on future MLRs in selecting the statutory MLR thresholds, it would be cleaner and more flexible to simply exclude those new fees from the MLR denominator.

These policy considerations make it attractive to include, at the least, the first three categories listed above as part of the regulatory definition of “Federal and state taxes and regulatory fees.” However, during the regulatory process there were parties arguing for both a more expansive and

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less expansive reading of that phrase. Arguing for a less expansive reading were six of the key Congressional Democrats involved in the passage of the ACA, who signed a letter sent to HHS in August 2010 opining that the sole intent of this wording was to allow the new taxes and fees created by the ACA to be removed from the MLR denominator. On the other side, industry argued that the words needed to be taken at face value, implying that every type of federal or state tax or fee could be removed from the denominator, including items in the last category above like payroll taxes.

Back in late 2010, regulators took the more literal view, allowing all forms of taxes and regulatory fees to be removed from the MLR denominator. More recently, a February 2015 regulation backtracked very slightly on this: Effective in 2016, issuers will no longer be allowed to exclude payroll taxes from the MLR denominator. (According to HHS, most issuers had not been excluding payroll taxes.)

Once it was decided that issuers would get to exclude federal income taxes from premiums for federal MLR reporting purposes, a key question remained unaddressed in the regulation: How exactly should an issuer allocate income taxes to rebate pools? The central (but not only) problem here is how the issuer should, or should not, think about the interaction between rebates and income taxes.

To start, consider an issuer whose entire business consists of individual medical policies written in one state, so that it has one pool for MLR reporting purposes and no other business. That issuer's reported federal income taxes will be derived from the underwriting gain of its sole block of business; so, it would seem natural to allocate all of the issuer's income taxes, whatever they might be, to this pool in that pool's MLR report. But, any rebates owed to customers in that pool would be a tax-deductible expense to the issuer, and hence would impact the issuer's income taxes. The income taxes in turn impact the issuer's reported federal MLR, and hence the rebate. So, we're in an intrinsically circular situation: The income taxes impact the rebate, which impacts the income taxes, et cetera.

Similar considerations hold for any issuer. But as it turns out, if you assume that the issuer's income tax rate is known, then this circular situation actually has a closed-form solution: One can derive a formula that calculates the rebate for a pool as a function of the MLR threshold as well as the issuer's premiums, claims, tax rate, and allocated expenses.¹ (In practice, the income tax rate would depend on the rebates rather than be known for certain in advance, but iteration of the calculations would allow convergence to an answer.)

This may be clever, and goodness knows that as actuaries we gravitate toward the clever; but is it practical? Many in industry felt that it was not, and that

the only practical course was to allow issuers to allocate income taxes to blocks of business based on underwriting gain before rebates. This would eliminate any circularity between the allocation of income taxes to rebate pools and the calculation of MLRs and rebates for those pools. As it happens, this noncircular approach to income tax allocation also leads, as a matter of math, to lower rebate levels than the circular approach.²

Remarkably, to my knowledge there is nothing in all of the regulatory and sub-regulatory guidance issued by HHS in 2010 and 2011 that touches on whether the circular or noncircular approach to income tax allocations ought to be used in MLR reporting. However, two things have become clear over time, with the effect that by now the circular approach to income tax allocation is purely of academic interest.

The first is that, prior to year-end 2011 MLR reporting, industry had coalesced around using the noncircular approach, citing as their support a single sentence that was included in the NAIC's October 2010 Model Regulation providing its technical recommendations on federal MLR: "All terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates..."

The second is that, by no later than March 2013, HHS had recognized the legitimacy of the noncircular approach to

income tax allocations for federal MLR reporting purposes. The preamble to a regulation issued that month specifically cited the NAIC sentence quoted above in explaining why the noncircular approach was used in MLR calculations, in the context of justifying why a similar noncircular approach was being adopted with respect to risk corridor calculations.

Rebate Administration

As noted earlier, the statutory language calls for issuers to provide rebates to "each enrollee." This specific reference to the "enrollee" rather than the "policyholder" as the intended rebate recipient caused quite a bit of concern within the industry, from an administrative implementation standpoint.

In draft regulations issued in late 2010, HHS put forward a proposal where if an issuer owed a rebate for a pool of group business, then the issuer would need to take each employer group's rebate and apportion it between an amount that the group would get to retain versus amounts that would need to be sent to each employee that had coverage during the year in question, based on their relative contributions to the premiums received by the issuer.

This proposal may have seemed equitable to regulators as a matter of policy, but it reflected an apparent lack of understanding of normal operating procedures in the health insurance industry. The proposal seemed to presume that, as a matter of course, issuers would have ready access to accurate employee-level

information regarding how the premiums paid by the employer group had been funded; whereas in reality, issuers had never needed to collect that information, since from the issuer's standpoint the entirety of the group's premium is provided directly by the employer and the internal funding thereof is not relevant (except, possibly, in broad strokes as an underwriting criterion). It also turned out that unintended tax consequences could arise if the issuer were to directly rebate premiums to employees, to the extent that a Section 125 cafeteria plan had been used to allow employees to pay their share of premiums using pretax dollars.

As a result, during 2011 industry started going down two paths simultaneously. One path involved trying to build the operational capability to collect and store information about all of its group customers' premi-

um contribution formulas, so that in the event rebates were owed the apportionment proposed in the draft regulations could be performed. The other path involved trying to convince federal regulators that the proposed approach was workable and that they ought to allow the issuer to give the entire rebate to the employer and let the employer figure out what to do with it, in a manner consistent with the employer's obligations as a benefit plan fiduciary under ERISA.

In the end, regulators responded to industry's concerns, thereby avoiding some significant administrative challenges for industry. The final MLR regulations issued in December 2011 created a framework whereby issuers would turn the entire rebate over to the group policyholder, who would then need to abide by certain regulatory constraints on what to do with that rebate.

LIVING UNDER SECTION 2718

In light of the various practical interpretations discussed above, I think most parties would acknowledge that the final MLR regulations struck a suitable balance between the interests of consumers and the interests of issuers. Left unresolved in the regulations themselves, however, were some questions about how various stakeholders would behave in a world where all commercial insurance is now subject to MLR-based rebate requirements.

As a matter of theory, the introduction of rebate requirements transforms the risk/return environment for issuers. Think of an issuer as being a portfolio of different blocks of health insurance business, serving different markets and different geographies. Historically, each block within the portfolio was subject to both upside and downside

risk, and the issuer enjoyed risk diversification benefits by having assembled a portfolio, to the extent that some of the risk factors inherent in the blocks were not perfectly correlated across markets and geographies; poor experience in some blocks was often offset by better-than-expected experience in others. As such, in the past it would have been reasonable to think of an issuer's portfolio of health insurance blocks as being analogous to an investor's portfolio of stocks. With the introduction of rebate requirements, however, the issuer remains fully exposed to downside risk but now enjoys only limited exposure to upside risk, because past a certain point excess gains need to be returned to policyholders via rebates. This suggests that, in the post-ACA environment, a better analogy would be to liken an issuer's portfolio of health insurance blocks to an investor that has written naked put options on a variety of stocks, capturing a capped return in upside scenarios while remaining exposed to large losses in downside scenarios. Viewed in financial economics terms, rebate requirements have made health insurance a somewhat different, and arguably less attractive, business than it once was.

This can be seen from a pricing perspective, in slightly different terms. Suppose you're pricing a product with best estimate assumptions so as to achieve a federal MLR that is exactly equal to the applicable threshold (e.g., 80% for individual business in a fully credible pool). Deterministically, your expected rebates to customers

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under those best estimate assumptions are zero. But probabilistically, the expected value of customer rebates is surely nonzero, because you're averaging across upside scenarios (where rebates are zero) and downside scenarios (where rebates are nonzero). The expected value of rebates in the situation where the issuer is pricing right at the MLR threshold might be equal, say, to 70 basis points of premium. This "cost" is probably not an explicit component of the issuer's pricing, but instead is implicitly buried within the issuer's desired pricing margin target.

This line of reasoning suggests that an economically rational issuer might prefer to embrace rebates rather than seek to avoid them. Suppose that instead of pricing to achieve a federal MLR equal to the rebate threshold, the issuer priced to achieve a federal MLR 300 basis points below the threshold (e.g., 77% instead of 80%). (Returning to the financial economics analogy, it's like writing deep-in-the-money naked puts instead of at-the-money naked puts.) Now, the issuer would be expecting to issue rebates in the vast majority of scenarios, and so the asymmetry of the situation is largely mitigated. The expected value of rebates in this situation might be, say, 320 basis points; so, relative to the hypothetical of the previous paragraph, on average the issuer has been able to preserve an additional 50 basis points of premium as margin.

Four or five years ago, one could have imagined that this might be how the health insurance industry would naturally evolve

in response to the introduction of ACA rebate requirements: Intentionally conservative initial pricing, so that rebates were very much an expected event, with a failure to pay out rebates only occurring in exceptionally adverse circumstances—not unlike what one sees with mutual life insurers, with respect to nonguaranteed policyholder dividends.

Of course, that didn't happen. And certainly one (necessary but not sufficient) reason it didn't happen was stances taken by regulators in the rate review process. Nothing in Section 2718 indicates issuers need, or even ought, to price their products under the assumption that federal MLRs will meet or exceed the rebate threshold. However, for the most part regulators chose to treat the rebate MLR thresholds as if they were pricing standards.

Since issuers were in practice unable to consider implementing a pricing philosophy under which rebates became a routine expectation, it is wholly unsurprising that total industry rebate levels have consistently fallen since enactment. Rebates paid in 2012 based on 2011 experience were in excess of \$1.1 billion; of course, as noted earlier, many of the premiums

collected in 2011 were priced before MLR requirements were enacted. Rebates paid in 2013 dropped to \$504 million, reflecting not only that issuers had additional time to adjust their pricing so as to achieve the MLR threshold, but also that 2011 happened to be a year in which the industry in general overestimated actual trend, which is precisely the type of scenario that leads to larger rebate payments. Payments under the third year of rebate requirements declined even further, to \$334 million. Another factor that may have influenced the decline in rebate payments over this period is the phase-in of multiyear MLR averaging from 2011 through 2013.

Another concern that some people had circa 2011, but does not appear to have materialized, was the risk that customers and/or regulators would challenge issuers' calculations of rebate amounts after the fact. As we've discussed, in determining the amount of rebates owed to a particular pool of customers, the issuer has needed to do a lot of things that it wasn't already doing: allocating groups as small versus large based on federal definitions; allocating customers to states using federal rules; allocating income taxes across blocks of

business; et cetera. Surely, one thought, in the fullness of time there would be lawsuits alleging that certain classes of customers ought to have received rebates but didn't, or alleging that rebates had been calculated incorrectly. However, if there has been that sort of activity, it has not made its way onto my personal radar screen. Federal audits of issuers' MLR filings could, in principle, lead to astronomical fines: the statutory cap for monetary penalties is \$100 per day for each individual impacted by an entity's violation, which in principle could eat through even the healthiest issuer's surplus. In practice, even though three annual filing cycles have elapsed, we're still in the early innings when it comes to regulatory audits of MLR filings and understanding the consequences thereof.

Similarly, another common concern in the immediate wake of Section 2718's enactment was from the producer community, who was very nervous that issuers might squeeze producer compensation in an effort to meet the new MLR thresholds. This led to a wave of lobbying activities from producers, a politically potent constituency in many states. A 2011 House bill that would have amended Section 2718 to allow issuers to exclude producer commissions from the MLR denominator attracted 221 co-sponsors but died in committee.

In the end, looking back after five years one might conclude that the introduction of commercial MLR rebates did not turn out to be a particularly transformative event for the health insurance industry. Reg-

Viewed in financial economics terms, rebate requirements have made health insurance a somewhat different, and arguably less attractive, business than it once was.

ulators took reasonable stances in implementation; adjustments have been made; and no “parade of horrors” has materialized.

Yes, the industry needed to make considerable administrative investment in order to facilitate rebate calculations and payments; and yes, there have been material amounts of money returned to consumers that in the absence of the ACA would have been retained by the industry; and yes, on the margins the introduction of MLR thresholds may have had a negative impact on some issuers’ ability to remain competitive; and yes, there may have been some compression of broker compensation by issuers seeking to rationalize their expense structure in light of MLR thresholds. But all in all, I think it is fair to conclude that the industry has adapted to this new aspect of the regulatory landscape with minimal adverse consequences—a result that is a testament to the care taken by regulators to achieve a balanced implementation of an ambiguous statute.

SECTION 1103: MLR AND MEDICARE ADVANTAGE

HCERA Section 1103, titled “Savings from Limits on MA Plan Administrative Costs,” added new language to Title XVIII of the Social Security Act, which governs the Medicare Advantage (MA) program.

The main thrust of this new language is that, starting with contract year 2014, any MA plan that reports an MLR below 85% needs to return a portion of its revenues to HHS. Note that there are no rebates

to policyholders contemplated in the MA MLR statute; the potential payments to HHS are referred to as “remittances” rather than rebates. There are secondary clauses in the statute that impact repeat offenders: An MA plan that reports an MLR below 85% for five straight years would see its contract terminated, while one reporting an MLR below 85 percent for three straight years would face marketing restrictions.

Of course, the statutory language neglects to define the term “medical loss ratio,” so naturally there was a need for regulatory guidance. For the most part, the draft regulations on MA MLR issued by HHS in 2013 intentionally mirrored the regulatory framework described above for commercial MLR—another example of a pragmatic regulatory decision. Below I highlight three areas where the MA MLR regulations deviate slightly from those developed for commercial MLR.

Granularity

There was some confusion at first as to whether the statutory language really applied only to MA plans, or whether it ought to be construed as applying also to stand-alone Medicare Part D prescription plans. Ultimately HHS concluded that, as a matter of law, the minimum MLR requirements would also apply to stand-alone Part D because they had been incorporated into Section 1857(e) of the Social Security Act, a subsection with which Part D plans were already required to comply.



Having made that determination, the question still remained as to the level of granularity at which MLR reporting and potential remittances to the Centers for Medicare & Medicaid Services (CMS) should be calculated. Here the regulators concluded that, given the existing regulatory framework of MA, the most natural level of granularity was the H-contract (for MA) or S-contract (for PDP) level. This level of granularity has some conceptual similarities to the entity/state/market framework used in commercial MLR, although there are certainly some situations in which this approach will end up being less granular (e.g., a national MA PPO contract) or more granular (e.g., an HMO entity that has multiple H-contracts within the same state) than what entity/state/market would have produced.

Credibility Adjustments

The credibility adjustment concept from commercial MLR was also adopted as part of the MA

MLR regulations. One difference was that the actuarial study used to justify the magnitude of the credibility estimates was not performed by a consulting firm (and made publicly available), but rather was performed by CMS’ Office of the Actuary (OACT) (and kept private).

Curiously, the OACT study concluded that the impact of block size on statistical fluctuation was more pronounced for MA plans than it was for stand-alone Part D plans: An H-contract was deemed to have fully credible experience at 15,000 members, whereas an S-contract was not deemed to have fully credible experience until 30,000 members. This conclusion seemed counterintuitive, to the extent that one normally thinks of medical claims as being subject to greater variability than drug claims. With the OACT study not having been made public, however, interested parties were not well-in-

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tioned to second-guess regulators' judgment.

Treatment of Part D Reinsurance

One of the principles underlying the development of the commercial MLR regulations was fidelity to existing statutory accounting guidance on what constitutes revenues and claims, albeit with some defined exceptions.

In an MA context, adherence to that principle would have implied that neither low-income cost sharing (LICS) subsidies nor Part D reinsurance would be included in the MLR numerator or denominator, as under statutory accounting both are considered to be self-insured elements of a partially insured plan and therefore are excluded from earned premiums and incurred claims.

However, the regulators concluded that for federal MLR reporting purposes, Part D reinsurance amounts would be included in both the numerator and denominator, whereas LICS amounts would be omitted from both. The preamble to the draft MA MLR regulations contains relatively little discussion as to why CMS reached this conclusion, other than the following terse statement: "Part D reinsurance is more appropriately classified as a cost-based reimbursement methodology than reinsurance, per se, and as such is appropriately treated as revenue."

The fact that Part D sponsors get to include an S-contract's Part D reinsurance amounts in both the MLR numerator and denominator creates a signifi-



cant upward boost to the federal MLR compared against the MLR reported in statutory financial reports, and seems to make it exceedingly unlikely that remittances would ever be owed on S-contracts. The same issue helps boost the federal MLR reported for H-contracts too, of course, but in a less material way. Having said that, the first round of MLR reports for MA plans will not be submitted until later in 2015, so as of yet there is no actual data on the actual impact to industry of the MA MLR requirements.

SECTION 9016: MLR AND BCBS PLANS' TAX BENEFITS

ACA Section 9016 added language to Section 833 of the Internal Revenue Code, a section that was added as part of the Tax Reform Act of 1986 in order to make Blue Cross Blue Shield (BCBS) plans subject to federal income tax for the first time.

As enacted, the new language stated that, starting in 2010, "this section [i.e., Section 833] shall not apply to any organiza-

tion unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85%."

Although this language obviously only impacts a subset of health insurance issuers, it was of deep interest to those impacted organizations. Ultimately, and very recently, those organizations' lobbying efforts were successful in achieving an exceedingly rare feat: an amendment to an ACA provision that was passed by the Republican-controlled Congress and signed into law by President Obama.

To understand why this statute was so important to certain companies and why a technical amendment was sought, there are two separate themes we need to explore: the benefits that BCBS plans receive from Section 833; and the ambigu-

ities inherent in the Section 9016 language.

First, let's talk about the benefits that BCBS plans may receive from being taxed under Section 833—although I should emphasize that I am not a tax professional! At the risk of over-simplifying, there are two particularly important provisions. One, known colloquially as "deemed status," is that a BCBS organization is automatically deemed to be a stock insurance company for federal taxation purposes, even if it wouldn't qualify under the normal rules to determine whether or not a company gets to use the special tax rules for insurers. Being taxed as an insurer is important in that it allows a company to take deductions for claims expenses on an incurred basis rather than on a cash basis. The other is that a BCBS organization may be eligible for something called the "833(b) special deduction," which insurers not falling under Section 833 do not get. In practice, the effect of the 833(b) special deduction has been that, even as

we approach the three-decade mark since BCBS plans first became taxable, many BCBS plans get to pay federal taxes at the 20% corporate alternative minimum tax (AMT) rate rather than at the normal 35% corporate rate.

With this in mind, a BCBS plan could face two significant adverse consequences if it were to fail the Section 9016 MLR test and thereby lose the benefits of Section 833. One is that it could lose its special deduction, and hence its tax rate might increase from 20% to 35%. The other is that it could lose deemed status, and hence it would need to demonstrate that it qualifies for tax treatment as an insurance company on other grounds. Some BCBS plans, particularly those who have more administrative services only (ASO) customers than they do fully-insured customers, were uncertain as to whether they would qualify as an insurance company in the absence of deemed status. And if you've been taxed as an insurance company for many years, but one day you wake up and it's determined that you're no longer an insurance company for tax purposes, then all of the deductions that you've taken over many years for your claim reserves might need to be unwound all at once, resulting in a massive tax bill—not a pleasant thought.

Next, let's talk about the specific language used within Section 9016. On the one hand, there is an explicit reference to the amounts that the organization reports under Section 2718, creating some type of tie be-

tween this MLR test and the commercial MLR reporting discussed above. On the other hand, a BCBS plan would typically be filing a single tax return covering one or more health insurance issuers, and therefore covering multiple entity/state/market combinations for which separate MLR reports were filed under Section 2718, as well as other types of health insurance business (e.g., Medicare Supplement) not covered under Section 2718. So, there was clearly a need for regulatory guidance to explain how the various MLR reports submitted under Section 2718 would be used to determine whether or not the overall taxable entity passes the 85% MLR threshold of Section 9016. In addition, notwithstanding the reference to Section 2718, the language found in Section 9016 was not in perfect alignment with Section 2718. For instance, there's no reference in Section 9016 to expenses on quality-improving activities, nor is there a reference to taxes, fees, and amounts related to the 3Rs as items that would be excluded from premiums.

As a result, there was tremendous uncertainty about the impact in practice of Section 9016, and large dollar amounts potentially at stake depending on the interpretation. Senior executives at one large BCBS plan told me, circa 2011, that minimizing the uncertainty relative to Section 9016 implementation and achieving a desirable outcome—via either regulation or legislation—was their company's top ACA-related lobbying priority.

In the end, the IRS regulations finalized in January 2014 gave the impacted organizations much, but not all, of what they had hoped to achieve. Under the regulations, the MLR test for Section 9016 purposes is a single calculation summing across all relevant entity/state/market combinations filing MLR reports under Section 2718 (and hence ignoring other lines of business like Medicare Supplement); the numerator and denominator are the same as in the Section 2718 reports, except that for Section 9016 purposes the regulations stipulated that the numerator could not include expenses on quality-improving activities. Also, the regulations concluded that if an entity failed to meet the test in one year but then met it the next year, then it could re-qualify as a Section 833 organization; that is, failing the test did not imply permanent loss of Section 833 benefits. However, the regulations did contain a significant defeat for the impacted organizations, as they stated that deemed status was indeed one of the Section 833 benefits that an organization would lose if it failed to meet the test in a given year.

With the IRS regulations in final form, the impacted organizations appear to have refocused their efforts on achieving a legislative fix. Which they did, in December 2014, via Section 102 of the so-called "Cromnibus" bill—the Consolidated and Further Continuing Appropriations Act, 2015. The relevant provision, representing less than half a page buried within a 1,600-page bill, amends the language that had

been added to the Internal Revenue Code via ACA Section 9016.

Now, instead of saying that "this section shall not apply" if the 85% MLR is not achieved, the amended language says that "paragraphs (2) and (3) of subsection (a) shall not apply." Since the concept of deemed status is found in Section 833(a) (1), the implication of this amendment is that a BCBS organization is always entitled to deemed status, even if it does not achieve an 85% MLR in a given year. Consequently, and after four-and-a-half years of concerted effort, the impacted organizations have permanently mitigated a significant source of income tax uncertainty emanating from the ACA and its MLR reporting requirements. In addition, the amendments also added language implying that this MLR numerator does include expenses on quality-improving activities, thus fully aligning the MLR metric with Section 2718. ■

ENDNOTES

- ¹ See slides 31-32 of a presentation the author made in 2011 at a meeting of the Chicago Actuarial Association: http://chicagoactuarialassociation.org/archives/A1_CAA2011_MLR.pdf.
- ² For an illustration, see the author's 2011 Valuation Actuary Symposium slides, available from the SOA website.



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Health Care Reform: Essential Health Benefits and Actuarial Value

By Catherine Knuth

The essential health benefit (EHB) requirements of the Patient Protection and Affordable Care Act (ACA) significantly impacted the landscape of benefit plans offered in the individual and small group markets by prescribing the benefits that must be covered, implementing limits on annual cost sharing (and, temporarily, on small group deductibles), and limiting benefit plans based on the percentage of estimated costs covered by the plan (i.e., bronze, silver, gold and platinum tiers).

Section 1302 of the ACA defines an “Essential Health Benefits Package” as coverage that:

- Provides EHBs
- Complies with certain cost-sharing limitations
- Provides a prescribed level of coverage, as measured by the plan’s actuarial value (AV).

All non-grandfathered individual and small group policies beginning on or after Jan. 1, 2014, are required to provide the EHB package. (This requirement was later revised to exclude “transitional” non-grandfathered individual and small group policies, which are policies that were in effect

on Oct. 1, 2013, thus allowing individuals and small groups who wanted to remain on pre-ACA policies to do so.)

In addition, the U.S. Department of Health and Human Services (HHS) determined that all non-grandfathered coverage, including large group and self-funded plans, was required to comply with the annual cost-sharing limitation portion of the EHB package requirements (discussed in more detail below).

ESSENTIAL HEALTH BENEFITS (EHBs)

The ACA itself requires that EHBs include coverage of the 10 categories shown in the table in Figure 1 and instructed HHS to consider the following when developing their full definitions:

- Scope equal to the scope of benefits provided under a typical employer plan.
- Appropriate balance among each of the 10 categories in Figure 1 “so that benefits are not unduly weighted toward any category.”
- Avoidance of discrimination (via coverage decisions, reimbursement rates, incentive programs or benefit design)



- related to age, disability or life expectancy.
- Allowance for the health care needs of diverse segments of the population, such as women, children, and people with disabilities.
- Prevention of denial of benefits on the basis of a person’s age, life expectancy, disability (actual or predicted), degree of medical dependency, or quality of life.
- Provision of coverage for emergency department services without requiring prior authorization or any limitation on place of service (i.e., provider network), including cost-sharing differentials.
- Periodic review of the EHB definition to determine whether:
 - Cost or coverage barriers to accessing needed services exist.
 - The definition needs to be revised to account for changes in “medical evidence or scientific advancement.”

Figure 1
ACA Essential Health Benefits, 10 Required Service Categories

1. Ambulatory patient services	6. Laboratory services
2. Prescription drugs	7. Maternity and newborn care
3. Emergency services	8. Preventive and wellness services and chronic disease management
4. Rehabilitative and habilitative services and devices	9. Mental health and substance abuse disorder services
5. Hospitalization	10. Pediatric services*, including oral and vision care

* Ultimately defined as services for individuals under the age of 19 years.

State determination of EHBs:

In response to the ACA's directive, HHS asked the Institute of Medicine (IOM) to recommend a process to help HHS define benefits that should be considered EHBs and periodically update the benefits as prescribed by the ACA. Based on the IOM's recommendations, HHS established a process by which a state would select a "base-benchmark plan"—an existing plan that might need to be adjusted to meet all EHB requirements. The adjusted "base-benchmark plan" is called the "EHB benchmark plan" and serves as a reference plan that reflects the scope of services and service (not cost-sharing) limits for carriers offering non-grandfathered individual and small group coverage. The EHB benchmark plan in each state was to apply for at least the 2014 and 2015 benefit years and now applies for 2016 as well. In February 2015, HHS released guidance for states to make EHB benchmark plan changes for 2017.

Each state was allowed to select one of the following types of health plans as its base-benchmark plan:

- The largest plan in any of the three largest small group products in the state's small group market
- Any of the largest three state employee health benefit plans
- Any of the largest three Federal Employees Health Benefits Program (FEHBP) plan options

- The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

If a state did not select a plan, the base-benchmark plan for that state defaulted to the largest plan in the largest product in the state's small group market. Ultimately, the base-benchmark plan in 44 of the 50 states is a small group plan. Four of the remaining states selected a commercial HMO and two selected a state employee plan.¹

Because many base-benchmark plans did not include coverage of all 10 prescribed categories, states were required to add the missing category from another base-benchmark plan option to create the EHB benchmark plan. For example, most employer plans did not cover pediatric dental and/or vision services, so almost every state had to supplement these services and most did so with Federal Employees Dental and Vision Insurance Program (FEDVIP), although 21 states used the pediatric dental coverage from their Children's Health Insurance Program (CHIP).² Three states had to add mental health coverage (all three used FEHBP coverage).

Another category that presented difficulties was "habilitative" services because many pre-ACA plans did not specif-

ically define or provide coverage for them. As a result, if the base-benchmark plan did not include habilitative services (21 did not), HHS allowed states to determine the services to be included in this category. If a state chose not to define habilitative services, issuers are required to cover habilitative services that are similar in scope, amount and duration to benefits covered for rehabilitative services. Alternatively, an issuer was allowed to provide HHS with a list of the habilitative services it intended to cover.

The ACA explicitly permits states to require issuers to offer benefits in addition to EHBs but requires them to make payments (to the enrollee or issuer) to defray the cost of the additional benefits.³ As such, state-mandated benefits that were enacted on or before Dec. 31, 2011, (regardless of when effective) can be considered EHBs in that state. Such benefits would apply in the same way they applied in 2011 (e.g., a benefit required in the individual market but not in the small group market would be considered an EHB only in the individual market, not in the small group market).

At each state's discretion, issuers are allowed to substitute benefits (or sets of benefits) that are actuarially equivalent to the benefits being replaced,

subject to the nondiscrimination requirements. Substitution is only allowed within one of the benefit categories (i.e., not between categories) in order to comply with the requirement that benefits are not unduly weighted toward any category. However, substitution within the prescription drug category is not allowed.

Finally, an issuer is not allowed to include the following services as EHBs:

- Routine non-pediatric dental services
- Routine non-pediatric eye exam services
- Non-medically necessary orthodontia
- Long-term/custodial nursing home care.

EHB changes for 2016/2017: HHS' Notice of Benefit and Payment Parameters for 2016, issued on Feb. 20, 2015, makes the following EHB changes:

- **Definition/clarification of habilitative services:** Beginning with the 2016 plan year, issuers will no longer be allowed to define the habilitative services covered by the plan (and notify HHS). Instead, HHS has adopted a uniform definition of habilitative services to be used by states and issuers, although states are allowed to maintain their previous definitions. The goal of this change is to minimize variability in benefits and lack of coverage for habilitative services versus rehabilita-

Most employer plans did not cover pediatric dental and/or vision services, so almost every state had to supplement these services.

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tive services. In addition, plans are not allowed to impose limits on coverage of rehabilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. For plan years beginning on or after Jan. 1, 2017, issuers must impose *separate* limits on rehabilitative and rehabilitative services.

- **Coverage of pediatric services:** Coverage of pediatric services must continue until the end of the month in which the enrollee turns 19.
- **Examples of possible discriminatory plan designs:** Since the original EHB rules were finalized, HHS has become aware of benefit designs they believe discourage enrollment based on age or health conditions—making the plans discriminatory. For example, a plan imposing an age limit on hearing aids (e.g., only covered up to six years of age), placement of drugs into the formulary tier with the highest cost sharing, or not having a certain drug on the formulary can discriminate on the basis of health conditions.
- **Prescription drug coverage:** Currently, plans are required to cover the greater of one drug per U.S. Pharmaceutical (USP) category or class or the same number of drugs in each USP category and class as the state’s EHB benchmark plan. Because USP was developed for Medicare, issuers have a hard time complying with this require-

ment (e.g., some drugs used for non-Medicare populations aren’t on the list, newly approved drugs aren’t counted, some drugs weren’t counted in multiple USP classes, etc.). In its proposed Notice of Benefit and Payment Parameters for 2016, HHS considered replacing this drug count standard with a requirement that plans adopt a pharmacy and therapeutics (P&T) committee and use that committee to ensure that the plan’s formulary drug list covers a sufficient number and type of prescription drugs. The final notice, however, adds the P&T committee requirement to the USP drug count requirement and specifies standards related to P&T committee meetings, membership, range of drugs included on formulary drug list, etc. The new approach will be required for plan years beginning on or after Jan. 1, 2017.

- **Base-benchmark plans:** Each state will be allowed to select a new base-benchmark plan for 2017 using 2014 plans.

COST-SHARING LIMITATIONS

The ACA defines cost sharing as “any expenditure required by or on behalf of an enrollee with respect to essential health benefits.” As such, ACA-prescribed cost-sharing limits apply to deductibles, coinsurance, copays and similar items, but do not apply to premiums, balance billing for out-of-network providers, or services that aren’t covered by the plan.

Annual limit on cost sharing: The ACA places a cap on the amount of cost sharing an enrollee can incur each year for in-network EHBs. HHS initially (in November 2012) proposed that these annual limits on cost sharing prescribed by the ACA (i.e., out-of-pocket (OOP) maximums)—see the table in Figure 2 for amounts—were applicable only to non-grandfathered individual and small group plans effective on or after Jan. 1, 2014. In its final rule, HHS clarified that the annual limits apply to all group health plans, including large group and self-funded plans.

For 2014, the annual limit on cost sharing was the OOP limit for high-deductible health plans (HDHPs) per the Internal Revenue Code. After 2014, the annual limitation on cost sharing increases by a “premium adjustment percentage,” which is set by HHS. Figure 2 displays the annual cost-sharing limits for 2014, 2015 and 2016.

Figure 2

ACA-Mandated Annual Cost-Sharing Limits, 2014-2016

Plan Year	Self-Only Coverage	Non-Self-Only Coverage
2014	\$6,350	\$12,700
2015	\$6,600	\$13,200
2016*	\$6,850	\$13,700

* Beginning in 2016, a family HDHP cannot require an individual in the family plan to exceed the annual limitation on cost sharing for self-only coverage.

quently asked questions (FAQs) document allowing plans extra time to administer the annual cost-sharing limit across all EHBs. For the first plan year beginning on or after Jan. 1, 2014, the annual limit on cost sharing was considered satisfied for carriers using multiple administrators if both of two conditions are met:

1. The plan complied with the annual limit for its major medical coverage.
2. Any separate OOP maximum on other, non-major medical coverage (e.g., the prescription drug coverage administered by a separate entity) did not exceed the ACA’s annual cost-sharing limit. If the other non-major medical coverage did not have an OOP limit, the plan was not required to add one for this transition year. It was noted, however, that plans had to continue to comply with existing mental health parity regulations.

Small group deductible limits: The ACA prescribed that, beginning in 2014, deductibles for non-grandfathered small group plans cannot exceed \$2,000 for self-only coverage and \$4,000 for non-self-only coverage. Recognizing the difficulty this

On Feb. 20, 2013, recognizing that many issuers use separate (often subcontracted) companies to administer a portion of their benefits (e.g., prescription drugs, mental health), the U.S. Departments of Labor, HHS, and the Treasury issued a fre-

limit placed on designing a bronze plan (see the AV section below for more information), HHS allowed issuers to use a deductible greater than the \$2,000/\$4,000 maximum “if it cannot reasonably reach a given level of coverage (metal tier) without doing so.” As a result, many small group bronze plans and even some small group silver plans had deductibles that exceeded the \$2,000/\$4,000 maximum.

Originally, HHS proposed that the small group deductible limit for plan years after 2014 be increased by the same “premium adjustment percentage” used to establish the annual limitation on cost sharing and in the final 2015 Notice of Benefit and Payment Parameters, increasing the limit to \$2,050/\$4,100. However, on April 1, 2014, the Protecting Access to Medicare Act of 2014 repealed the limit on small group deductibles.

ACTUARIAL VALUE REQUIREMENTS

The ACA defines “actuarial value” as the percentage of expected EHB costs a health plan will cover for a standard population. AV can be described by this formula:

Anticipated Plan-Paid Allowed Charges for EHB Coverage for Standard Population

Anticipated Total Allowed Charges for EHB Coverage for Standard Population

For example, a plan whose AV is 80 percent is anticipated to cover 80 percent of a standard member’s costs for EHBs and the member is expected to cover the other 20 percent through cost sharing.

For plan years beginning on or after Jan. 1, 2014, plans must be categorized as bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV) or platinum (90 percent AV) in order to be sold in the individual or small group market (except for grandfathered plans and “transitional” plans as described at the beginning of this article). Each plan must qualify for one of these metallic tiers by having an AV that meets the applicable de minimis AV range shown in the table in Figure 3.

Figure 3
ACA-Prescribed AVs for Metallic Tiers

Metallic Tier	Prescribed AV	De Minimis AV Range
Bronze	60%	58%-62%
Silver	70%	68%-72%
Gold	80%	78%-82%
Platinum	90%	88%-92%

In addition, an issuer may offer a catastrophic plan, which does not technically have an AV. Catastrophic plans are sold in the individual market to enrollees under the age of 30 or others for whom insurance is deemed unaffordable. While there is no AV requirement for catastrophic plans, there are several benefit design requirements:

- The deductible must equal the annual cost-sharing limit for the year (\$6,850 for 2016).
- At least three primary care visits must be covered before the deductible has to be satisfied.
- There can be no cost sharing for preventive services.

An issuer has two options if it determines the AVC doesn’t appropriately handle a particular benefit design.

Cost-sharing reduction (CSR) variations: Each silver plan offered in the individual on-exchange market must have an associated set of CSR variation plans that have lower member cost sharing than the standard silver plan. Enrollees with in-

The 73 percent CSR variation plan must also have an AV that differs from the associated standard silver plan’s AV by at least 2 percent. Therefore, if the standard silver plan’s AV is 71 percent, the 73 percent CSR variation plan’s AV must be at least 73 percent.

Actuarial Value Calculator (AVC): Issuers are required to use HHS’ AVC to qualify a benefit plan as bronze, silver, gold or platinum (or one of the CSR variations), with certain exceptions (discussed below).

The AVC is a Microsoft Excel tool that calculates the AV for a given benefit plan using claims continuance tables based on a standard population that has been determined to resemble enrollees in the 2014 individual and small group markets (for the 2014 AVC). Because utilization of health care services is influenced by the level of member cost sharing, the AVC uses a separate continuance table for

comes below 250 percent of the Federal Poverty Limit (FPL) are eligible to enroll in one of these CSR variation plans and the issuer is reimbursed for the cost-sharing difference by HHS. These variation plans have a smaller de minimis range and lower annual cost-sharing limits than standard plans, as shown in the table in Figure 4.

Figure 4
ACA-Prescribed AVs for CSR Variation Plans

Income	2016 Annual Cost-Sharing Limit*	Prescribed AV	De Minimis AV Range
100%-150% FPL	\$2,250/\$4,500	94%	93% - 95%
150%-200% FPL	\$2,250/\$4,500	87%	86% - 88%
200%-250% FPL	\$5,450/\$10,900	73%	72% - 74%

* Self-only/Non-self-only

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Figure 5
Implied Impact of Cost Sharing on Utilization in the AVC (2014-2016)

Metal Tier	Medical	Prescription Drug	Total
Platinum	14%	29%	17%
Gold	7%	15%	9%
Silver	1%	14%	3%
Bronze	0%	0%	0%

each metallic tier. The table in Figure 5 displays the implied impact of cost sharing on utilization of services, relative to the bronze plan, in the AVC (2014-2016).

The AVC user inputs various cost-sharing amounts (deductible, coinsurance, OOP maximums, copays, certain copay limits) and then runs a macro to obtain the plan’s calculated AV and qualifying metallic tier (or a message indicating the calculated AV is outside the de minimis range for one of the metallic tiers).

The underlying enrollment and claims data used to develop the 2014 AVC was 2010 experience data for commercial insurance plans nationwide, supplemented by separate data sources to fill in missing EHBs (e.g., pediatric vision and pediatric dental), and trended to 2014. Because plan design information was not available to the developers of the AVC, they used algorithms to impute cost sharing and then grouped plans by their implied AVs. In addition, HHS determined that, because such a small percent of total costs are incurred by non-network providers, the AVC only considers in-network services and cost sharing.

An issuer has two options if it determines the AVC doesn’t appropriately handle a particular benefit design:

1. **Adjust the inputs:** Adjust the benefit design inputs to fit the parameters of the AVC.
2. **Adjust the outputs:** Use the AVC for the benefit design components that fit the parameters of the AVC and then calculate appropriate adjustments to the resulting AV for unique plan design features.

The use of either alternative requires a member of the American Academy of Actuaries to certify that the approach is in accordance with generally accepted actuarial principles and methodologies. In addition, any adjustments made to AVC inputs or outputs must exclude out-of-network benefits.

Because of limitations of the data underlying the AVC, several features common to commercial benefit plans aren’t directly addressed in the AVC:

- As mentioned earlier, the AVC does not consider out-of-network benefits or cost sharing.

- The AVC does not account for the impact of family deductible limits. For plans with high deductibles and, especially, plans with aggregate family deductibles, these limits can have a material impact on AV.
- The AVC cannot accommodate outpatient surgery copays unless the user converts the copay to an effective coinsurance.
- The AVC cannot accommodate plan designs in which both a copay and coinsurance apply to prescription drug benefits.
- For services subject to the plan deductible and a service-level copay, the 2014 AVC assumed copays apply before the deductible, which is uncommon in pre-ACA benefit plans and can have a material impact on a plan’s true (or pricing) AV. Note: The 2016 AVC, released in January 2015, allows the user to specify, at a service level, whether the deductible applies before or after copays.

In addition, the use of continuance tables and some of the AVC algorithms resulted in counterintuitive AV results. Many of these issues have been at least partly resolved in the 2016 AVC, as discussed below. In August 2013, the American Academy of Actuaries released an exposure draft of a *Minimum Value and Actuarial Value Determinations Under the Affordable Care Act* practice note, which provided nonbinding guidance

to actuaries for handling plan designs not accommodated by the AVC. In December 2014, the Actuarial Standards Board released an exposure draft of a proposed Actuarial Standard of Practice (ASOP), *Determining Minimum Value and Actuarial Value Under the Affordable Care Act*, which addresses many of the same issues.

It is important to note that the AVC is intended to assist in the design and, more importantly, qualification of a benefit plan as bronze, silver, gold or platinum. Because the AVC inputs and calculations are simplified for this purpose, it is not intended as a pricing tool, especially because it does not consider the following variables, which can have a material impact on expected costs and, therefore, pricing:

- Contracted provider discounts
- Cost of services provided by non-network providers
- Degree of health care management
- Prescription drug formulary
- Age/gender mix
- Geographic area
- Pent-up demand
- More detailed service category splits
- More precise measurement of the impact of cost sharing on utilization of services
- Other morbidity adjustments
- Family cost-sharing limits.

2016 AVC Updates

Per 45 CFR 156.135(g), HHS can make the following changes to the AVC:

- Update the maximum amount that can be entered into the OOP Maximum field to comply with changes in the annual limit on cost sharing
- Update the continuance tables to reflect more current claims and/or enrollment data
- Annually trend the claims data when such a trend adjustment would result in an increase of no less than 5 percent
- Update the AVC algorithms to accommodate new benefit plan designs
- Update the user interface if the change would “be useful to a broad group of users” of the AVC, would not affect its function, and would be technically feasible.

HHS initially released a revised AVC for 2015 that used the same underlying continuance tables (not trended) but corrected some of the calculation algorithms that caused counterintuitive results for 2014. After soliciting feedback on the proposed 2015 AVC, HHS chose to finalize the 2014 AVC with no changes for the 2015 plan year (other than an updated annual cost-sharing limit) to minimize market disruption (i.e., to avoid benefit changes between 2014 and 2015).

In addition to increasing the OOP maximum, the 2016 AVC includes many of the algorithm changes originally proposed for 2015, including allowing the user to specify whether the deductible applies before service-level copays. In addition, the underlying claims data has been trended an additional two years to 2016 at 6.5 percent per year.⁴ As a result, it is likely that many plans that qualified in one of the metallic tiers for 2014 and 2015 will need to be modified to qualify in 2016. The trending of the underlying claims data alone has been shown to produce a 1.5 to 2 percent increase in AV for many plans.

CONCLUSION

The ACA’s impact on the benefit designs of health plans now offered to individuals and small groups is already evident. As the new markets continue to evolve, actuaries are becoming better at navigating the new landscape created by ACA requirements, including the critical impact of AV on health plan designs. But the changes remain dynamic and unpredictable. We continue to need the input and guidance of the actuarial profession to understand the nuances and issues involved in using the AVC. Actuaries can help health insurers meet ACA requirements and even attempt to insulate them from labor-intensive annual benefit plan updates. (For example, at present it appears that it might be efficient to design plans with an eye toward the bottom of the de minimis ranges.) As actuaries

continue to work with the AVC, they should provide feedback to HHS so that the calculator continues to improve in accuracy, usefulness and appropriateness for emerging benefit designs. The Centers for Medicare and Medicaid Services (CMS) can be reached with questions and feedback related to the AVC at actuarialvalue@cms.bhs.gov. ■

ENDNOTES

- ¹ Kaiser Family Foundation (Jan. 3, 2013). Essential Health Benefits (EHB) Benchmark Plans, as of January 3, 2013. State Health Facts, Retrieved Feb. 18, 2015, from <http://kff.org/health-reform/state-indicator/ehb-benchmark-plans/>.
- ² Per HHS’ final rule on EHBs and AV, issuers are not required to include the pediatric dental EHB in their plans if a stand-alone dental plan (SADP) is available in the exchange.
- ³ State-required benefits are interpreted by HHS to be “specific to the care, treatment, and services that a state requires issuers to offer to its enrollees. Therefore, state rules related to provider types, cost-sharing, or reimbursement methods” would not be included in the interpretation of state-required benefits for purposes of determining costs to defray.
- ⁴ Centers for Medicare and Medicaid Services (Jan. 16, 2015). Memo: RE: Final 2016 Actuarial Value Calculator Methodology.



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A Regulatory Perspective on Rate Review Before and After the Affordable Care Act

By Annette James and Jaakob Sundberg

INTRODUCTION

The implementation of the Patient Protection and Affordable Care Act (ACA) launched the regulatory rate review actuary into an alternate universe similar in many ways to the magical Land of Oz. Will we emerge from it unscathed, safe in our beds with a smile on our faces reminiscing about a magical land of flying URRTs¹ and AV calculators,² or will there be an alternate ending to this story?

As much as we wanted to be holed up with Auntie Em in the storm cellar, rate review regulators were caught up in the same ACA whirlwind as everyone else. SCOTUS³ dropped the house⁴—and squashed the “wicked” rating practices of the past, the effective rate review slippers are on, and we’re off to see the wonderful wizard of CCHIO.⁵

In theory, regulatory actuaries have been asked to perform the same job as before the ACA—rate review—but virtually every aspect of the job has changed. Toss the state insurance code book you have used, studied, memorized, and relied on for years (but not too far just in case the make-up of Congress and the executive branch changes). The old rules don’t

apply (unless you are reviewing a grandfathered or transitional plan). Now is the time to prove your mettle as an effective rate review state.⁶

RATE REVIEW PROCESS

In the past, states received rate filings throughout the year and reviewers were able to manage and streamline the rate review process based on state-specific requirements and timelines. The regulator would review the actuarial memorandum, which documented the rate development process for each product submitted, to determine if the rates were reasonable and in compliance with state law and the appropriate actuarial standards of practice.

Under the ACA, all annual rate filings are submitted at once, generally in the late spring/early summer in accordance with federal timelines. Regulators have a three-month window, fondly known as the rate review season, to review hundreds of plans. Due to the single risk pool concept, a carrier now submits one filing for all of its plans in a given market in a state. Therefore, there are fewer filings submitted, but, due to the federal definition of a plan under the ACA, the actual number of plans that need to be reviewed has ballooned. It

is not unusual for a state with a dozen or so separate single risk pool filings to have over 400 plans that need to be reviewed. This has stretched already scarce state resources, and, even in the states that use consulting actuaries to assist in the rate review process, regulatory actuaries have their hands full keeping up with the plethora of regulations and resolving the many technical issues that come up during the rate review process.

Additionally, the amount of information needed to be reviewed in order to satisfy federal and state requirements has also exploded. Regulators are now responsible for reviewing the URRT, which is a federally required data repository intended to demonstrate compliance with the single risk pool requirements, along with the accompanying Part III Actuarial Memorandum. These two documents are important for reviewing the index rate development for compliance with federal requirements but do not necessarily provide sufficient support for the determination of the reasonableness of rates in accordance with federal or state standards. Therefore, many states require carriers to separately submit supplemental information in order to perform a thorough review.

The combination of the voluminous rate filing submissions to be reviewed in compressed time frames results in a less than optimal process in which regulators and carriers perform a circular three-step dance of review/request/submit additional information, which all

ends when the music stops at the allotted end of the rate review season.

Everything associated with the current rate review process is so removed from the way we used to do things that even the familiar seems out of place. Vestiges of the Kansas that we came from are everywhere, but we can’t discern that the URRT is an integral part of rate review any more than Dorothy could tell that the Tin Man is actually the farmhand, Hickory. Similarly, AV is no longer an indicator of pricing differences; the actuarial memorandum does not necessarily provide details of the development of the premium; the ACA version of composite rating for small group plans is almost unrecognizable; and a new plan is not necessarily a new plan under the federal uniform modification rules. Everywhere there are reminders of the old Kansas, but there are sufficient differences to keep us off balance, wondering where indeed this yellow brick road is leading.

Over time, the issues that cause the rate review actuary the most angst have changed. For the 2014 rate review season, lack of compliance with the single risk pool concept, inadequate documentation of the rate development process, and the impact of the 3Rs⁷ were the focus of many animated discussions between regulators and carriers. For 2015, the appropriate calibration of the plan adjusted index rate and the correct application of the uniform modification rules brought new life to those discussions. The 2016 rate review season started with no sin-

gle obvious winner, but as it got underway, two issues surfaced to keep regulators off-balance. We found ourselves still unsure of the correct way to apply the uniform modification rules. Additionally, pricing actuaries are struggling to determine whether to revise 2016 rates (if allowed by the states) to reflect the final 2014 risk adjustment payment information which was released on June 30, more than a month after the 2016 rates were submitted to states for review. Similarly, rate reviewers need to determine if the new information is sufficient to justify an adjustment to the already filed rates for 2016.

ROLE OF THE RATE REVIEW ACTUARY

As the rate review process has become more complicated and stressful, the role of the state regulatory actuary has also expanded. In addition to the traditional role of technical expert, assuring compliance with state and federal law as well as the actuarial standards of practice, state regulators often have to come out of the backroom to educate and communicate with nontechnical audiences. More and more, actuaries are asked to provide information to state officials, consumer groups, the media and the general public to educate and facilitate effective policymaking decisions. Actuaries have to let go of their innate need for precision and accept that the “average rate increase” provided to the media is not really an accurate representation of the actual increase in rates that may be experienced by any one individual or even the average consumer in the state. There is no perfect

As the rate review process has become more complicated and stressful, the role of the state regulatory actuary has also expanded.

measure that would be easy for the public to understand, so this is one example where “close enough” has to be “good enough.”

The review of rates is now more often subject to public scrutiny from individuals who may not be fully fluent in “actuarialese,” the official language of our version of Oz, but have learned enough to explain “adverse selection,” “actuarial value” and “medical loss ratio” with relative ease to their less adventurous counterparts. Actuaries have learned not to cringe when the explanation is not exactly correct and to smile with pride at their students’ accomplishments.

Paradoxically, even though the responsibility of the state regulatory actuary has increased, the actuary’s sphere of control is smaller than ever before. What used to be a purely analytical exercise is now peppered with political overtones. The fact that a rate increase is actuarially justified may not mean that it is politically palatable. The carefully reviewed rates could be changed due to external pressures and the actuary has to meticulously document the results of the actuarial review in order to demonstrate compliance with the actuarial standards of practice if the adequacy or reasonableness of

the final approved rates is ever questioned.

In many states, the rate review actuary is also the protector of the state’s effective rate review status, which is granted by Oz of CCIIO similar to the medal of valor awarded to the lion. Transparency of rate filing information is one of the requirements of keeping the medal, but much of this information has historically been kept confidential in accordance with state law. Additionally, early release of proposed premiums could lead to a “race to the bottom,” which may adversely impact the solvency of carriers, particularly the new entrants to the market—such as co-ops⁸—and ultimately lead to reduced competition.

UNCERTAINTY

State regulators are as curious and uncertain as anyone about where this yellow brick road will take us. We’ve been given one basic instruction: Follow it. The rest we’ve struggled to figure out for ourselves. We’ve all given up recreational reading so that we can instead review every proposed regulation, provide comments through the National Association of Insurance Commissioners (NAIC), and then digest the finalized regulation to discover the changes that we’re expected to enforce for the coming year.

Getting answers from the Wizard is challenging. There is a never-ending stream of conference calls to attend and sometimes the correct SMEs⁹ are unable to attend.

Some uncertainty in the market originated not from the law itself but from a line from a political speech.¹⁰ The invention of transitional policies threw each state into a political quagmire. Is it better to allow some consumers to have a lower-cost plan with fewer benefits, or is it better to shore up the new market with these potentially “better” risks? The decision in some states was likely influenced by political alignment rather than introspection into the potential market effects. By the time the transitional population is integrated into the market, two of the three programs intended to help smooth the transition from a pre- to post-single risk pool will be unavailable. This is particularly worrisome for states with co-ops and other new entrants to the health insurance market that need a solid enrollment base (but not too much) and help from the 3Rs to get their feet under them.

The review of transitional and grandfathered rates is supposed to be back to the way things were, but it just isn’t the same. Plans have to be checked to ensure that there are no benefit changes that void the grandfathered status. The accompanying actuarial memoranda now seem skimpy and uninformative compared to the voluminous Part III memoranda. It’s difficult to separate out the

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market reform requirements and provide a consistent rate review analysis between pre- and post-ACA plans.

The 3Rs have not been the pillars of stability that they were intended to be. The 2015 notice of benefit and payment parameters, which establishes the pricing parameters for the year, sets a reinsurance attachment point of \$70,000. Within a few months, the Centers for Medicare & Medicaid Services (CMS) released separate guidance indicating that the U.S. Department of Health and Human Services (HHS) “intended to propose changes to the reinsurance parameters for 2015,” moving the attachment point to \$45,000. This laid an unsure foundation for 2015 pricing because issuers were uncertain if they were allowed to price using the lower attachment point and regulators were uncomfortable allowing pricing based on an “intention.” Additionally, state regulators had to determine if they would pick either \$45,000 or \$70,000 and only allow that level to ensure uniform pricing, or permit each carrier to choose the attachment point reflecting a company’s rights to price according to its own understanding of the law.

Recent reports on risk corridor payments do not assuage regulators’ fears that funds will be inadequate to cover receivables booked for 2014. Solvency has always been a regulatory concern. However, rate review regulators typically have not had to work intimately with solvency regulators when reviewing pricing assumptions. If a company files substantially the

same plans each year with only a “trend” rate increase from 2014 to 2016, but is booking an enormous risk corridor receivable for 2014 that indicates that the 2014 rates were inadequate, should that be a red flag that the 2015 and 2016 rates may be inadequate? Certainly no company will explicitly price assuming a risk corridor receivable, but states are concerned that some companies are at least tacitly assuming this.

The permanent risk adjustment program has thankfully had the fewest surprise changes. Even so, the concurrent model poses timing difficulties. States are no more privy to individual company risk scores compared to the whole risk pool than the individual companies are. This complicates the task of evaluating year-end expected receivables and payables. Regulators have to decide how much scrutiny they will apply with regard to the accuracy of these booked values. A non-qualified opinion might bring up just as much uncertainty as to the credibility of the values as a qualified opinion.

One of the biggest challenges to thoroughly reviewing rates is the lack of credible post-ACA data. State regulators are chomping at the bit to review 2016 rates since that will be the first time that credible post-ACA experience data will be available. There will finally be a full year’s worth of data to support or negate the reasonableness of key assumptions such as the morbidity of the newly insured and the impact of the 3Rs (although the final risk adjustment and risk corridor

impact will not be known until the middle of the rate review season).

Just keeping up with all of the changes is physically and mentally exhausting. It would sure be refreshing to leave it all behind and go take a nap in a field of poppies.

LACK OF STATE CONTROL

Prior to the ACA, state regulators felt relatively comfortable making ultimate decisions on all aspects of rate filings. We had the backing of the McCarran-Ferguson Act and little in the way of superseding federal regulation to interfere with that confidence. Now, even benign questions like, “Can a company round their rates to the dollar?” have to be sent up to the great and powerful Oz¹¹ of CCIIO for a final determination.

Some state and federal laws directly conflict so that it is uncomfortable for states to sanction pre-eminence. The ACA requires posting of information in the actuarial memoranda that many states would consider proprietary and confidential. State regulators have struggled with trying to determine ways to meet the law’s requirements without posting each company’s “secret sauce” on the state and federal websites.

Accessibility to the wisdom of Oz has been frustrating for states. The timelines set by CCIIO give little room for back and forth, so when questions arise the answers are needed quickly. The process for regulators to get answers from CCIIO has changed over time. At first, states had no more direct meth-

od of contacting CCIIO than individual companies did. Then states were assigned a specific state representative through whom all questions were to be channeled. Now we are back to submitting questions to a general email address. With the changing process, it has been difficult to track down which questions have been asked and which answered. Rather than responding directly to the state, sometimes the answer will be posted to one of several websites (CALT, SERVIS, REG-TAP, zONE) so regulators have to be familiar with these sites and check them frequently.

It turns out that the great and powerful wizard behind the curtain is neither omniscient nor omnipotent, but is a regular, fallible Kansan¹² like the rest of us. Folks at CCIIO are given the charge to answer questions and interpret the law simply by virtue of arriving in Oz a few months earlier than we did. Answers are not immediately forthcoming because there hasn’t been time to contemplate all of the questions being asked.

States have been given opportunities to take back some of the control, but often there is a lack of political will, funding or time. All of these opportunities (state-based exchanges, risk adjustment, reinsurance, AV calculator continuance tables, merged markets) take time to consider. It’s far easier to punt to the federal government when you already feel overwhelmed with current implementation issues that you can’t reassign. States also need data to make some of these decisions and they don’t have it. Many states

are now establishing all-payer claims databases (APCDs) so they'll be better prepared to assess these options.

ROAD AHEAD

As much as we may long for the comfort of the old ways, regulators aren't clicking their heels together just yet. The road so far has been challenging and unexpected, and time will only tell where it will lead.¹³ We certainly haven't reached the end of the rainbow.

King v. Burwell evokes a sense of déjà senti; the unnerving feelings from the summer of 2012 were back in 2015. While that decision is now behind us, could a 2017 summer sequel appear to potentially upend the market again? These long-running cases along with short filing timelines put state regulators in the unpalatable position of reviewing rates multiple times and in an abridged time frame. Should states allow companies to submit multiple sets of rates depending on decisions beyond their control?

As the full reality of the market reforms applicable to the small group market hits, state regulators have to evaluate the merits of self-funding alternatives that allow employers to avoid the ACA market reforms. Traditionally, small employers were too small to absorb the risks associated with self-funding their health benefit plans and wanted the security of a fully funded rate. Now insurance companies are offering very low specific and aggregate attachment points for small employer plans that create a self-funded rate where much of the risk is ceded to a stop-loss

insurer. It is unclear how much risk needs to be retained by the employer in order for a small employer plan to be governed by ERISA¹⁴ rather than state insurance law. Since self-funding of health plans is most attractive to those employers with historically favorable experience, regulators are concerned that if too many small employers go the self-funded route, the fully insured small group market may become a field of poisoned poppies with premium rates spiraling out of control. For that reason, some state regulators are contemplating, or have already made changes to their stop-loss laws to raise the attachment points in an effort to maintain the integrity of the fully insured small group risk pool.

Insurance agencies are also looking for self-funded solutions for their clients. Leveraging the captive insurance markets, agencies establish relationships with their groups through a captive and negotiate stop-loss rates for the conglomerate. The distinction between this type of state-regulated group captive and a Multiple Employer Welfare Arrangement (MEWA) is not well-defined. As more of these arrangements are proposed, regulators in each state must determine the parameters around which these new arrangements will be allowed.

For state regulators the epithet of "there's no place like home" has little comfort because there is no "home" to return to. Rating practices and rate review have changed too much and they're more likely to change again than to stay the same.

The political winds could shift, and we could be blown out of Oz down a rabbit hole with other decisions to make as we gingerly handle a bottle that says, "Drink me." ■

ENDNOTES

- ¹ 45 CFR 154.215(b)(1), Unified Rate Review Template (pronounced "hurt" without the "h").
- ² 45 CFR 156.135 Actuarial Value Calculator.
- ³ The Supreme Court of the United States (SCOTUS).
- ⁴ On June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court upheld two of the main provisions of the ACA—the individual mandate and Medicaid expansion.
- ⁵ The Center for Consumer Information and Insurance Oversight (CCIIO).
- ⁶ 45 CFR 154.301.
- ⁷ Transitional reinsurance, risk corridor and risk adjustment programs created per Sections 1341, 1342 and 1343 of the ACA.
- ⁸ Consumer Operated and Oriented Plans established in accordance with Section 1322 of the ACA.
- ⁹ Subject matter expert (pronounced "smee").
- ¹⁰ "If you like your health care plan, you'll be able to keep your health care plan." President Barack Obama, Green Bay, Wisconsin, June 11, 2009.
- ¹¹ One other commonality between CCIIO and the Wizard of Oz is an inexplicable affinity for acronyms. The wizard's real name is Oscar Zorroaster Phadríg Isaac Norman Henkle Emmanuel Ambroise Diggs, which he shortened to OZPINHEAD, and ultimately to just "OZ" for obvious reasons.
- ¹² This is not a direct reference to the Kansan Kathleen Sebelius.
- ¹³ We are personally hoping to see a flying monkey.
- ¹⁴ Employee Retirement Income Security Act of 1974, as amended.



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The Individual Market and ACA Products: Starting from First Actuarial Principles

By Kurt Wrobel

It has been an amazing five years since the Patient Protection and Affordable Care Act (ACA) was passed. Like many in our profession, I have watched with interest as the public discussion has moved from one ACA-related topic to another. After starting with a broad ideological focus on the proper role of government in health care, the discussion moved to operational concerns regarding the exchange website and now to developing an interpretation of the rate increases associated with the ACA products. This debate has also been played out as court cases have been considered that could materially impact the rules and funding of the exchanges. Unfortunately, as the public discussion has changed, we have not paid nearly enough attention to the long-term sustainability of the exchange—particularly the question of whether health insurers can accurately rate the exchange population once two of the three risk protections are removed.¹

In response, this article will review the ACA exchanges following the elimination of two of the three risk protections (reinsurance and risk corridors) in 2017 according to a set of simple actuarial principles. In addition to defining these core

principles, this article will compare these features relative to the other major lines of business in health insurance. Combining the actuarial first principles with an analysis of the major lines of business, I then make an evaluation of the risk associated with the exchange relative to other product lines. As I suggest, the relative risk assumed under the exchange has the potential to impact the willingness of health insurers to participate on the exchanges in 2017.

ACTUARIAL FIRST PRINCIPLES: CONSIDERATIONS WHEN ESTIMATING THE RISK OF A POPULATION

Although the populations and rating rules differ among the major lines of business, we still have basic characteristics that we look for in rating a population—whether it is an employer group or an individual in a government-sponsored program. These characteristics are the prime determinants on whether a population can be accurately rated and represent the most important drivers on whether an insurance company will accept this risk. These include:

Historical data. The lifeblood of actuarial science is historical data that can be linked to a popu-

lation. This historical claims information provides the most important guidance on the prospective claims costs for a population and—along with a trend estimate—provides the basis for rating a population. Without this historical information, actuaries are typically required to use historical data from another population to serve as a proxy for the covered population. As the connection becomes further removed from the covered population, our estimates become less reliable.

Consistent population. When we have information on a population that is expected to be consistent from one period to the next, our estimates can be accurate and largely relied upon when developing cost estimates. However, if the population is not stable, we have to make assumptions about the expected population in the rating period or draw a connection between the cost of the expected population and another population. Similar to the challenges without sufficient historical data, this further limits our ability to develop accurate rates.

Revenue uncertainty. Similar to any business, we need to know our revenue and costs in order to make judgments about the true financial performance of a product. This feedback on the financial performance of a product line can then be used to make important operational changes in provider contracting, medical management and pricing. Without this feedback, important operational deficiencies have the potential to continue without the necessary

improvements required to ensure the long-term viability of a product line. As highlighted below, the revenue structure across the medical lines of business includes three primary models:

- Revenue that is based on the contract terms agreed to prior to the beginning of the contract year (large group, pre-ACA small and individual). In this case, the revenue stream is known with certainty and is based on the expected claims costs for the specific group or individual at the time of rating.
- Revenue that can be accurately predicted based on the historical performance of the risk adjustment program (Medicare Advantage). As highlighted in the sidebar on the Medicare program, the risk adjustment payment is initially estimated and then further refined over a period of time.
- Revenue that will not be determined until a comparison with other health plans occurs six months after the conclusion of the policy year (ACA exchange). See sidebar for a description of the risk adjustment process for the exchanges.

ACTUARIAL FIRST PRINCIPLES APPLIED BY LINE OF BUSINESS

Using these principles as a basis, the following chart highlights the characteristics among the most important lines of business.

Line of Business	Historical Experience	Population Consistency	Revenue Certainty
Large Group (100+)	Provided by the large group employer.	With the exception of layoffs, large group populations are generally stable.	Contract terms are agreed to prior to the beginning of the contract year.
Small Group—Pre ACA	Available across the entire segment. Although group-level information is not considered credible, the rates can be varied based on the specific medical conditions of the group. (The extent the rates can vary differs by state.)	Generally stable but less stable than large group.	Contract terms are agreed to prior to the beginning of the contract year.
Individual—Pre ACA	Available across the entire segment. Although individual-level historical information is not considered credible, the individual rate is initially based on an in-depth medical underwriting process.	Because this population is required to pass an initial medical screen, this group is more likely to remain on their existing policy than move to another underwritten policy.	Contract terms are agreed to prior to the beginning of the contract year.
Medicare	Available across the entire segment, but not used to develop individual-specific rates. The risk adjustment process is designed to account for the expected cost differences among individuals.	The Medicare population has traditionally had a very high retention level.	Risk-adjusted revenue is initially based on historical data and then updated during and after the policy year. (See Medicare sidebar for additional detail.)
Small Group—ACA	In states with no transitional relief, the historical pre-ACA population could serve as a reasonable proxy for the broader ACA population—assuming the population has a similar risk profile as the ACA population. ² In states allowing transitional relief, a judgment must be made on the expected migration to the ACA products.	Potential for greater instability as groups exit the ACA pool through either self-funding or eliminating insurance.	Because the risk adjustment mechanism does not provide a final estimate until the middle of the following year, the revenue is not known with certainty until the release of the risk adjustment transfer. (See exchange sidebar.)
Individual—ACA	Only data on existing individual policies were available at the beginning of the program at the health-plan level. This information did not include data on the previously uninsured. Because of the timing for rate filings, a complete year of historical ACA information for specific health plans will not be available until pricing for the 2016 contract year occurs. Market-level information will not be available until the 2017 rating period—following the release of the risk adjustment transfer in the summer of 2015.	Extremely difficult to quantify—largely dependent on the mandate, the influx of transitional members, and the reaction of individuals to rate increases net of any subsidy changes.	Because the risk adjustment mechanism does not provide a final estimate until the middle of the following year, the revenue is not known with certainty until the release of the risk adjustment transfer. (See exchange sidebar.)

Using the criteria to the left as the basis, the ACA exchanges can then be compared across all the lines of business.

Historical data. Relative to the other lines of business, the exchanges have far less historical information to serve as the basis for the rate development through the initial period of the program (2014 to 2016). In the small group segment, health plans could rely on their existing book under the assumption that the risk profile would match the broader ACA population. On the other hand, for the individual product line, the historical information on individual plan members is much less useful because of the entrance of previously uninsured individuals into the risk pool in 2014. Looking forward to the 2017 rating period and the elimination of two of the risk protections, the historical claims information for a specific health plan will be available for two periods (2014 and 2015) and the data for the entire risk pool will be available for one period (2014) following the release of the risk adjustment transfers in the summer of 2015.³ In the other lines of business, historical data has been available for an extended period of time.

Population consistency. Under employer-based plans, most populations remain consistent from one period to the next with the one exception being in the case of significant layoffs. With guaranteed eligibility and a strong incentive to participate in the program based on age-related health conditions,

CONTINUED ON PAGE 28

Medicare plans have traditionally had a stable population. In contrast, the individual exchange population has the potential to change significantly based on a wide range of factors, including changes in the mandate, the influx of transitional plan members, and the response of individuals to significant net premium changes.

Revenue certainty. As suggested in the above charts and in the sidebars, the large group, pre-ACA individual and small group, and Medicare Advantage product lines provide a relatively predictable revenue stream. In contrast, because the exchange is based on a concurrent methodology that is compared with other plans following the conclusion of the policy year, the exchange population is subject to significant variation following the conclusion of the policy year.

Taken in total, following the elimination of the reinsurance and risk corridor programs in 2017, the ACA products will represent the riskiest line of business in a health insurer's portfolio.

CONCLUSION

Like a difficult math problem without a simple solution, it's sometimes useful to go back to first principles to help identify the most important parts of a problem. By following a similar approach with the ACA products and actuarial first principles, a similarly simple conclusion could be developed. While

MEDICARE ADVANTAGE RISK ADJUSTMENT

The Medicare program uses the Hierarchical Condition Category (HCC) risk adjustment methodology with historical diagnosis information as the basis to adjust premium revenue for the next calendar year. Although the mechanics of the development are somewhat complicated, the broad intent is to ensure that the risk score for an individual is properly calibrated against a fee-for-service population using historical data to adjust prospective rates. Because the risk scores are based on historical data and a published methodology, the health plans can have a reasonably accurate picture of their revenue for the upcoming year.

Risk score adjustments to revenue. Health plans in the Medicare program receive an immediate risk score for each enrollee at the beginning of the plan year. This initial risk score is then updated with two additional reviews that allow updated data and additional run-out from the historical experience period. The following schedule highlights the risk analysis for the calendar year 2014:

Risk Score Basis	Applicable Payment Period	Historical Experience Basis for the Risk Score Development
Initial risk score	Jan. 1, 2014 to July 1, 2014	July 1, 2012 to July 1, 2013
Midyear adjustment—initial risk score adjusted and the risk score adjusted for the remainder of the calendar year	Jan. 1, 2014 to July 1, 2014 (retrospectively adjusted) July 1, 2014 to Dec. 31, 2014 (adjusted to account for new information)	Jan. 1, 2013 to Dec. 31, 2013—with paid claims through March 15, 2014
Final adjustment	Jan. 1, 2014 to Dec. 31, 2014	Jan. 1, 2013 to Dec. 31, 2013—with paid claims through Jan. 31, 2015

Consistency of risk scores. The risk scores are also likely to be relatively consistent from one year to the next because a health plan's Medicare population is not likely to undergo substantial change from one year to the next—relative to other populations, seniors are much less likely to move from one plan to another. In addition to ensuring a bid consistent with the underlying risk and revenue of the population, this consistency also helps the health plan ensure adequate medical management support and allow for accurate budget estimates.

The net effect of these features is a risk adjustment program that is known in advance of developing the Medicare bid and a revenue stream that can be predicted with some certainty after the open enrollment period. Most importantly, this program creates a feedback loop that ensures a health plan can make changes in the operations—including contracting or medical management activities—that could influence both the quality of care and financial results. ■

the absolute level of risk could be debated, the ACA products are relatively more risky than the other traditional lines of business as the two risk pro-

tections are removed. As we consider the long-term implications in 2017, this additional risk could impact the willingness of insurers to participate

in the program—particularly among those organizations with a more modest risk tolerance or capital—and compromise the long-term sustainability of the program. ■

Taken in total, following the elimination of the reinsurance and risk corridor programs in 2017, the ACA products will represent the riskiest line of business in a health insurer's portfolio.

ACA EXCHANGE

While the Medicare program allows health plans to have visibility into their premium, in the exchange program, health plans are required to rely on risk scores that will not be known until after the calendar year, and the actual revenue impact will not be developed until a final reconciliation is completed relative to the other health plans. In this final reconciliation, the risk scores are compared among the plans and payments are either made or received among the health plans depending on the relative risk attracted to each health plan. The specific features are highlighted below:

Concurrent risk scores. Although the model uses a similar HCC methodology as Medicare, the model is based on the diagnosis information within the policy year rather than from the prior historical period. While this method provides a theoretically more accurate approach to adjusting premium, this mechanism does not allow health plans to have information on their own risk scores until their experience matures throughout the plan year.

Risk adjustment timing. While the Medicare model provides an immediate impact on revenue, the true impact of the ACA exchange revenue payments is not known until the risk level is compared with other health plans in the middle of the following calendar year (June 30, 2015, for the final invoice with the final settlements made later). In the meantime, unlike in the Medicare program, the ultimate premium levels during the current calendar year will be unknown. This potential uncertainty in payments will also be magnified by the potential changes in the exchange risk pool and the potential for consumer switching among health plans. ■

ENDNOTES

- ¹ The risk protections provide protection for health plans that attract high-cost claimants (reinsurance), sicker-than-average individuals (risk adjustment), and incorrectly estimate the cost of the exchange population (risk corridors). After the initial three years of the program, only the self-financing risk adjustment program will continue to be implemented. In this program, health plans reallocate money among themselves based on the relative risk attracted to each health plan. The broad intent of the risk protection policy is to allow insurance companies the opportunity to better understand the underlying cost of this population and ensure rates can be developed without the reinsurance or risk corridor protections that will sunset after the 2016 calendar year.
- ² Because the exchange program was developed to eliminate adverse selection among insurers through the risk adjustment program, health plans have been instructed to develop rates based on the expected risk for the entire risk pool. As a result, historical information within a health plan—while accurate for rating their own population—may not accurately reflect the cost for the entire risk pool and could lead to inaccurate rates after accounting for the risk adjustment payment.
- ³ In order to estimate the expected cost for the entire risk pool, the risk adjustment transfer is necessary to adjust the historical claims specific to a health plan.



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Surplus and the ACA

By Daniel Pribe

INTRODUCTION

The passage of the Patient Protection and Affordable Care Act (ACA) introduced significant changes to the health insurance marketplace, including:

- Federal premium and cost-sharing subsidies
- Minimum loss ratio (MLR) requirements
- Individual and employer mandates
- Insurance market reforms
- Medicaid expansion.

These changes affected the dynamics of the individual and small group markets, in particular. For example, insurance market reform includes a guaranteed issue provision. As a result, several states eliminated their high-risk pools, placing individuals obtaining coverage through these pools into the individual market. A second example is the individual mandate. This provision of the ACA is intended to motivate uninsured individuals to obtain coverage. The question insurers had to answer was how many of the previously uninsured would actually enter the market and what the underlying risk of these individuals was. Further com-

plicating the market landscape are the “transitional” plans that were added to allow individuals to keep their pre-ACA policies. The impact of these examples—as well as the other provisions of the ACA affecting market risk, profitability and surplus—is still unknown.

The drafters of the ACA recognized the additional uncertainty issuers face, especially in the first years after enactment; thus they included the “3Rs”—risk adjustment, reinsurance and risk corridors¹—in order to help mitigate some of the uncertainty and level the playing field. However, issuers needed to include the impact of the 3Rs in their initial and subsequent pricing estimates. These impacts are difficult to assess. For example, in order to estimate the impact of risk adjustment, issuers have to estimate their own risk score, the risk score of the entire market, the average market premium, and the distribution of enrollment by plans in the risk pools. None of these were known at the time 2014 premium rates were filed nor are they known precisely even now. Given that the risk adjustment is needed for both pricing and accrual determination, an issuer could misjudge its net income in two ways.

As this demonstrates, the ACA increased the potential variability of the net income of an issuer. This increased variability raises the required surplus level.

RISK AND THE NEED FOR SURPLUS

Insurance is, by definition, a risky business. Health insurance issuers participate in a very competitive market with potentially small and unpredictable margins. Even prior to the ACA, health insurers faced a multitude of risks including:

- Asset risk (e.g., asset concentration, market returns, ownership structures, capital adequacy, etc.)
- Underwriting (e.g., cost and utilization trends, pricing accuracy, rational and sometimes irrational competitors, underwriting, etc.)
- Credit risk (e.g., reinsurance, capitation, etc.)
- General business risk (e.g., administrative expenses, growth strategy, legal and regulatory environments, mix of business)
- Other risk (e.g., reputation, market concentration, service area size, provider reimbursement rates, distribution systems, etc.).

Health insurers must be financially strong in order to withstand adverse financial situations resulting from these risks. Thus, the primary need for surplus is to prevent insurer insolvency. Surplus is intended to allow plans to withstand sustained periods of adverse financial conditions including

inadequate premiums, cash flow shocks, unexpectedly high medical claims, and adverse risk selection. Surplus also serves as a capital resource allowing companies to invest in infrastructure, technology—some of which is necessary to comply with regulations (e.g., the Edge Server and ICD-10), and growth.

Growth poses unique challenges. A growing organization with significant new membership most likely needs to hold surplus that is much higher than an organization in a steady state. They must consider expenses incurred prior to launch (e.g., technology, marketing/sales, etc.) and expenses incurred after launch (e.g., claims, reserves, systems, etc.). Possibly more importantly, they must also recognize that new business takes time to generate retained earnings.

Thus, a company’s target surplus is unique to each organization and its individual circumstances and business characteristics. Determining the appropriate surplus is complex, varies by the risks each individual issuer faces, and is also somewhat subjective.

DETERMINING TARGET SURPLUS

Surplus is basically the excess of assets over liabilities. Target surplus is the amount company management thinks it needs given the risk that the company is balancing and the interests of its investors, regulators and rating agencies. It can be a function of management’s risk tolerance (desired level of conservatism), risk-based capital (RBC) requirements and regulatory en-

vironment. It need not be 100 percent of a worst-case scenario.

There are several methods to determine and measure target surplus. One of the most straightforward methods is a fixed capital and surplus requirement. Under this method, issuers are required to hold a minimum amount of capital. This amount is typically dependent on requirements by a state in order to be licensed to write business. As insurers have grown and changed, this standard is not necessarily considered effective in providing sufficient cushion for many insurers.

A second method is “surplus as a percentage of revenue” (SAPOR). SAPOR measures capital and surplus (“surplus”) as a percentage of insured premium revenue net of reinsurance (“total revenues”). SAPOR enables the study of surplus from single to multiyear gains/losses that can occur during the underwriting cycle. Results can be translated to an RBC equivalent once the modeling is done.

A third, and probably the most common, method in measuring surplus is RBC. This is discussed in greater detail below.

RBC

After a string of large-company insolvencies in the late 1980s and early 1990s, the National Association of Insurance Commissioners (NAIC) established a working group to study the development of an RBC requirement for insurers. The result was an RBC construct intended to be an early warning system for U.S. insurance regulators and provide capital adequacy standards that are uniform across states. This construct has two main components: 1) an RBC formula establishing a hypothetical minimum capital requirement; and 2) an RBC model law that grants automatic authority to the state insurance regulator to take specific actions based on the level of impairment.

The purpose of the formula is to establish a minimum capital requirement based on the types of risks to which a company is

exposed. Since different insurance types (i.e., life, property/casualty, health and fraternal) face different economic environments and risks, separate RBC models have been developed for each.

The NAIC’s RBC health formula recognizes the unique and complex nature of health insurance coverage and takes into consideration an issuer’s size, structure and risk profile. The formula focuses on three major areas: 1) asset risk; 2) underwriting risk; and 3) other risk. The calculation produces an “RBC ratio” of the total adjusted capital (TAC) over the authorized control level (ACL).

There are four levels of action that a company can trigger depending on the RBC ratio: company action, regulatory action, authorized control and mandatory control levels. Each RBC level requires some particular action on the part of the regulator, the company, or both. These are described in Exhibit 1.

For a health insurer whose RBC ratio is between 200 and 300 percent, an additional test is performed to compare the plan’s recent RBC trends. The additional test compares the ratio of the insurer’s underwriting deductions to revenue and 105 percent. Failure of the trend test triggers a company action level event.

While RBC is a commonly accepted measure of surplus, it is not amenable to modeling. Therefore, health insurers will most likely need to use more than one method and be able to model target surplus over multiple time periods.

WHAT DRIVES DEMAND FOR SURPLUS

Various business factors drive higher or lower surplus requirements. For example, nonprofit plans may need higher surplus to offset specific operating constraints since they have less access to capital. They don’t have access to capital markets, and terms of borrowing funds are dependent on financial performance and stability. Thus they may have to hold more surplus in order to meet business needs. On the other hand, public for-profit plans tend to hold relatively lower levels of retained surplus. They may use surplus to buy back shares, thus improving their return on equity, and if they find they need more capital, they have access to equity markets.

Ownership structure is another example. If, for instance, the issuer is a provider-owned plan or its owner is a holding company, then some of the sur-

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Exhibit 1

Risk-Based Capital Authoritative Action Outcomes

RBC Ratio (= TAC / ACL)	Action Level	Outcome
> 200%	—	No action is required.
150% to 200%	Company Action Level	The health care insurer is required to submit a business plan to improve financial strength.
100% to 150%	Regulatory Action Level	The health care insurer is required to submit a business plan to improve financial strength. Also, the regulator is authorized to perform a review of practices.
70% to 100%	Authorized Control Level	The regulator is authorized to take actionable steps to improve the financial strength of the health care insurer.
< 70%	Mandatory Control Level	The regulator is required to take actionable steps to control the health care insurer.

plus may be moved “upstream” quickly with the minimum required amount being held by the issuer.

Different situations may require higher or lower relative surplus levels (see Exhibit 2).

ers may severely under-rate (or over-rate) their products as a result.

A second area of uncertainty is membership that will enroll with a particular issuer. Areas where an issuer may be off in its estimates include its total

merous products were developed with narrow networks and some form of risk sharing ranging from gain-sharing to full capitation. The impact to surplus depends on the type of contract and arguably the financial strength of the provider organization.

still be “cash-out-the-door” during the policy year. For example, say an issuer is expecting a risk transfer payment because it has a higher risk population. During the policy year, it will be collecting lower premium (since its premium should have been set to the market risk) and it will be paying higher claims. These will combine to create a cash flow issue that needs to be supported by higher surplus until the risk transfer payment is received.

Additional uncertainty is driven by the impact of the risk corridor, Medicaid expansion, and revenue that may be at risk due to performance guarantees. The estimated accruals associated with these and other ACA-related items could vary quite significantly from the actual amounts due to this uncertainty.

Finally, the timing of payments for the 3Rs should be considered. These will not be reconciled and paid to the issuer until several months after the close of the policy year for which they apply. However, the claims to which these apply will

CONCLUDING COMMENTS

The impact of the ACA on surplus will vary by issuer based on their individual circumstances. It may be relatively small for issuers that are large, offer a diversified product portfolio, or have very little exposure to the individual and small group markets, in particular. It could be quite large for a small, private or not-for profit issuer with a narrow product portfolio

Exhibit 2

Situations Requiring Higher or Lower Relative Surplus

← Lower Surplus Required	Higher Surplus Required →
<ul style="list-style-type: none"> • Large (national) issuers/large market share • Mature markets with known risk factors • Diversified product or regional portfolios • For-profit due to access to capital • Effective care management • Stable markets • Reinsurance • Contracting <ul style="list-style-type: none"> o Capitation o Risk sharing 	<ul style="list-style-type: none"> • Regional, smaller issuers/small market share • Markets with significant unknown risk factors • Niche player susceptible to wide fluctuations • Not-for-profits or privately owned issuers • Lack of care management programs • Markets with significant churn • Lack of reinsurance • Fee-for-service (FFS) reimbursement

IMPACT OF THE ACA

The ACA has increased the variability, and thus the risk, that health issuers face driving a need for increased capital and surplus. One of the first places this is evident is in premium rate setting. The underlying risk of the market used to determine the premium and an issuer’s share of that market is unknown at the time of premium rate development. Factors driving this uncertainty include Medicaid expansion, the individual mandate, churn caused by actions of employers and individuals, and the underlying risk of the entire market. Issu-

enrollment expected, the distribution by metallic level, and the estimation of its plan risk and risk-transfer payment. These may not greatly impact a dominant player in the market or a large multiline issuer. However, these could be quite significant for an issuer new to the market or who is not well-diversified. For example, if the issuer is small or new to the market and it has under-estimated its rates, then its enrollment could be so large as to create significant surplus strain.

A third area of uncertainty is provider contracting. Nu-



Risk Mitigation Program	Expected Timing of Transfers	Other Considerations
Risk Adjustment	Per the 2014 Notice of Benefit and Payment Parameters, issuers who are net payers are required to pay by July 31 in the year following the benefit year and net receivers will receive by Aug. 31 in the year following the benefit year subject to the funds collected to achieve a zero-sum program at a state and market level.	Subject to the 7.3 percent sequestration holdback, but the U.S. Department of Health and Human Services (HHS) has the authority to pay out the holdback amount in the next fiscal year.
Reinsurance	Not finalized but HHS indicated on a REGTAP call in February 2015 that issuers could expect the first installment of 2014 reinsurance payments to be paid around July 2015 with a second installment in the October/November time frame. A potential third installment could be made in December.	Subject to the 7.3 percent sequestration holdback, but HHS has the authority to pay out the holdback amount in the next fiscal year.
Risk Corridor	To be determined.	HHS intends to settle the risk corridors in a budget-neutral manner over the life of the program (2014-2016). Further, in September 2014, the Government Accountability Office (GAO) found that ACA section 1342 did not make an explicit appropriation of funds. Therefore the government must look to other sources of appropriations for risk corridor payments. GAO ultimately concluded that risk corridor payments would have been available for FY 2014 under the program management fund had risk corridor collections/payments occurred in the fiscal year. Future congressional appropriations will be required for risk corridor collections/payments to occur.

or large exposure to the individual and small group markets.

Issuers should consider not only the minimum surplus that is required; rather, their determination of the appropriate surplus should include balancing the long-term goals of their organization with the risks they face and the potential uncertainty posed by the ACA and market conditions. This requires a multiyear view and simulation of the variables, including premium rates and rate position, enrollment, product and plan distribution, and morbidity risk. ■

Special thanks to Richard Tash, Nilabh Sanat, Ken Lim and Rebecca Owen for their review of this article.

Further readings recommended by the author are:

- Thomas D. Schnook, “Target Surplus Considerations for a Managed Care Organization”, © 2000 Milliman and Robertson, Inc.
- NAIC RBC article: http://www.naic.org/cipr_topics/topic_risk_based_capital.htm

ENDNOTE

¹ Risk adjustment is a permanent program. Reinsurance and the risk corridor are temporary programs ending in 2017.



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The Affordable Care Act's Five-Year Anniversary—Wall of Comments

A Compilation of Feedback from Members of the Health Section Describing what the Passing of the Affordable Care Act Meant for Them as Actuaries

On a personal level, working more and seeing my children less.

A lot more work! It's not a finished project, but more of a work in progress. The ACA is a good start toward comprehensive health coverage in the United States, but will require some adjustments over the years to get it right.

New people to work with, new challenges to meet, new puzzles to solve ... and a lot more people covered!

More work. More interesting work. Job security. Excitement.

The ACA is a blessing on so many levels. As an actuary, the ACA has allowed me to do some fun work that I otherwise wouldn't have done. As a health policy wonk, the ACA has applied some new and innovative methods toward the aim of managing costs and providing universal coverage whilst retaining the private insurance structure. As an American citizen, I am proud our country took a step in the right direction to improve our health financing system. As a father, I feel good

that when it comes time for my daughter to purchase insurance on her own, the ACA will ensure that it is available.

I categorize the last five years as "actuarial nirvana!" Actuaries were at the center of creating a whole new health insurance system in the United States. For those of us who went into this field because we: want to make a difference in people's lives; like creating new products and systems; and enjoy building models to make business decisions from skimpy data and unknowable assumptions, then preparing one's company for the new exchanges gave us all the challenges we could ever want. The ACA also produced its share of challenges for those working in Medicare, Medicaid, or employer group as new markets were created, federal capitation was reduced, and new product and underwriting rules were dictated. All traditional and nontraditional actuarial fields were affected: network contracting, product development, trend forecasting, predictive modeling, financial reporting and reserving, regulatory analysis and guidance. I am particularly proud of the role actuaries played in helping regulators craft regulations in a way that made the ACA law

more practical and fair in its implementation. One example is the way we worked with the NAIC to draft the MLR rules with our notable contribution in creating the credibility adjustment. Another example is working with HHS to clarify the treatment of payments to clinical risk-bearing entities.

I am a consultant to many large employers with self-funded health plans. Naturally, when the ACA passed, our clients were interested in knowing what they would be required to do, and more importantly, what it would cost them. I spent a lot of time analyzing the law's requirements, combing through regulations, and working with others in my organization to develop communications and calculators designed to help answer our clients' questions. I have also done numerous custom analyses for clients. In most cases, the answers have been: 1) There is very little you have to change; and 2) The resulting increase in cost is manageable. However, a lot of them have used "Obamacare" as an

opportunity to make changes to their plans that would have been much more difficult under other circumstances. There are many employers who have had to make big changes to their plans and/or eligibility rules, and have or will incur significant additional cost. For some, the administrative effort is even more daunting than the potential increase in cost. Think about employers with seasonal fluctuations in their business or with very high turnover among full-time workers. The effort to determine who is in what measurement period, and who is a new hire vs. ongoing employee can really make a person's head spin! The next big issue will be the "Cadillac tax." Many employers have already made changes to their plans in order to avoid this tax that doesn't take effect until 2018. Expect a lot of controversy about this aspect of the ACA in the next couple of years.

[The] ACA was the momentous once-in-a-career opportunity to observe/participate in all the



political drama and disruption in your industry. The opportunity has accelerated my career and added lots of learning opportunities in what I feared could become a dreary career requiring a career change at some point. Seven years into my career I'm still learning things I know nothing about—I just can't learn them fast enough. [The] ACA has also increased the demand for actuaries that the supply can't keep up with, which produces opportunities and financial rewards. The only downside of the land grab of opportunities has been losing my 20s to working 60- to 70-hour weeks. That's going to be my biggest regret unless I can save my 30s from the same fate and find the balance.

I've been an actuary working with provider-owned health plans for many years. Back in the '90s my breed of actuary was the life of the party. Providers everywhere wanted to know if they were loosely or well-managed and how far they could reduce costs. Specialist referrals and segmented networks were the norm, but then the president started calling us "bean counters" and the source of a national problem. Suddenly, we were not even welcome at the party. Health Care Reform 1.0 came and went and what remained left little doubt that "choice" ruled the day.

Flash forward to 2010 and the ACA passage—glory days are here again! At least for a short while. Soon, the acronyms start flying—ACO, PCMH, DoHM, HCC, MSSP, PCORI, 3Rs—everything to get a health ac-

The ACA has made me value my education, my judgment and abilities as an actuary much more than ever before.

tuary excited again! Migration models are all the rage. Where would people go? What would they choose? How would subsidies incent people to various options? Providers, never one to be left out, had their own world of questions. Would providers be able to manage risk this time around? Haven't I seen this movie before? What exactly are population health and accountable care? It sounds a lot like capitation to me. Quality measures were touted as the differentiating factor—this time it's not just about cost, it's the Triple Aim!

Now I ask you, just what is the Triple Aim? Cost and quality, for sure, but what's that last leg of the stool? If you're of my vintage, the last leg was choice (see above) and you couldn't have all three, but now it's service or satisfaction. But doesn't choice mean you change providers if you're not satisfied? Measuring quality takes on a life of its own. But where are the safeguards for the other half of care delivered that isn't measured in HEDIS, CAHPS or STARS?

ACOs were touted as the answer to just about everything—cost, quality, and how to assign risk. Shared savings rules proliferated as did legal protections for network collaboration. What used to be called PHOs now are ACOs with PCMH

and MSSP. And then came venture capitalists—with shiny new money to burn on the hottest tool for "pop health." A company I worked for got \$100 million in funding—Google here we come! With smart financial minds (and their money) come stringent targets for growth and profit. That episode is still running now, with perhaps a surprise ending to come, but the party is getting fun again.

Consolidation is the key now. Hospitals, health insurers, physician groups (now called "clinics" for reasons I'm not following), all buying or creatively joining with each other. I'm sorry, DaVita owns who now? I thought Aetna was an insurance company.

Actuaries change chairs as the job market heats up. New employers emerge—health systems, device manufacturers, startups in everything from reference pricing and price transparency (think negotiating eBay-style with your orthopedic surgeon) to software for physician offices that interface with medical records on your cell phone. The recruiter calls start—and seem to never end. LinkedIn—what a nice, mild-mannered contacts program that used to be—explodes with offers and "who do you know?" If you're a consultant, here's your chance to run a

department. If you're in operations, here's a data strategy opportunity. Revenue optimization becomes a new specialty. The list seems endless. Personally, I launched from Texas, to Washington, D.C., to Iowa (yes, Iowa) from consulting, to a technology startup, to health plan CFO. Change is definitely to be embraced.

What a long, strange trip it's been....

I began working with a state department of insurance as an actuary in the spring of 2012, to perform health rate reviews for many types of plans. I constantly tried to keep up with the barrage of federal regulations, instructions, Q&As, and letters to issuers, many of which came out on Fridays or days such as late on a Wednesday before Thanksgiving. Our state did not apply for any federal grant money to assist with rate review or to explore creating an exchange....

In the first quarter 2013, many plans and rates were filed for ACA-compliant plans for January 2014 effective dates. We had no way to anticipate the volume of companies or plans that would be filed in our state in advance. Previously, filings were spread out during the year due to rolling renewal dates. We did not anticipate the volume of time needed to fulfill the many open records requests that we received at that time. Our SERFF open records computer didn't allow for most federally created templates, URRT, new actuarial memo format, and actuarial calcula-

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tors to be seen, so we downloaded and created other digital files to share for open records requests. Due to revisions and additional filings, those digital files needed to be updated at the time of each request. The Part III actuarial memos and URRT did not provide us with what I needed for effective rate review. ACA filings were much larger but required many more questions than in the past. The federal HIOS system didn't connect at all with our SERFF filing system, for FFM states, requiring duplicate rate filings. The HIOS rate review system, including where we were supposed to enter our findings, was not user friendly.... The HIOS system limited the rates otherwise allowed by law, as it could not handle monthly small group trend factors (only quarterly or fewer), nor a rate slope limit of more than 3x even though smoker was supposed to allow up to 5x. Additionally the quarterly trends required an entire resubmission because [the] HIOS rate template didn't accommodate a trend.

CCIIO expected us to perform many administrative functions for review in HIOS. After issuers began plan preview, especially in the first year, they found numerous administrative corrections needed, which led to numerous new template uploads, such as for a URL link

correction in only one field because such fields were frozen. Normally in our SERFF system we can reopen filings, but I was told, as late as early 2015, that we could not undo our rate approval to allow a company [to] upload an administrative correction because no IT testing had been performed to know what might happen in HIOS if that were allowed.

Guidance about certain plan features that may be considered to be discriminatory by CCIIO was given to us without clear actuarial or statistical backing. On one phone call with CCIIO we were told to examine and address outlier rates, and if not, we might lose our federal effective rate review status, yet our working relationship was characterized to be “cooperative.” New requirements and expectations for state rate reviewers were set by CCIIO, such that we must re-run the actuarial value calculator and reproduce the AV reported for every silver plan filed by all companies. Random spot checking within a carrier and/or accepting screen shots as evidence was apparently not enough, according to CCIIO. Solutions to major problems with the AV calculator in 2014 were proposed but not implemented before 2015.... Plans that had AV gold prices were categorized silver, due to out-of-network

benefits, without consumers understanding why the prices were higher and why the term actuarial value may not relate to benefits. We received many consumer complaints in our state about rate increases and network narrowing. We questioned sufficient network adequacy certifications given by firms because blanket network certification extensions seemed given during the first few years of the ACA. ACA networks were being formed and evolving and changing rapidly.

We could not get good numbers on enrollment in our state, thus we had data calls to the carriers to find out the enrollment. Those numbers were lower than what was being reported to us by CCIIO. Until very close to the first open enrollment date, CCIIO couldn't tell us who the multistate carrier was in our state. Multistate agreement was made without us except that we received only one form filing that related to other plans we had already approved by that company in our state....

■

The ACA has made me value my education, my judgment and abilities as an actuary much more than ever before. I treasure all that I have learned from other wise actuaries in the past and today. The education and

experience that I had helped me tremendously. The ACA involves not only health insurance but taxes, medical fees, reinsurance, DOL rules, and more. After some pieces of the ACA were postponed, the ramifications have not yet played out. So much was expected to be changed and the pieces were integral to each other, so that the ACA would not work without all the parts, for good or for bad. Having the support of many other state actuaries and outside examining actuaries to handle the massive number of changes has provided me with much more actuarial knowledge than I could have imagined gaining over three years. The fact that I could apply so much of my work experience to date to handle the work involved with this massive ACA regulation and related rules has been rewarding. What a great profession this is. Not only from a mathematical perspective but from watching other aspects of the ACA unfold, such as the “Keep your Plan” response to allow “Grandmothering,” the expansion of the IRS hardship rules, the DOL small group employer definitions, and the waiver of employer penalties and analyzing the potential implications of so many interacting parts of the ACA continues to fascinate me. Never a dull moment! ■

Medicaid and the ACA

By Rebecca Owen

The Patient Protection and Affordable Care Act (ACA) changed Medicaid in ways that made front-page news, but there were also more subtle effects that, while unheralded, made a difference to all people involved in the program. Medicaid actuaries found themselves not in a niche practice, but front and center as the membership grew rapidly. Here are some brief highlights—more information on the specifics of the legislation as it pertains to Medicaid is available at *Medicaid.gov*.

THE BIG DEAL— MEDICAID EXPANSION

The original version of the bill expanded coverage to people whose income was at or below 138 percent of the federal poverty level. As with all complicated programs, this statement glosses over other eligibility nuances, but this summarizes the largest change. This expansion meant that many adults who were not previously able to qualify for Medicaid would be eligible for coverage. States that expanded Medicaid would receive federal matching funds that started out at 100 percent in 2014 and declined gradually to 90 percent by 2020.

On June 28, 2012, the U.S. Supreme Court issued a decision that while the individual mandate could be upheld, each state would decide whether or not to expand Medicaid. Immediately after the ruling some states made decisions to expand and some did not. For other states it was not an easy decision, with legislative bodies and governors frequently at odds. Several states used alternative methods of expanding, creat-

ing plans that required some sort of cost share or premium. As of the writing of this article, 29 states, including the District of Columbia, have chosen to expand; 16 states have not. After three years, the expansion question is still being discussed in six states.

One of the consequences of states not expanding Medicaid was that childless adults whose income fell below 100 percent of poverty remained ineligible for coverage, and because the original bill envisaged that these people would be in Medicaid, there was no provision for financial assistance for them from ACA exchange plans.

Using expanded income criteria for Medicaid eligibility means that there will be a need to interface between the

exchanges and Medicaid that is more seamless than ever before. The bill earmarked federal funds to streamline the enrollment process for members. Many members applied for exchange coverage only to discover they were eligible for Medicaid, and there were some creative solutions implemented to help beneficiaries end up with the best coverage, including things like a chat box, message or phone call when a person appeared to be a potential Medicaid beneficiary.

One interesting challenge arises with the incarcerated population. Many qualified for coverage by income standards, but were, at the time, the responsibility of the criminal justice system. Some agencies were quick

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to enroll this population—and the challenges of providing continuity of care for prisoners arrived at a time when care managers were stretched thin starting programs for existing members. This is not a population whose risk is well understood, so actuaries found it challenging to estimate costs.

Most of the states that expanded Medicaid began enrollment on Jan. 1, 2014, although some states availed themselves of an option to expand early to specific populations. The response was emphatic and startling. Members poured in, swamping member service lines and often creating long wait times for primary care and mental health services. Of the millions of people who obtained coverage due to the ACA, approximately 65 percent were Medicaid eligible. Some of these members were newly eligible because of the change in coverage rules, but others—the woodwork population—would have been previously eligible for Medicaid. Some states reached target enrollments years ahead of schedule, and this onrush was challenging for anyone trying to estimate financials associated with Medicaid.

MORE THAN EXPANSION

The ACA created the concept of a benchmark or a benchmark equivalent benefit for Medicaid expansion beneficiaries. While this did not eliminate large differences between state coverages, it tried to create a coherent connection between the exchange plans and Medicaid plans.

The ACA addressed a number of core elements of Medicaid programs in less visible ways. Quality of care is a focal point for the discussion of how the health system transforms and in particular how quality and performance measures for adults are developed and used. There was a temporary increase in payments to primary care physicians. Health Homes, particularly for chronic and expensive patients, are encouraged through enhanced funding. Community-based long-term care services and supports (LTSS) are a formidable component of Medicaid care, and the ACA facilitated the delivery of these services through better tools and funding improvements.

Understanding metrics on enrollment, cost and utilization, quality metrics, and population profiles has not been a seamless process. The ACA provides federal funding for better eligibility systems—in no small part due to the need for good coordination with the exchanges. Also this beefed up investigations and consequences for providers who engage in fraudulent behavior, as is evident in the increase in reports of investigations and convictions.

Portions of the ACA focused on specific populations, in particular on members who are Medicare-Medicaid enrollees. The ACA created a new office to work on ways to improve the coordination of care between the two payers, including better connections between service types that have typically not been connected, such as LTSS and acute care or behav-

ioral health. Aligning care for these beneficiaries is important for actuaries to consider, not just because coordinated care is more efficient, but because it is much better for the beneficiaries.

THE ACTUARIAL ROLE

While the specifics in the bill can be summarized into a neat list, the way the ACA transformed the lives of those who work in the Medicaid space is less quantifiable. Certainly the expansion of Medicaid, particularly with the increased emphasis on managed Medicaid, meant there were many more opportunities for health actuaries to work on Medicaid projects. Since many of the programs and the covered populations were new, it was not an easy task to estimate how and to what extent members would use services. The increased emphasis on coordination of care, especially the expectations of successful management of care included in rate estimates, required actuaries to have a much clearer idea of the sorts of programs that successfully reduced costs—and the size of these reductions. Demonstration projects, such as those focused on dual integration, brought together work groups from other disciplines. This was a great way to learn more than could be taught from mere data extracts. ■



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Medicare Advantage: Five Years after the ACA

By Andrew Mueller and Caroline Li

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA), passed in March 2010, brought about many changes to the health insurance industry. For the Medicare Advantage (MA) program, the most significant changes were to reduce MA benchmark payment rates such that federal payments under this program are more consistent with payments made for beneficiaries in fee-for-service (FFS) Medicare, to introduce incentives for higher-quality care, and to foster a more competitive market environment. While there were also changes made to the Part D program as a result of the ACA, this article focuses on MA (Part C).

Five years later, MA enrollment is at an all-time high, increasing more than 40 percent since 2009. Quality of care also continues to improve, and the number of affordable and competitive MA plan options remains strong.

CHANGES INTRODUCED BY THE ACA

Benchmark Payment Rates

Possibly the most significant impact to MA as a result of the ACA is the reduction in MA benchmark payment rates. Starting in 2012, all coun-

ties began a phase-in process whereby published county-specific benchmark payment rates would be based entirely off FFS costs and star ratings. The Centers for Medicare and Medicaid Services (CMS) developed a county-specific transition period using predetermined metrics. Each county was assigned a six-, four-, or two-year phase-in period. By 2017 all counties will be fully phased in.

Counties are also stratified into four quartiles based on estimated FFS costs for each county. Once fully phased in, counties in the first quartile (i.e., those

with the highest FFS costs) will receive payments equal to 95 percent of the estimated FFS costs, prior to any bonus adjustments for star ratings. The second, third, and fourth quartiles receive 100 percent, 107.5 percent and 115 percent of the estimated FFS costs (subject to ACA payment rate caps), respectively. The quartiles are re-ranked every year, so mobility across quartiles is allowed.

The impetus of the change was to have payments based on FFS costs, as illustrated in Figure 1. In the years before the ACA was passed, MA plan payments were consistently higher than 110 percent of FFS costs, reaching a high of 114 percent in 2009. As shown in Figure 1, in 2015 MA plan payments dropped to 102 percent of FFS and are expected to continue to drop in the future years.

In addition to plan payments being reduced, the ACA also

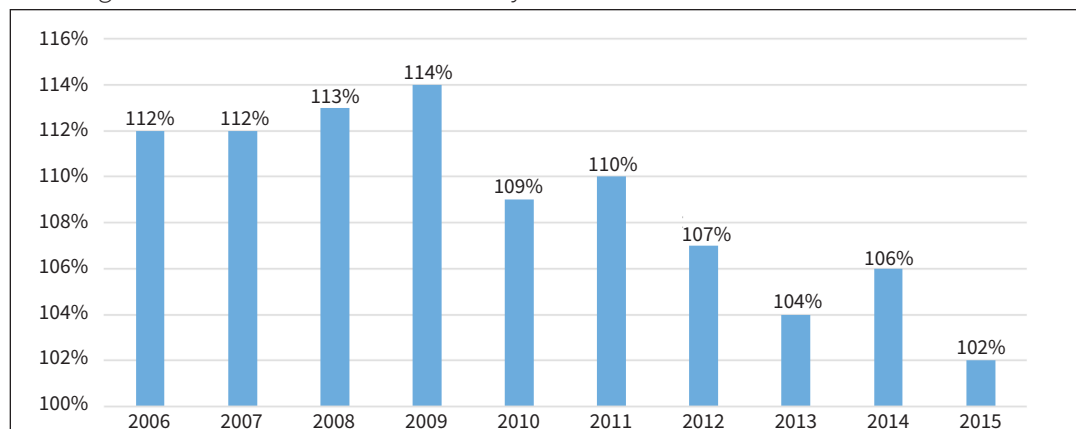
introduced a new excise tax on the health insurance industry starting in 2014. The tax applies with some exceptions to all qualifying health insurers and is allocated based on premium revenue of the previous year. The total fee collected started at \$8 billion in 2014, is gradually increasing to \$14.3 billion in 2018, and will be indexed to premium growth thereafter.

QUALITY

Another significant change for plans and members in MA as a result of the ACA was a larger focus on quality of care. To encourage plans to make this a primary focus, the ACA introduced a star rating system. Higher-star plans receive quality bonus payments in addition to their ACA-defined payments. The star ratings, ranked on a scale from 1 to 5 stars, in half-star increments, are based on criteria such as customer service and management of chronic conditions. For 2015

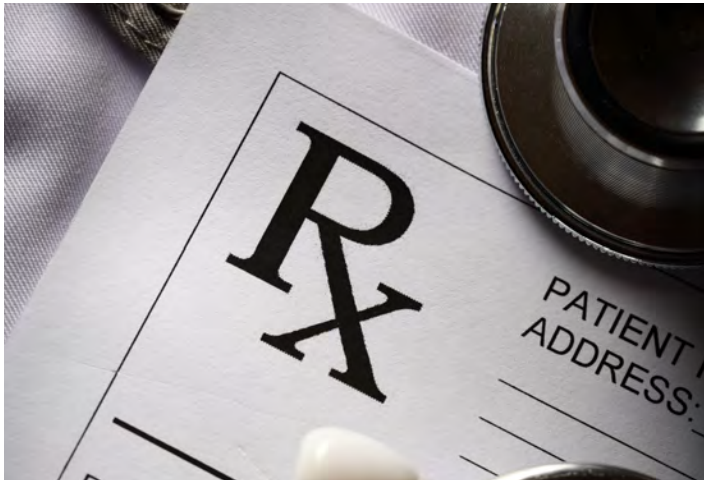
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Figure 1
Average Differential Between MA Plan Payments & FFS Cost



Source: MedPac and Citi Investment research and analysis

Note: MedPAC changed its methodology for estimating FFS expenditures in 2010 in a way that reduced the estimated MA payment ratio. Data for years 2006 to 2009 reflect projection of FFS experience under current law, which includes the expected cut in physician fee schedule that is due to the Sustainable Growth Rate (SGR) system. This understates the actual FFS payments, and overstates the ratio of MA payments to FFS. For 2010 to 2015, the FFS projection is based on a scenario of 0 percent physician update.



through 2017, plans with a 4-, 4.5-, or 5-star rating receive a 5 percent bonus to their benchmark payment rates (subject to ACA payment rate caps). Plans with star ratings of 3.5 or under receive no quality bonus.

The ACA also reduces plan revenue by cutting Part C rebates. Prior to the ACA, plans that bid below the benchmark retained 75 percent of the savings to provide additional benefits regardless of their star ratings. Plans now retain only 50 to 70 percent of the savings, depending on the star rating (50 percent for under 3.5 stars, 65 percent for 3.5 or 4 stars, and 70 percent for 4.5 or 5 stars).

PLAN RESPONSES TO ACA

To combat the decline in payment rates, MA plans have taken a variety of measures, as summarized below, in an attempt to remain profitable while also staying competitive in the marketplace and retaining membership.

Implementing higher levels of medical management

Prior to the implementation of the ACA, plans were able to

achieve reasonable profits without focusing heavily on medical management. However, as the ACA continues to drive down payment rates, plans need to manage medical costs, both from a unit cost and a utilization perspective, to remain competitive and profitable.

Improved coding efforts

Because payments to plans are risk-adjusted using the CMS-Hierarchical Condition Categories (HCC) risk model, capturing more patient diagnoses will increase plan revenue via increased risk-adjusted payment rates. However, plans only benefit from improved coding if the level of improvement exceeds the MA coding intensity adjustment. The MA coding intensity adjustment was introduced in 2010 to account for MA plans having better overall coding than FFS Medicare. The coding intensity adjustment was introduced as a 3.41 percent reduction to MA risk scores in 2010 but has grown to 5.41 percent for the 2016 plan year and will get larger in the coming years. This increase is meant to offset increases in coding specific to

the MA program. CMS has indicated it will be analyzing this coding intensity adjustment for plan year 2017 to determine if a larger adjustment is more appropriate.

Re-contracting with providers

In recent years, plans have been focusing more and more on contracting efforts to lower costs and align incentives with providers. These efforts include lower reimbursement, risk-sharing deals, and/or partial or full capitation arrangements with providers. CMS has instituted some restrictions on these arrangements, particularly for related parties, to avoid the over- or under-subsidizing of providers to make a plan's results look more favorable.

Also related to contracting with providers, plans have begun

implementing narrow network products to help manage increasing unit costs and to better align the plan with providers that are more effective at managing utilization. This allows plans to focus their year-over-year changes away from member cost sharing and premium changes.

Achieving higher star ratings

Plans have clearly understood both the impact of high star ratings on member retention and attraction as well as increased payments. In 2015, approximately 60 percent of MA enrollees will be in 4-, 4.5-, or 5-star plans, which is an increase of 36 percentage points since 2011. Figures 2 and 3 illustrate how the percentage of plans with higher star ratings has increased over the years.

Figure 2
Nationwide Enrollment by 2011 Star Ratings

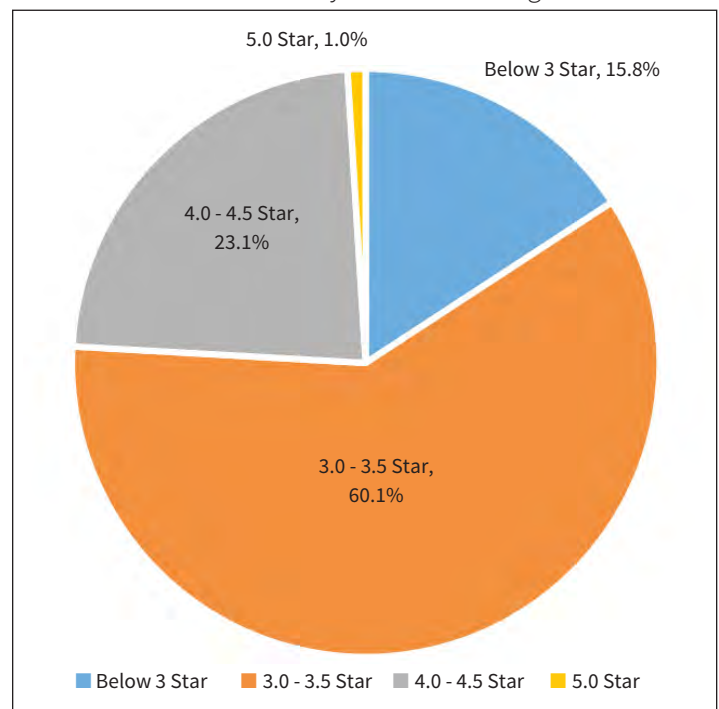
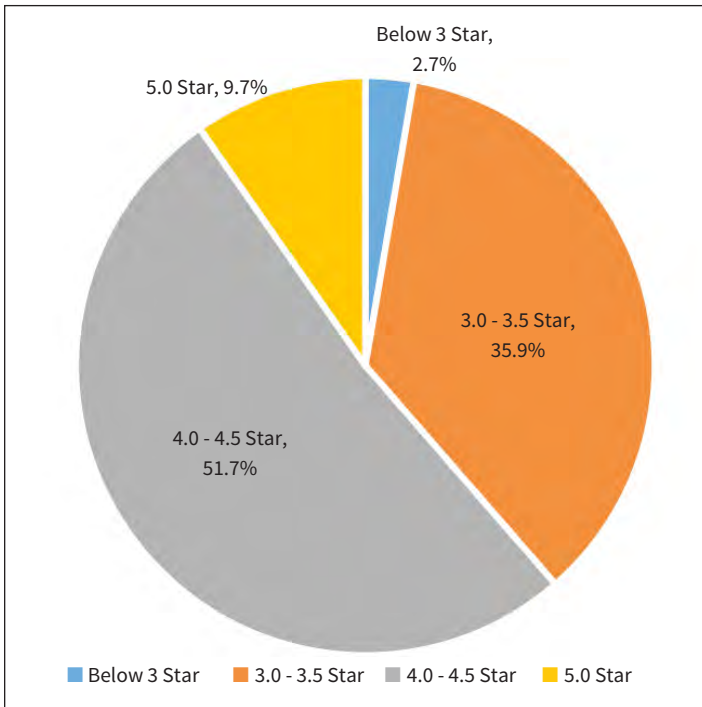


Figure 3

Nationwide Enrollment by 2015 Star Ratings



Decreasing benefits and/or increasing member premiums

Inevitably, once plans had maxed out the increases in revenue or decreases in costs they could achieve from reductions in administrative costs, increases in risk scores, increased star ratings, and increased medical management, plans began to focus required changes on plan benefits, including member cost sharing and member premiums. Plans typically try to avoid significant changes in benefits and premiums to avoid member disruption and loss of membership. However, continued decreases in payment rates have led plans to target benefit and premium changes on a plan-by-plan basis to maintain profitability. Using the total beneficiary cost (TBC) tests, CMS limits on an annual basis the value of benefits, cost-shar-

ing and premium changes a plan can make to avoid member disruption. With that said, plans have continued to be able to offer plans with low member premiums in certain areas, albeit with higher cost sharing than five years ago.

A side effect of these member cost-sharing and premium changes as a result of the ACA is a reduction in the “value add” that members are receiving. “Value add” is defined as the value of benefits provided to a plan’s beneficiaries above traditional Medicare that are not funded through member premiums. A recent Milliman study done in conjunction with the Better Medicare Alliance¹ showed Part C benefit value and premiums in composite (i.e., net of the effect of plan additions and terminations and

with more members enrolling in lower-premium plans) have been decreasing every year, but benefit value has been decreasing faster than premium, resulting in a decrease in value add every year.

Managing administrative costs

One of the first steps plans took in managing the reduction in payment rates was to focus on reducing administrative costs. By doing so, plans attempted to avoid passing the cuts directly on to the members in the form of reduced benefits and/or increased premiums. Early on, plans were able to realize reductions that were due to increased efficiency or synergies (including mergers and acquisitions). However, five years after the ACA was implemented, plans are finding it harder to continue to reduce administrative costs.

Decreasing profit targets

Some plans have dropped their target profit margins, understanding that margins that may have been achieved prior to the implementation of the ACA may not be plausible or allowed under increased scrutiny from CMS. Moreover, minimum loss ratio (MLR) requirements included in the ACA essentially limit the profits a plan can achieve before having to return a portion of its revenues back to the government.

ACA’S IMPACT ON THE MARKET

At the onset of the ACA, many were concerned that the payment reductions introduced by it would irreparably harm the MA market by causing plans to either withdraw or significantly reduce member benefits to the point where members would leave MA in masses. The transformation the market went through in the past five years has proven that the majority of plans were able to weather the storm by a combination of benefit reductions, utilization management, and reductions in administrative costs. Inevitably, some plans succumbed to the rate pressures of the ACA and either exited the market or merged with other plans. That is evidenced by a reduction of a little more than 10 percent in the number of MA contracts from 2009 to 2014. Similarly, members saw a reduction in the number of plans to choose from of nearly 30 percent from 2009 to 2014. Some of this reduction can be attributed, though, to CMS rules, which limit the number of plans any particular contract can offer in the same area.

Even with the decline in the number of plan options, MA enrollment has been growing at a higher-than-expected rate, from 11.3 million in 2009 to

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Five years later, MA enrollment is at an all-time high, increasing more than 40 percent since 2009.

16.5 million members in 2014. The MA penetration rate has also steadily risen, from 23 percent in 2008 to nearly 31 percent in 2014, and is expected to continue to grow in many states.

Not to be overlooked, quality of care has also significantly improved, as evidenced by the increase in plans' star ratings since the ACA was introduced. The bonus payments for higher star ratings properly incentivized plans to focus on quality of care. As noted earlier, more than 60 percent of MA enrollees will be covered by plans with a 4-star or higher rating, as compared to 24 percent of enrollees in 2011. In addition, many of the other ways plans coped with the ACA changes have led to improved quality, directly or indirectly. For instance, medical management initiatives that were meant to control costs likely resulted in plans more closely monitoring patients' treatments.

WHAT LIES AHEAD

MA is likely to continue to grow as more baby boomers transition into the Medicare population. With that continued growth, plans will look for new ways to increase efficiency. CMS will likely continue to put pressure on plans, through payment cuts and other methods, to become even more efficient in order to maintain profitability. As a result, a likely theme in

the years to come is the continued growth of alternative payment arrangements whereby plans put more pressure on providers to ensure they are providing good value without sacrificing quality. Providers who can do this will also likely see success in the MA market through increased volume and better reimbursement arrangements. ■

Special thanks to Jack Burke, FSA, MAAA, and Eric Goetsch, FSA, MAAA, for their review of this article.

ENDNOTE

¹ Swanson, B.L., and E.P. Goetsch (Feb. 18, 2015). Medicare Advantage Funding Cuts and the Impact on Beneficiary Value. Milliman Report. Retrieved March 11, 2015, from <http://www.bmadev.org.php53-22.ord1-1.websitetestlink.com/sites/default/files/Report-Medicare-Advantage-Funding-Cuts-and-the-Impact-on-Beneficiaries.pdf>.



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ACA Impact on Employers— The Road Ahead and the Road Behind

By Sujaritha Tansen and Brian Stentz

As actuarial consultants who collaborate with many types of employers, insurance companies and regulators, we are actively abreast of the Patient Protection and Affordable Care Act’s (ACA’s) impact on the health insurance market. Of the many dimensions of the ACA, we will explore the ACA’s impact on employers, which, as of now, is an ever-evolving landscape where material changes are still to take place. Per the fact sheet¹ released by the IRS in February 2014, approximately 96 percent of employers are small businesses that are exempt from the employer mandate provisions of the ACA. Mid-size and large-size employers constitute 2 percent each of all U.S. employers and are subject to phased-in employer mandate provisions of the ACA. These 4 percent account for a major portion of the insureds in the United States. Per the report² issued by the U.S. Census Bureau, over 169 million buy employment-based health insurance. According to Congressional Research Service,³ 72.4 percent of all employees work for firms that are large enough to be potentially subject to the penalty, but only 2.4 percent of employees work in firms that do not already offer health insurance. Considering the scope and range of new

requirements, it is imperative that employers have strategies in place that help them navigate the new landscape.

The government’s delay of the employer mandate until 2015 gave employers additional time to consider various strategies such as eliminating employee medical coverage, providing unsubsidized medical coverage only, limiting spousal coverage, and using private health exchanges (PHEs). As 2015 unfolds and the employer mandate takes effect, employers are now facing the reality of having to involve legal counsel, IT personnel and human resources in meeting the compliance and reporting requirements of the ACA.

SCOPE

This paper presents an overview of three key W’s (who, what, when) of the ACA’s impact on employers and does not delve into the “why” aspect. Considering that ACA regulations are well over 1,000 pages, the information presented here is by no means exhaustive, but is meant to provide a bird’s eye view of the impact on employers. We will be focusing more on the prospective impact on employers and less on changes that have already taken ef-

fect. We will not be making predictions about the future of employer-sponsored health coverage, possible erosion, or clean-cut exit from offering coverage, as it is too early in the game to comment on the future with any degree of certainty.

We will employ the following definitions shown in Figure 1 to help clarify the impact on small, mid-size and large employers.

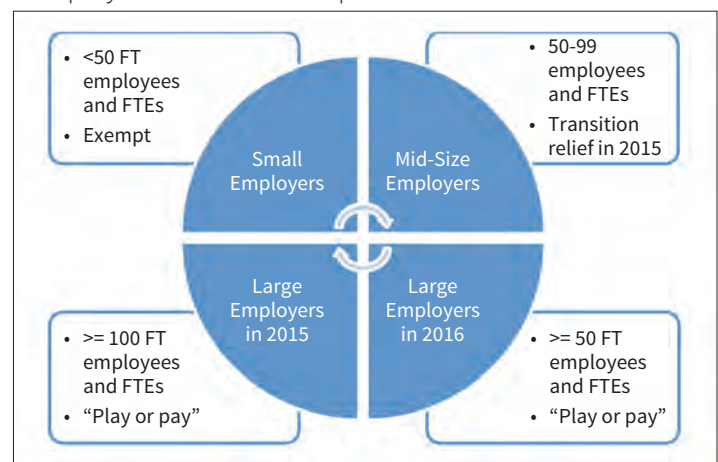
In this parlance, an employee is

two measurement methods (monthly measurement versus look-back measurement) for determining whether an employee has sufficient hours of service to be an FT employee.

LARGE EMPLOYER PERSPECTIVE—BRIEF HISTORY OF TIME AND WHAT LIES AHEAD

On Feb. 12, 2014, the IRS published the final regulations pertaining to “Shared Responsibility for Employers Regarding

Figure 1
Employer Size and ACA Impact



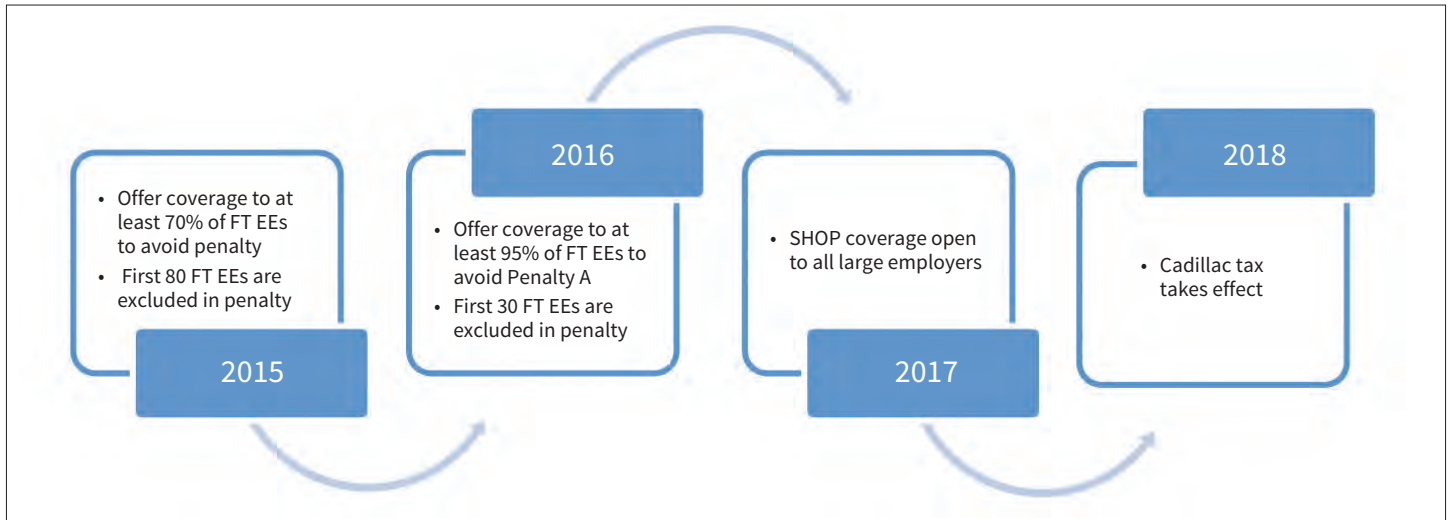
a full-time (FT) employee for a calendar month if he or she averages at least 30 hours of service per week. For the purposes of determining FT employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week. Full-time equivalence (FTE) is applicable if the business employs part-time employees. It is computed by dividing hours worked in a month by all part-time employees by 120. We direct the reader to the final regulations⁴ for details on the

Health Care Coverage,” which provided guidance to employers that are subject to the “play or pay” provisions of the ACA.

The employer mandate was originally intended to take effect in 2014 when the federal or state marketplaces became operational. Subsequently, the mandate was delayed until 2015 or 2016, depending on employer size. Even with the delay, employers needed to be abreast of the new requirements, including IRS reporting forms, to ensure that the company has

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Figure 2
Employer Impact—A Timeline



an efficient infrastructure to collect and submit the needed data for the following year. A snapshot of the large employer impact by timeline is presented in Figure 2.

WHO?

Intending to allow a gradual phase-in and to better assist employers subject to the employer mandate, the “play or pay” provisions apply only to larger firms with 100 or more FTE employees starting in 2015 and employers with 50 or more FTE employees starting in 2016.

WHAT AND WHEN?

As part of the gradual phase-in, the employer mandate provisions in 2015 are less stringent than in later years. Transitional relief was allowed in 2015 to mid-size employers as long as they do not restructure their workforce and they continue to maintain or enhance previously offered coverage beginning Feb. 9, 2014 and ending on Dec. 31, 2015. Large em-

ployers, however, are subject to employer mandate provisions in 2015.

The Employer Shared Responsibility Payment (informally known as the employer mandate fee or penalty) is a per employee per month fee, applicable to large employers under the scenarios listed below. As demonstrated below, large employers do get some transitional relief in 2015 by the way of a lesser penalty relative to 2016. In this context, we present the definitions of the two most-cited provisions:

Minimum Value: A health plan meets the minimum value (MV) standard if it is designed to pay at least 60 percent of the total cost of medical services for a standard population (i.e., the employee pays via deductibles, coinsurance, copayments and other out-of-pocket amounts no more than 40 percent of the total value of benefits under this plan). The U.S. Department of Health and Human Services (HHS) regulations

allow an employer to meet the MV requirement by applying the MV calculator provided by HHS or a safe harbor established by HHS and the IRS. For nonstandard plans, MV can be established through an actuarial certification. In November 2014, the IRS clarified that an employer plan cannot be considered to meet the MV standard unless it provides substantial coverage for inpatient hospital and physician services, thus eliminating the lure to offer potentially unattractive benefit packages just to avoid the employer penalty.

Affordable Coverage: If the employees’ share of the premium costs more than 9.5 percent of their annual household income, the coverage is considered not affordable. Since an employer may not be aware of its employees’ aggregate household income, employers can use one or more of three affordability safe harbors defined in the final regulation. Employers should now have strategies in

place to track affordability of coverage and the safe harbor method that best suits them.

- **Employee’s W-2 wages:** Affordability is based on whether an employee’s premium contribution for the lowest-cost, self-only MV coverage does not exceed 9.5 percent of the employee’s W-2 Box 1 wages for that calendar year.
- **Rate of pay:** Affordability is based on the monthly wage of hourly employees (hourly rate of pay for each hourly employee multiplied by 130 hours per month) or the monthly salary of salaried employees.
- **Federal poverty line (FPL):** Coverage is affordable if the employee’s premium contribution does not exceed 9.5 percent of the FPL for a single individual.

It is important to note that the affordability provision only applies to employee coverage, not

for dependent coverage. Each of the safe harbor methods has pros and cons that employers need to assess so they can make decisions that best fit their organization. For instance, employers need to wait until the end of the year to compute affordability based on W-2, while the rate of pay computation can be made at the beginning of the plan year. The W-2 method might be more suited for employers with a relatively stable workforce constituting mostly FT employees whose wages

least 70 percent/95 percent of its employees

If the employer does not offer health insurance coverage to at least 70 percent (95 percent in 2016) of its FT workers and their dependent children, and if at least one FT employee receives a premium tax credit or cost-sharing subsidy in the marketplace, then the employer is subject to a penalty as shown in Table 1a.

Transitional relief is provided in 2015 by:

Table 1a
Penalty A

2015 Penalty per Month	2016 Penalty per Month
\$2,084 / 12 * (# of FTs - 80)	\$2,084 / 12 * (# of FTs - 30) with indexed penalty amounts for 2016

are not likely to fluctuate significantly. The rate of pay safe harbor requires multiplying the hourly rate by 130 hours per month regardless of the number of hours actually worked by the employee, whereas the actual wage is used in the W-2 method. The FPL safe harbor is the easiest from a computational standpoint. Based on the 2014 FPL of \$11,670 for an individual, the maximum employee contribution would be \$92.38. This method typically provides the lowest threshold amount for most employers.

It is important that employers understand and proactively plan for compliance with affordability provisions. We are presenting below the employer penalty under three different scenarios.

Scenario 1—Employer does not offer health insurance to at

- Decreasing the coverage requirements to 70 percent (instead of 95 percent in 2016) of the FT workforce; and
- Subtracting 80 FT employees for 2015 instead of 30 FT employees in the penalty computation.

It is important to note that the actual penalty is calculated based on the count of FT employees, but the employer size is determined by taking into consideration FTEs as well.

Assuming the penalty amount of \$2,084 will be the same in 2016, an employer with 200 average employees under this scenario will pay an annual penalty of \$250,080 in 2015 and \$354,280 in 2016.

Scenario 2—Employer offers health insurance to at least 70

percent/95 percent of its employees, but does not meet MV standards

This scenario is the case when an employer offers health insurance coverage to at least 70 percent (95 percent in 2016) of its FT workers and their dependent children, but does not offer MV coverage. Employees and their dependents can opt to buy coverage in the individual marketplace and can apply for premium tax credit and cost-sharing subsidies. If at least one FT employee receives a premium tax credit or a cost-sharing subsidy in the marketplace, then the employer is subject to the minimum of Penalty B and Penalty A (defined above).

In most cases, Penalty B will be less than Penalty A as it is paid

Table 1b
Penalty B

2015 Penalty per Month	2016 Penalty per Month
\$3,126/ 12 * (# of FT employees receiving a premium tax credit or cost-sharing subsidy)	Similar to 2015, but penalty amount will be indexed by increase in health insurance premium

only on those employees who receive a premium tax credit or a cost-sharing subsidy.

Scenario 3—Employer offers at least MV health insurance to at least 70 percent/95 percent of its employees, but not affordable coverage

This scenario is the case when the employer offers MV health insurance coverage to at least 70 percent (95 percent in 2016) of its FT workers and their dependent children, but the coverage is not “affordable” (as defined earlier) for its FT employees.

If at least one FT employee receives a premium tax credit or cost-sharing subsidy in the federal or state marketplace, then the employer is subject to the minimum of Penalty B and Penalty A (defined in Tables 1a and 1b.)

SMALL EMPLOYER PERSPECTIVE

While not subject to shared responsibility provisions like large employers, the ACA did have an impact on small employers. Small employers with fewer than 50 employees could simply choose not to provide insurance at all and rely on their employees to purchase their own coverage in the individual marketplace.

Some mid-size employers have reduced the size of their workforce to fewer than 50 employ-

ees and/or converted their FT positions to part time to give themselves additional flexibility in determining their health care benefit packages or to reduce their potential penalties for failing to provide health coverage. Regardless of whether small group employers choose to either maintain the health coverage they offered prior to the passage of ACA or choose to provide their employees coverage in the post-ACA marketplace, they need to have a thorough understanding of their

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options. For example, insurance purchased after 2014 must comply fully with ACA-mandated provisions such as guaranteed issue, essential health benefits and revised rating rules. The enactment of the ACA has also provided incentives to encourage small employers to begin and/or continue offering health coverage to their employees. These incentives include tax credits and the creation of the Small Business Health Options Program (SHOP) for the small group market.

Tax Credit Incentives

One provision of the ACA is designed to incentivize certain qualifying small employers to offer health insurance coverage to their employees. These tax incentives are available if an employer:

1. Has fewer than 25 FTE employees;
2. Pays an average annual wage below \$50,000;
3. Pays at least half of the cost of its employees' health insurance; and
4. Purchases coverage on the SHOP exchange as of 2014.

For years 2010 to 2013, the maximum credit was 35 percent of premiums paid by small employers for insurance coverage (25 percent max credit for small tax-exempt employers). This percentage varied on a sliding scale depending on the number of employees and the average annual wage.

For years 2014 and later, the maximum tax credit increases from 35 percent to 50 percent

for qualifying small employers (from 25 percent to 35 percent for qualifying tax-exempt employers) and is available for two consecutive years.

Since the primary goal of ACA reform was to increase insurance coverage to the uninsured, these tax incentives were included to encourage small employers with a low-income workforce to provide health insurance coverage. According to GAO report,⁵ fewer small employers claimed the tax credit in tax year 2010 than were estimated to be eligible. Of the estimated 1.4 million to 4 million eligible small employers, only 170,300 employers claimed the tax credit, totaling \$468 million in 2010. The GAO report noted that small business representatives and tax preparer groups indicated that the credit was not large enough to incentivize employers to begin offering health insurance, and complex rules coupled with the time needed to calculate the credit often deterred claims. As per HHS,⁶ more than \$1.5 billion in credits have been provided to small businesses since the tax credit first became available in 2010. It is important for small businesses to understand this incentive is available when deciding on their employee health benefit packages.

Grandfathered and Grandmothered Group Health Plans

The ACA allowed small businesses the opportunity to continue offering grandfathered plans. Plans are grandfathered if they were purchased before March 23, 2010 and did not make major changes to the

plan design and coverage (e.g., cutting benefits, increasing cost sharing significantly, etc.). Maintaining a grandfathered plan allowed a small employer to avoid some ACA requirements (e.g., covering essential health benefits, not requiring coverage of preventive services without cost sharing, etc.).

In addition, there are grandfathered or transitional plans that are not grandfathered but were effective prior to Jan. 1, 2014. In late 2013, HHS announced a transitional relief program wherein states and health insurers could allow such non-ACA-compliant individual and small group policies to renew at the end of 2013. These plans do have to comply with some of the provisions of ACA (e.g., no annual limits on coverage, mandatory preventive care coverage without cost sharing, coverage for dependents until age 26). In March 2014, HHS extended transitional relief, allowing these grandfathered plans to renew up to Oct. 1, 2016 in states that allowed them.

Even though employers and individuals have been given transitional relief via grandfathered and grandmothered alternatives, it is expected that the majority of health coverage will eventually be fully compliant with the ACA. It's important for employers to fully understand the impact these reforms will have on the plans they currently offer as well as be cognizant of what will be available once the transitional periods end.

Small Business Health Options Program (SHOP)

One of the primary impacts the ACA has had on small employers is the creation of SHOP exchanges—online marketplaces for small employers with fewer than 50 FT employees. Starting for plan year 2016, the SHOP exchanges will be opened to employers with 100 or fewer FT employees. Starting in 2017, states have the option to allow employers with more than 100 employees to buy large group coverage through SHOP.

The main purpose of these SHOP exchanges is to give small employers a convenient way of reviewing multiple plan options offered by different insurance companies. An additional goal was to reduce costs by pooling similar risks in the development of the rates as well as to reduce administrative costs. It is too early to tell if SHOP exchanges will impact the small employer market significantly, but employers should realize that this marketplace is available to them.

CADILLAC TAX—THE TAX AHEAD!

Another provision of the ACA that has yet to take effect is an excise tax on high-cost employer-sponsored health coverage. This upcoming tax, commonly referred to as the “Cadillac tax,” is scheduled to begin in 2018 and will potentially affect employers of all sizes who offer health coverage to their employees.

The stated purpose of this new tax is to generate \$80 billion in new tax revenue to assist the federal government in covering the costs of health care reform.

Another purpose is to slow down rising medical cost trends the insurance industry has faced for many years by encouraging employers to reduce rich “low-cost-sharing” plan designs and to reduce utilization of health care services.

The Cadillac tax is a 40 percent tax on the total value of the medical benefits in excess of an annual dollar limit set by the ACA. The amount used in determining the tax is the total costs of the medical benefits for both current and former employees regardless of whether the costs are paid by the employer or the employee. This also includes FSA & HSA contributions.

The annual limits are currently set at \$10,200 for self-only coverage and \$27,500 for family coverage and are subject to certain adjustments. The adjustments account for health inflation, age and gender characteristics of participants, and the presence of qualified retirees and high-risk professionals. A brief description of the adjustments included in Section 4980I is below:

- **Health cost adjustment:** There is a one-time “catchup” adjustment to the annual dollar limits set in 2010 in the event the cost of health insurance increases more than originally expected. If the cost for providing coverage per employee in 2018 under the Blue Cross/Blue Shield (BCBS) standard benefit option for Federal Employees Health Benefits Plan (FEHBP)

increases by more than 55 percent compared to 2010, then the excess is the adjustment amount. For 2019, the annual limit is tied to the consumer price index (CPI) plus 1 percent. For 2020 and beyond, the annual limit is tied to CPI alone.

- **Age and gender:** There is an adjustment to compensate employers that have high-cost coverage that is a

sions (e.g., law enforcement, fire professionals, mining, etc.). The adjustment allows for the dollar limit to be increased by \$1,650 for self-only and \$3,450 for other coverage.

To illustrate, a simple scenario to demonstrate the potential tax liability facing a small employer in 2018 is included in Table 2. This example is for an employer with 40 employees and has

An alternative that some employers are utilizing is the so-called “private exchanges.” These exchanges are unrelated to the publicly funded marketplaces promulgated by the ACA. These private exchanges do not provide premium subsidies or standardized coverage tiers. The Kaiser Family Foundation’s September 2014 report⁷ estimates enrollment of 2.5 million subscribers in the private exchanges in 2014.

Table 2
Small Employer with 40 Employees

Tier	EE Count	2014 Annual Premium	Assumed Annual Trend	2018 Annual Premium	Annual Limit	Amount Subject to Tax per EE	Excise Tax Rate	2018 Estimated Tax
EE Only	15	\$10,000	6.0%	\$12,625	\$10,200	\$2,425	40%	\$14,549
Family	25	\$27,500	6.0%	\$34,718	\$27,500	\$7,218	40%	\$72,181
Estimated Total Tax								\$86,730

result of the demographic profile of their employees. This adjustment is also calculated using the BCBS standard benefit option. It is based on the difference between the premium of the FEHBP standard option priced for the age and gender mix of the employer compared to the premium if nationwide averages were used for age and gender characteristics.

- **Retirees and high-risk professions:** There is an adjustment to allow for higher limits if employers have high-cost coverage that is a result of covering qualified retirees or as a result of covering high-risk profes-

only employee only or family coverage. We have assumed a 6 percent trend assumption starting in 2014 and that none of the potential adjustments described above were required.

Even though it’s commonly assumed this tax will affect only rich plan designs, it’s easy to see how this could ultimately affect even less rich plans due to medical inflation that has been rising faster than the CPI (which the annual limits are tied to). It is important that employers of all sizes understand and proactively plan for this potentially new tax provision.

PRIVATE EXCHANGE MARKET

Kaiser’s 2014 Employer Health Benefit Survey estimated market penetration of private exchanges to be approximately 2 percent of large employers. Kaiser’s report estimates that 20 to 33 percent of employers will adopt a private exchange approach over the next three to five years. Given that the value proposition of private exchanges includes the flexibility to design benefit tiers specific to employer segments and freeing the employer from administrative burdens associated with annual enrollment and ongoing tasks, we assess that private exchanges are very likely to have increasing enrollment in the years ahead.

ANNUAL REPORTING REQUIREMENTS—TRANSITIONAL RELIEF AND WHAT LIES AHEAD

The enactment of the ACA increased many employers' annual reporting responsibilities, particularly to the IRS. Some of these reporting requirements have already been implemented. The ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' W-2 forms. Beginning in 2012, the IRS made this reporting requirement mandatory for large employers. There are other reporting requirements that have already taken effect. We would like to draw focus primarily on new requirements for 2015.

Code Sections 6055 and 6056
Starting in February 2016, all applicable large employers (ALEs) are required to report to the IRS significant health coverage information based on calendar year 2015.

The ACA requires ALEs to file information returns with the IRS and also provide statements to their FT employees about the health coverage the employer offered or to show the employer did not offer coverage. Similar to the delay in the employer shared responsibility mandate, the implementation

of the temporary transitional relief period postponed the enforcement of most reporting provisions until 2016. While information reporting was voluntary for calendar year 2014, we assess that it is unlikely that many employers were ready to file the IRS forms in February 2015 as the final forms and instructions were made available only recently.

To prepare for 2016, ALEs need to have processes in place to track 2015 information monthly. This includes whether FT employees and their dependents were offered minimum essential coverage that meets the MV requirements and affordability requirements. It is important for employers to review the IRS forms 1094-B, 1095-B, 1094-C and 1095-C and to ensure that they are on track for information reporting on all forms applicable to them. It is very possible that there will be additional revisions and clarifications to the published IRS form instructions. ALEs should keep abreast of these requirements in order to be able submit these forms that are due by February 28 (if filing on paper) or March 31 (if filing electronically) of the year following the calendar year.

The reported information will be used by the IRS to determine

if a premium tax credit is available to the employees as well as to determine the penalty if the employer does not provide minimum essential coverage.

Employers who fail to file timely, correct information returns to either the IRS or the employee are subject to significant penalties. We refer the readers to section 6055 of the IRS code for further guidance on the information reporting requirements, applicable filing methods and possible penalties for compliance failures.

CONCLUSIONS

The ACA's impact on employers will vary based on the size and structure of the employers' workforce. There is no one-size-fits-all solution that best fits all employers in their efforts to comply with ACA. With the employer mandate taking effect in 2015 for large employers, the impact on large employers will gain traction in the forthcoming months. While additional provisions of the ACA, such as the Cadillac tax, will take effect in 2018, it remains to be seen how benefit plans offered by employers will be transformed in the years ahead. Additionally, in light of new reporting requirements, it is imperative that employers are proactive in developing a compliance strategy for what lies ahead. ■

ENDNOTES

- ¹ <http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%2020121014.pdf>
- ² "Health Insurance Coverage in the United States: 2013," September 2014, <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>.
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The Role of the Affordable Care Act in Payment Reform

By Juliet Spector

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010.¹ The law challenged the existing health care system through sweeping reforms related to making coverage more accessible, expanding covered services and benefits, and reducing costs, along with curbing the high medical cost trend and improving health outcomes. The ACA proposed various changes related to payment reform. These changes were an attempt to not only achieve a lower cost of care, but also to increase both the accessibility and quality of medical care.

Even with these goals, the ACA was not necessarily the catalyst for payment reform, but happened in sync with trends that were already brewing in the provider market. The long-standing provider payment model of fee-for-service (FFS) was losing its effectiveness for some providers. Commercial utilization rates were starting to flatten and reverse, making the FFS model less reliable for assuring providers earned the revenue levels upon which they depended (a provider's FFS revenue decreases with decreasing utilization). In addition, the growing Medicare population (along with the

aging of the population) and the expansion of Medicaid² to millions of new people due to the ACA also intensified financial pressures on health care providers because both Medicare and Medicaid pay for services at lower rates than commercial plans. These factors are contributing to more providers taking on risk and ultimately influencing the overall treatment patterns of the population. Along with the enactment of the ACA, physician integration, quality improvement and information technology (IT) infrastructure investments are making it easier to design and implement payment models that depart from the standard FFS design to help providers better manage these risks while still maintaining the overall quality of care of the population.

OVERVIEW OF ACA PAYMENT REFORMS

In concert with these changes, the ACA introduced its own payment reforms, including:

Reforms regarding quality improvement

- Establishing the Medicare Hospital Value-Based Purchasing (VBP) program:

VBP programs allow acute care hospitals to receive

rewards, or incentive payments, for providing care that improves the health outcomes for patients (programs like this are also known as “pay-for-performance”).

- Strengthening quality for Medicare Advantage:

The ACA also established incentives for Medicare Advantage programs through several channels: establishing bonus payments for programs that can show increases in managed care, especially for patients with chronic conditions; identifying gaps in coverages for current beneficiaries and non-covered members in surrounding service locations; and improving general quality through educating staff, technological improvements, and providing additional support in the form of nurses, physicians, etc.

Reforms regarding accessibility

- Creating programs that address primary care shortages and support the building of the health care workforce:

The ACA includes measures to address the accessibility of health care services—for instance by examining the health care workforce and assessing how the government can support its appropriate training.

- Adding a temporary increase in Medicaid payments for primary care doctors (from Jan. 1, 2013, to Dec. 31, 2014):

To boost the incentive for primary care physicians to better manage care, the ACA established incentive payments of up to 10 percent of the total amount for certain qualified services.

- Increasing payments for rural health care providers:

The ACA extended the Rural Community Hospital Demonstration Program created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. One of the largest efforts to analyze accessibility in low-utilization, low-access areas was establishing the study by the Medicare Payment Advisory Commission (MedPAC) on adequacy of Medicare payments for health providers in rural areas.

- Requiring commercial health plans to meet specific criteria in terms of distance and mix of specialties in establishing provider networks.

Reforms regarding affordability and cost

- Establishing the Independent Payment Advisory Board (IPAB) to monitor Medicare cost trends
- Addressing the benefit discrepancies between a Medicare FFS beneficiary and a Medicare Advantage beneficiary
- Reducing unnecessary paperwork and administrative costs.

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Reforms regarding affordability and cost and quality improvement

- Establishing the Center for Medicare and Medicaid Innovation (CMMI, or Innovation Center):

The ACA established the CMMI under the Centers for Medicare and Medicaid Services (CMS) to encourage and promote the development of payment delivery models that attempt to improve patient outcomes through several channels. Examples of the innovations these models promote include: more efficient coordinated care, increased risk sharing among physicians and hospital groups, fostering collaborative institutions that promote best practices for improving the quality and cost of care for beneficiaries, and generally to increase managed care services that monitor and improve patient health status.

Each of these payment reforms targets one or more of the three main problems facing the health care system: achieving a higher quality of health care, increasing or maintaining current levels of accessibility for beneficiaries, and reducing cost by either cutting wasteful expenditures or controlling payment rates. It is difficult to succeed in all three simultaneously because improving quality and access will typically result in increased expenditures from hiring more experienced staff or providing more training and monitoring for quality control. Likewise,

The ACA was not necessarily the catalyst for payment reform, but happened in sync with trends that were already brewing in the provider market.

reducing costs can potentially lead to less accessibility if high-cost, low-utilization procedures are strategically consolidated or relocated in larger hospital groups—for instance from a rural to a more urban setting.

The ACA has made substantial headway in the transformation of Medicare and Medicaid programs, one of the driving forces toward payment reform. These changes have created trickle-down effects in the commercial market. Certain programs from the ACA, such as the Medicare Shared Savings Program (MSSP) and the Bundled Payments for Care Improvement (BPCI) pilot, have served as frameworks for programs emerging in the commercial market. However, reduction in payments in the Medicare and Medicaid markets incentivizes some providers to seek other sources for offsetting shortfalls, most typically commercial market reimbursement levels. Effectively, through its dictating public program provider payment levels, the government has apportioned the challenge to control costs to private health insurance plans. ■

This article was prepared on behalf of the Society of Actuaries (SOA) from various published reports, interviews and other sources to provide information on provider payment reform, as well as to stimulate discussion about the ability of the ACA to

achieve higher quality and lower costs in our healthcare system. The article is not intended for other purposes and the reader should seek qualified professional advice appropriate to their own specific needs. The statements contained in the report are those of the authors and do not necessarily represent the views of Milliman or its other consultants.

ENDNOTES

¹ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

² The expansion of Medicaid has resulted in fewer charity cases and higher revenue from people who were previously uninsured. However, the trade-off is that the Department of Health and Human Services (HHS) restructured uncompensated care payment by cutting disproportionate share hospital (DSH) payments and adding a new type of payment (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>). Fewer charity cases for the hospital could jeopardize its not-for-profit status. In addition, some providers and hospitals have invested resources in educating their patients on expanded coverage and helping them enroll. Providers in non-Medicaid expansion states had their DSH payments cut without receiving the extra bump from expanded coverage but may have received additional uncompensated care payments. It is difficult to generalize how exactly this will net out.



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Taxes and Fees Introduced by the ACA

By Rowen Bell and Mike Gaal

While much of the funding necessary to implement the Patient Protection and Affordable Care Act (ACA) was intended to come from general government revenues, the ACA did contain several revenue-raising provisions taking the form of new federal taxes, fees or penalties. (Of course, in one famous instance—the individual shared responsibility payment—one such provision had been called a “penalty” only for Chief Justice Roberts, critically, to conclude that it in fact was a “tax.”)

This article¹ focuses on three specific taxes or fees introduced by the ACA that have proven to be of significant interest to actuaries, namely:

- **Transitional reinsurance fee or reinsurance contribution (RC)**, which is levied under ACA Section 1341 primarily for purposes of providing funding for the individual market’s 2014 to 2016 transitional reinsurance program
- **Health insurer fee (HIF)**, levied under ACA Section 9010, starting in 2014
- **Excise tax on high-cost health plans or “Cadillac tax,”** levied under ACA Section 9001, starting in 2018.

From our current vantage in 2015, five years after ACA enactment, we know that the RC will pass into history in the near future, while the HIF has moved from an area of significant concern to an ongoing fact of life. Meanwhile, the Cadillac tax is starting to loom large and will likely be a focal point of energy over these next five years.

REINSURANCE CONTRIBUTION

ACA Section 1341 provides that, during the years 2014 to 2016, \$20 billion will be made available to carriers in the individual market under a gov-

ernment-provided reinsurance program. In addition, ACA Section 1102 provided that, between enactment and 2014, up to \$5 billion would be made available to employers under what was known as the temporary reinsurance program for early retirees.

In an effort to generate an offsetting \$25 billion in government revenues, ACA Section 1341 created a new fee on health insurers and self-funded health plan sponsors, generally known as the reinsurance contribution (RC). Unlike the other items discussed in this article, the RC is explicitly temporary, starting in 2014 and sunseting after 2016.

The statute provided flexibility for regulators to assess the RC on either a percentage-of-premium basis or a per capita basis, but only on commercial major medical coverage (i.e., by statute the RC does not apply to

Medicare or Medicaid coverage). Draft regulations implementing Section 1341 proposed the percentage-of-premium approach, under the theory that it would create better state-level alignment between the funding of the reinsurance program and the associated expenditures, as it would lead to higher RC amounts in states where health care is more expensive. However, the final regulations issued in early 2012 switched to the per capita basis, largely on administrative simplicity grounds. Because self-funded plan sponsors are part of the RC funding base, implementing a percentage-of-premium approach would have necessitated calculation of “premium equivalents” for self-funded plans; a per member charge may be less equitable in theory but was clearly going to be far less complex in practice.

So, by mid-2012 it was known that an insurer’s RC expense

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for 2014 would be calculated by taking a per member per month (PMPM) rate promulgated by the Centers for Medicare and Medicaid Services (CMS) and multiplying by its 2014 commercial member months. As such, contracts with effective dates of Feb. 1, 2013, or later would, in principle, contribute to the insurer's 2014 RC expense. Consequently, shortly after the ACA was upheld by the Supreme Court in the summer of 2012, insurers needed to consider taking actions to incorporate a load for the RC into pricing.

A very common pricing approach for a contract with a mid-2013 effective date was as follows: Take the load that would be appropriate for a contract on Jan. 1, 2014, multiply by the fraction of the contract year that overlaps 2014, and include that PMPM load in all 12 months' premiums. For example, if you expected the 2014 RC rate to be \$6.00 PMPM, then for a contract of March 1, 2013, you'd seek to include two-twelfths of that, or \$1.00 PMPM, in premiums. This approach preserved the ability to have level premiums over the contract year while still collecting the cash needed to fund the insurer's expense, albeit with the side effect that some of the premiums collected in 2013 were intended to cover an expense in 2014. An alternate approach, involving a defined premium step-up in the middle of the contract year (i.e., at Jan. 1, 2014), was less commonly used but had the advantage of better matching revenue and expense across years.

There are five important ways in which the HIF, by statute, differs from typical state premium taxes.

At the time that rates for early 2013 effective dates were being set in late 2012, insurers still needed to estimate what the 2014 RC rate would be. The statute indicated that the RC was supposed to produce \$12 billion in government revenues in 2014. Given that objective, one could estimate the 2014 RC rate by first estimating how many people in the United States would have commercial major medical coverage (whether insured or self-funded) in 2014. Based on materials from late 2012, most insurers expected that the 2014 RC rate would be in the \$5.70 to \$6.00 PMPM range, consistent with an expectation that somewhere around 165 million to 175 million members would be subject to the RC in 2014.

In December 2012, CMS published a regulation setting the 2014 RC rate at \$5.25 PMPM, implying that it expected about 190 million members to be subject to the RC. As of this writing, it is not clear whether or not the \$5.25 PMPM rate for 2014 has proven to be adequate to generate the intended \$12 billion of 2014 revenue; any shortfalls in the revenue raised by the RC could have implications for the collectability of insurers' 2014 transitional reinsurance receivables. A December 2014 regulation has set the 2016 RC rate at \$2.25 PMPM, which is consistent with an assumption that 185 million members

will pay the RC in 2016, a year where by statute the goal is to generate \$5 billion of revenue. However, because the deadline for 2014 RC submissions had been extended to January 2015, the 2016 rate would have been set without knowledge of actual 2014 collections.

One last technical item of interest regarding the RC involves income statement presentation. For an insurer not participating in the individual market, the insurer's entire RC payment is treated as an administrative expense. For an insurer participating in the individual market, however, a more nuanced treatment was adopted: A portion of the insurer's RC payment arising from its individual members is deemed to be a premium paid for by the government-provided reinsurance coverage funded by the RC, while the remainder of the RC payment is treated as administrative expense. The appeal of this approach is obscure, given that the amount deemed via this process to be reinsurance premium is surely far less than what a private reinsurer would seek to charge for the associated reinsurance protection.

HEALTH INSURER FEE

ACA Section 9010 is titled "Imposition of Annual Fee on Health Insurance Providers." It created a new premium-based federal tax, starting in 2014. This revenue-raiser has been

known by a number of different names, but for purposes of this article we will refer to it as the health insurer fee (HIF).

There are five important ways in which the HIF, by statute, differs from typical state premium taxes.

First, the statute defines an exact amount of revenue to be raised via the HIF in each calendar year, rather than specifying a tax rate to be applied. This feature has led to a process whereby insurers report their premiums to the Internal Revenue Service (IRS) on newly created Form 8963, and then the IRS apportions to each insurer a share of the statutory revenue target (which was \$8 billion in 2014) based on that insurer's proportion of total industry-wide reported premiums.

Second, the statute defines the HIF as being a nondeductible excise tax. As a consequence, from 2014 forward health insurers are reporting much higher effective tax rates (meaning, the ratio of income taxes to pretax income) than in the past, because pretax income is reduced by HIF expense whereas taxable income is not.

Third, the HIF expense that is due for the current year is not connected directly to the insurer's premiums for the current year. Instead, while it is the act of writing health insurance coverage in the current year that creates the insurer's obligation for HIF in the current year, the IRS uses insurers' reported premiums from the previous calendar year in the HIF apportionment calculation. (This has similarities to how the high-

risk pool assessments of many states worked historically.)

Fourth, the statute carves out certain classes of insurers for special treatment. One class is not-for-profit insurers that garner at least 80 percent of their revenues from Medicare Advantage and/or Medicaid; these insurers are exempted from the HIF. Another class is insurers that are exempt from federal income taxation; these insurers get to haircut their reported premiums by 50 percent.

Finally, the HIF does not apply to all types of health insurance premiums. Although dental, Medicare Advantage and Medicaid premiums are included alongside major medical in the HIF's scope (unlike the RC), other coverages such as Medicare Supplement, long-term care (LTC), disability and stop-loss are excluded.

These comparatively unusual facets of the HIF created a host of interesting issues for health insurers and their actuaries to confront over the past few years, as we now discuss.

The threshold question that insurers faced was whether they should seek to fully pass through the cost of the HIF to their customers, via premium increases. Although at first glance one might think the answer is obviously “yes,” there is more to think about here than meets the eye.

An important and unusual consideration here is the non-deductibility of the HIF. If a taxable company seeks to fund a \$10 million nondeductible expense, then increasing revenues by \$10 million will not make the company whole, because the company would need to pay income taxes on 100 percent of the incremental revenue. So, for an insurer paying federal taxes at the normal corporate rate of 35 percent, revenues would need to increase by \$15.4 million, or \$10 million divided by (1 – 35%), in order to generate \$10 million in after-tax dollars.

As a result, the HIF structurally places “fully taxable” insurers at a competitive disadvantage relative to other classes of insurers. As shown in the illustrative table in Figure 1, the amount by which the insurer would

need to increase its premiums to make itself whole with respect to the HIF (*ceteris paribus*, i.e., assuming no change in volume) can vary widely based on the insurer's tax status.

Now suppose you're a fully taxable insurer in a market that has competitors with different tax statuses. How elastic do you believe demand for your product is, relative to that of your competitors?

If you believe that demand is very elastic, then you might conclude that the economically rational thing to do is to not fully pass the HIF costs through to customers via premium increases, out of a fear that if you tried to increase your rates by 2.3 percent while your nontaxable competitor increased them by 0.8 percent, you might lose enough volume that you're worse off in the end on an underwriting margin basis. Conversely, if you believe that your product is sufficiently differentiated from competitors that customers will be sticky when faced with a 1.5 percent price differential shock, then you'd go ahead and seek to fully recoup the HIF costs via premiums, despite the theoretical competitive disadvantage.

With these dynamics in play, and with all the players needing to stake out their pricing strategies at roughly the same time, it was conceivable that different companies would pursue different strategic pricing paths—some deciding to fully pass the HIF costs on to customers, and others deciding to absorb some or all of the costs in the hope of making it up through volume.

In the end, however, it appears that all of the major fully taxable insurers chose to fully pass the HIF costs through and take their chances with respect to maintaining volume. History would seem to judge that this was the right strategy; the implementation of the HIF does not appear to have resulted in a significant shift of market share toward nontaxable insurers, despite the unlevel playing field it created.

After reaching the decision to pass through HIF costs to customers via premiums, insurers still faced a number of interesting decisions about precisely how to do that. In discussing that, we first take a detour into accounting considerations, as they became relevant to the selection of pricing tactics.

As noted above, under the statute an insurer's 2014 cash HIF payment was to be calculated as a function of its 2013 premiums, with the caveat that, if the insurer did not write any health insurance in 2014, then it would owe no HIF. Given these facts, in which year's income statement ought the insurer to recognize expense for the 2014 HIF payment: the year the cash will be paid (2014), or the year whose premiums were used in the calculation of the payment amount (2013)?

A similar issue had been addressed in GAAP many years earlier. A pronouncement from the American Institute of CPAs (AICPA) called Statement of Position (SOP) 97-3 contained guidance for how insurers should account for pre-

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Figure 1
Premium Increases to Pay for HIF

	Est. HIF as % of prem. (pretax)	Required make-whole prem. incr.
“Fully taxable” insurers (i.e., paying 35% corporate rate)	1.50%	2.31%
Insurers paying 20% alternative minimum tax (AMT) rate (some Blue Cross/Blue Shield plans)	1.50%	1.88%
Nontaxable insurers	0.75%	0.75%
Exempt nonprofit Medicare/Medicaid plans	0.00%	0.00%

mium-based, insurance-related assessments, e.g., an assessment on workers' compensation premiums to fund the operating budget of a state workers' compensation board. Under the AICPA SOP 97-3 model an insurer would record a liability, and hence also administrative expense, for a premium-based assessment in the year whose premiums were being used to determine the amount of the assessment, even if the assessment itself was not due until the subsequent year.

The SOP 97-3 framework, had it been applied to the HIF, would have implied that insurers would recognize the 2014 HIF payment as an expense in their 2013 financial statements. And that, in turn, would have suggested that insurers ought to collect a load for the HIF in the premiums earned in 2013, in order to avoid a material mismatch between income and expense in 2013.

However, a contrary accounting precedent was established in GAAP shortly after the ACA's adoption, with respect to yet another ACA-introduced fee: the Section 9008 fee on pharmaceutical manufacturers. This revenue-raiser was structured very similarly to the HIF, except that it took effect three years earlier, in 2011. As a result, there was an immediate post-adoption need for accounting guidance on this issue: Did pharmaceutical companies need to recognize an expense in 2010 for the 2011 payment? The conclusion of the Financial Accounting Standards Board (FASB) in 2010 was that no, the expense did not need to be rec-

ognized until 2011 even though 2010 sales figures would be used to determine each manufacturer's share of the total industry fee burden. The logic was that, under the statute, the activity triggering the manufacturer's liability for 2011 was not sales that had been made in 2010, but rather the first sale made in 2011.

Several months later, the FASB issued a pronouncement called Accounting Standards Update (ASU) 2011-06, which extended the same reasoning to the HIF, clarifying that the HIF was deemed to not be an "insurance-related assessment" (thus placing it outside the scope of SOP 97-3), and implying that for GAAP purposes health insurers would not recognize any HIF expense until 2014. Ultimately—although not without considerable debate and controversy—the same answer was reached by the National Association of Insurance Commissioners (NAIC) for statutory accounting.

In light of not only these accounting considerations, but also the general uncertainty that existed throughout the first half of 2012 about whether the ACA would survive Supreme Court review, insurers in general did not include any load for the HIF in premiums for policy years starting Jan. 1, 2013, or earlier.

From the cohort of Feb. 1, 2013, onward, however, most insurers started to include a pro rata HIF load, as part of premium rates that would remain level for 12 months, in a manner similar to that discussed above

for the RC. So, if an insurer was of the view that a 2.4-percent-of-premium load would be required for the cohort of Jan. 1, 2014, then rates for the cohort of March 1, 2013, would include two-twelfths of that, or 0.4 percent. Other insurers preferred an approach that used a defined mid-contract premium step-up at Jan. 1, 2014.

One drawback with the approach of including an HIF load in some of the premiums collected in 2013 was the interaction with medical loss ratio (MLR) rebate requirements. The federal definition of MLR allows insurers to reduce premiums by taxes/fees; so in the steady state, if an insurer is collecting the right amount in each year's premiums to cover its taxes/fees expense paid out that year, then its federal MLR is unaffected. However, 2013 was a special case: Insurers had increased premiums in order to start funding their 2014 HIF and/or RC, but had no HIF or RC expense to recognize, so the net effect was to lower the reported federal MLRs, which may have increased rebates in some cases. The industry made an effort to lobby the U.S. Department of Health and Human Services (HHS) for relief from this phenomenon in 2013 federal rebate calculations, without success.

The next key issue that insurers faced in thinking about incorporating the HIF into pricing was how to compute the required load. In theory, an insurer would have needed to estimate each of the following variables in order to determine

what its HIF load for the Jan. 1, 2014 cohort, ought to be:

- The 2013 premiums that the insurer would report to the IRS on Form 8963
- The total 2013 premiums that the industry would report to the IRS on Form 8963
- The amount of the insurer's 2014 premiums to which the HIF load will be applied
- The insurer's 2014 (federal and state) income tax rate.

Given that these estimates needed to be made in early 2013, it should not have been surprising that there was a lack of uniformity across the industry in the assumptions made for the Jan. 1, 2014 cohort's HIF load. In general, however, most of the fully taxable insurers came up with estimates in the range of 2.2 to 2.6 percent of premium.

Moreover, for a large insurer operating through multiple statutory entities or with multiple, separately managed lines of business, the insurer faced a philosophical decision: Should the HIF load be estimated at the holding-company level and applied equally across all entities and lines, resulting in some implicit cross-subsidization; or should different calculations be made for different entities and lines, reflecting differences in expected rates of premium growth from 2013 to 2014 or in income tax rates? Based on our inspection of 2014 rate filings, major insurers came down on both sides of this question.

One other issue of note involves the impact of the HIF on Medicaid rates. As noted above, Medicaid premiums are included in the scope of the HIF, although some nonprofit Medicaid insurers may qualify for an exemption from the HIF. As such, in order for a taxable insurer accepting Medicaid risk to be made whole, the capitation rate paid to the insurer from the state Medicaid program ought to include not only the HIF expense but also a provision for incremental income taxes. In March 2015 the Actuarial Standards Board (ASB) adopted Actuarial Standard of Practice (ASOP) 49 on Medicaid managed-care capitation rate development, and the new ASOP acknowledges this, stating (in Section 3.2.11.d) that the actuary should include in the capitation rate an adjustment to reflect the income tax impact of any nondeductible taxes that the insurer is required to pay out of the capitation rate.

As we move forward beyond 2015, much of these uncertainties and transition concerns lie behind us. The overall industry HIF burden is growing by statute, from \$8 billion in 2014 to \$11.3 billion in 2015 and 2016 and then on to \$13.8 billion in 2017. This has led to an increase in HIF loads from 2014 to 2015, with current loads typically being around 3.0 percent for fully taxable insurers; also, the ability to estimate future HIF load requirements is enhanced by the fact that the industry has now been through one HIF reporting and collection cycle. Most observers expect that HIF loads will not need to increase materially be-

yond the current level in the foreseeable future. As such, now that the HIF's existence has been taken into account in pricing, future changes in the HIF are not expected to be a material contributor to future rate increases; the shock has been absorbed.

Despite that, HIF repeal remains of interest to many stakeholders. A 2013 bill whose sole purpose was to repeal ACA Section 9010 attracted 231 co-sponsors in the U.S. House of Representatives, yet died in committee; a similar bill introduced in February 2015 has attracted 196 House co-sponsors as of the end of March. Another 2013 bill would instead have delayed HIF implementation until 2016 and obligated insurers to return to their customers any amounts that had been collected for purposes of funding 2014 or 2015 HIF payments; it attracted 98 co-sponsors in the House but also died in committee. As this latter bill highlights, a practical difficulty with simply eliminating the HIF at this point is how to do so without creating windfall profits for insurers.

EXCISE TAX OR "CADILLAC TAX"

ACA Section 9001 is titled, "Excise Tax on High Cost Employer-Sponsored Health Coverage." It amended Internal Revenue Code Section 4980I to create an "excess benefit" tax on employer-sponsored health care coverage, beginning in 2018. This provision is often referred to as the "Cadillac tax," in reference to the high value of benefits provided by a number of employer health plans.

This provision is one of the key revenue drivers of the ACA, and beyond the initial legislation there has been little additional information provided about how the Cadillac tax will be implemented and operationalized. However, on Feb. 23, 2015, the IRS and U.S. Treasury issued Notice 2015-16, which is "intended to initiate and inform the process of developing regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage."

While Notice 2015-16 did not provide us with all of the answers we have been seeking for the past five years, it did attempt to clarify some of the existing language, as well as suggesting some approaches to handle other aspects of the calculation. The notice was also very clear that Treasury and the IRS are very interested in receiving public comments to inform the proposed regulations. Comments were to be submitted by May 15, 2015. At the very least, the notice seems to indicate the government is moving full steam ahead to implement the Cadillac tax, so those employers that were maintaining status quo while holding out hope for a repeal or delay may need to change course.

The remainder of this section addresses the following key questions:

- Who has responsibility for calculating and paying the Cadillac tax?
- How is the amount of the Cadillac tax determined?
- What coverage is included in the calculation?

- How is the cost of coverage determined?
- What are the next steps?

Who has responsibility for calculating and paying the Cadillac tax?

In terms of calculating the tax, the responsibility falls on the employer to both calculate the amount of the excess benefit and notify the HHS secretary and each "coverage provider" of the amount. For multiemployer plans, the plan sponsor is required to perform the calculations and provide the notice to coverage providers.

Ultimately, it is the responsibility and liability of the coverage provider to pay the tax. However, there has been some confusion as to what entity actually bears this responsibility. While it seems clear that, in a fully insured plan, it is the insurance provider that will pay this cost, the language regarding self-insured plans is less straightforward, noting "the person that administers the plan benefits" will be liable for paying the tax, which is further defined to include the plan sponsor if the plan sponsor administers benefits under the plan.

Regardless of what entity ultimately pays the tax, the expectation is that any payable tax will ultimately flow back to the employer in the form of higher insurance rates and/or administrative expenses, even if it is the third-party administrator (TPA) or insurance carrier that is responsible for paying the tax.

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How is the amount of the Cadillac tax determined?

At its most basic level, the tax will be determined as follows:

- For any employee with an “excess benefit,” the employer will pay an amount equal to 40 percent of the excess benefit.
- The excess benefit is defined as the monthly cost of the applicable employer-sponsored coverage of the employee less one-twelfth of the annual limitation.
- The annual limitation is defined as:
 - \$10,200 for an employee with self-only coverage
 - \$27,500 for an employee with coverage other than self-only.

Additionally, there are some potential adjustments to the annual limitation to consider, such as:

- **The health cost adjustment percentage.** If the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield (BCBS) standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010 by more than 55 percent, the excess of that amount will be used to increase the annual limitation.
 - For example, if the BCBS standard benefit option increases by 65 percent

from 2010 to 2018, the health cost adjustment percentage will be 110 percent (100% + 65% - 55%), and the annual limitations would be \$11,220 and \$30,250 for self-only and other-than-self-only coverage, respectively.

- Through 2015, the BCBS standard benefit option has increased by only 18 percent over 2010, which seems to indicate there will be no adjustment for this factor.

- **Age and gender adjustment.** After any application of the health cost adjustment percentage, if the premium for the BCBS standard benefit option for the age and gender characteristics of the employer is greater than the premium determined for the age and gender characteristics of the national workforce, then the excess amount would also be used to calculate the annual limitation.
 - It should be noted that there is very little information available regarding the exact methodology to be used for this adjustment. However, Notice 2015-16 is seeking comment regarding this provision.
- **Exception for qualified retirees and those engaged in high-risk professions.** For these individuals, the dollar amounts noted above are increased by \$1,650 for self-only coverage and \$3,450 for other-than-self-

only coverage, resulting in the following amounts:

- \$11,850 for an employee with self-only coverage.
- \$30,950 for an employee with coverage other than self-only.
- It should also be noted that these amounts cannot be stacked (i.e., a qualified retiree who was engaged in a high-risk profession would only receive one adjustment, not both).
- A qualified retiree is defined as an individual who is receiving coverage by reason of being a retiree, has attained age 55, and is not entitled to benefits or eligible for enrollment under the Medicare program.
- While some high-risk professions have been clearly identified (e.g., those who repair or install electrical or telecommunications lines, law enforcement officers, paramedics), there is still uncertainty regarding what other professions may qualify as high-risk. Notice 2015-16 is seeking comment on this topic as well.

After 2018, the annual limitation (including the health cost adjustment percentage and exception for retirees and high-risk professions) will be equal to the prior year’s annual limitation increased by the consumer price index (CPI), with the exception of 2019 where the increase will be the CPI

plus 1 percent, rounded to the nearest \$50.

One additional key note is that, with respect to the annual limitation, any coverage provided under a multiemployer plan will be treated as other-than-self-only coverage.

What coverage is included in the calculation?

The definition of applicable employer-sponsored coverage is “coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).”

The term “group health plan” refers to a plan (whether self-insured or fully insured) that provides health care (directly or otherwise) to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship or their families. In addition, it does not make a difference whether the employer or the employee pays for the coverage, and the full amount of the benefit is includable in the calculation.

While the regulations regarding what’s in and what’s out are very detailed, complex, and require a significant amount of research to understand, we can attempt to boil it down to the most basic level that most employers would be concerned about. In general, the most significant items employers and multiemployer plans should be

concerned about are the following:

- Medical and pharmacy coverage
- Tax-free contributions to accounts (flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs) and medical savings accounts (MSAs))
- Dental and vision coverage, if they are attached to the medical plan election
- Coverage for on-site clinics (if not de minimis)
- Executive physical programs.

Notice 2015-16 addresses a number of these items and over the next couple of years the details will be worked out. As it stands today, in early 2015, as employers assess their potential liabilities, the focus will be on the items listed above.

How is the cost of coverage determined?

According to the regulations, the cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f) (4), which apply for purposes of determining the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applicable premium. However, any portion of the cost that is attributable to the excise tax cannot be taken into account. The regulation also states that the amount shall be calculated separately for self-only coverage and other-than-self-only coverage.

While the ACA only dedicated about a half-page to this discussion of determination of cost, Notice 2015-16 dedicated nearly 11 pages to the discussion of this topic. Some of the most important topics addressed in the notice are the following:

- A discussion of the two methods prescribed under the COBRA regulation, which are:
 - The actuarial basis method
 - The past cost method.
- A suggested approach to prevent abuse of switching between methods.
- A discussion of whether there should be specific standards or factors that need to be satisfied, and whether assumptions and methods should be prescribed under these two methods.
- Confirmation that “applicable coverage” is based on coverage in which the employee is enrolled, rather than coverage offered to the employee but in which the employee does not enroll.
- A discussion of how to determine which enrollees are “similarly situated,” including:
 - Separating employees by benefit package election
 - “Mandatory disaggregation” into self-only and other-than-self-only coverage

- “Permissive aggregation” in the other-than-self-only bucket, i.e., combining employee + spouse, employee + child(ren), and family tiers together
 - The potential for “permissive disaggregation” into other categories, such as collective bargaining status or bona fide geographic distributions.
- A discussion regarding the appropriate methodology to determine HRA costs.
 - A discussion of the determination period.

To summarize, although a number of unknowns remain in terms of determination of cost, Notice 2015-16 provides a great deal of insight regarding the key issues that still need to be addressed. For the time being, we expect plans will continue to evaluate costs in a COBRA-like manner until the comments are sorted out and proposed regulations are developed.

With respect to retirees, whatever the ultimate guidance on aggregating plans for excise tax, there will be no impact on the requirements for financial statement determinations of liability—calculations will still need to reflect the “true” cost of the plan for each participant.

What are the next steps?

Employers and actuaries have waited five years for guidance on how the Cadillac tax will be implemented. With the release of Notice 2015-16, some additional insight has been gained, but many questions still remain.

First and foremost, there was an opportunity to submit comments about the notice in an attempt to help shape the proposed regulations and future guidance. But most importantly, for employers, the window to implement a long-term cost containment strategy is closing. In less than two years from now (early 2017), employers will be working toward finalizing their 2018 benefits program offerings. While a number of employers have been focused on this issue over the past few years (and simply need to stay the course), those who were taking a “wait and see” approach just received a clear indication that waiting is no longer a prudent alternative. ■

ENDNOTE

- ¹ Rowen Bell authored the sections of the article discussing reinsurance contribution and the health insurer fee. Mike Gaal authored the section discussing the excise tax on high-cost plans.



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The CLASS Act and Its Aftermath

By Robert Yee

BACKGROUND

The Community Living Assistance Services and Supports (CLASS) Act is a part of the Patient Protection and Affordable Care Act legislation relating to a voluntary federal insurance program for long-term care (LTC). This program was subsequently repealed due to serious actuarial issues in implementation. This article discusses the lessons learned from the CLASS program and the prospect for future social LTC financing.

LTC is comprised of a broad range of chronic care services for the elderly and younger individuals with disabilities. Such services include care in nursing facilities, therapeutic services, adult day care, home care services, homemaker services, etc. LTC services are generally not covered by private medical insurance. Medicare covers very limited LTC services for retirees.² Medicaid provides LTC only for individuals with minimal income or assets. However, since the costs of LTC can rapidly deplete an individual's assets, a sizable portion of low- to middle-income individuals can qualify for Medicaid after they start paying for LTC services. Thus, Medicaid serves as an LTC safety net for many

more individuals besides the indigent.

Approximately 1 out of 2 persons over age 65 will need some form of formal LTC services over his or her lifetime.³ The current average annual cost of nursing home services per person is \$77,000; the corresponding cost for home health care services per person is approximately \$20,000.⁴ An average LTC episode is about 30 months.⁵ Thus LTC expense poses a significant financial risk for seniors.

Because of the aging population, it is also a social financial risk for all Americans as well. In 2015, there are 6.3 persons of working ages 18 to 64 for every elderly person age 70 and over. By 2040, there will be only 3.5 workers to support every such elderly person.⁶ Unless the current "pay-as-you-go" funding mechanism for Medicare and Medicaid is changed, LTC will put an increasingly heavy financial burden on future generations of workers.

Private LTC insurance has generally been proven to be ineffective for financial protection against LTC risk for the society as a whole. Because premiums are relatively expensive and unstable, sales have been ane-



mic with less than 6 percent of the adult population covered.⁷ More importantly, there is hardly any penetration on the low-income population that is most at risk to become future Medicaid beneficiaries.

CLASS ACT

The CLASS Act legislation was forged under this stark context by the late Senator Edward Kennedy in 2010. It was intended to be a voluntary insurance program funded only through participants' contributions. The statute required the program to be self-sustaining and to accept participation with no underwriting. In lieu of underwriting, the act enforced a five-year waiting period from the enrollment date before a participant can claim benefits. The daily benefit varied from \$50 to \$75, which was adequate for home and community care but insufficient to pay for typical nursing facility care. Students and low-income indi-

viduals would only pay a token premium. Other challenges for program implementation included payment of benefits in cash, payments to family members, restricted administrative expenses and the lack of marketing allowance. Besides these obstacles, the major requirements of voluntary participation and guaranteed issue made the program design actuarially unsound.

Because the final version of the statute was drafted almost overnight, there was no legislative history for interpretative guidance. Nevertheless, the Secretary of the U.S. Department of Health and Human Services had sufficient latitude under the act to implement a viable program, subject to potential legal challenges. The Administration was on the defensive at the very start. The program was under constant attack by Republicans particularly in regard to the advertised promise

of federal savings over the first 10 years due to the waiting period provision. Another obstacle to implementation was the mandatory launch of no later than 2013. This precluded the possibility of testing various designs that might maximize participation and thereby minimize adverse selection.

After nearly a year of deliberation, the Secretary declared that the CLASS Act was unworkable. It was repealed under the 2012 American Taxpayer Relief Act. In its place, an LTC Commission was formed to study various LTC issues and make recommendations. The commission concluded its findings in 2013 but failed to recommend specific financing solutions.

FINANCING CHALLENGE

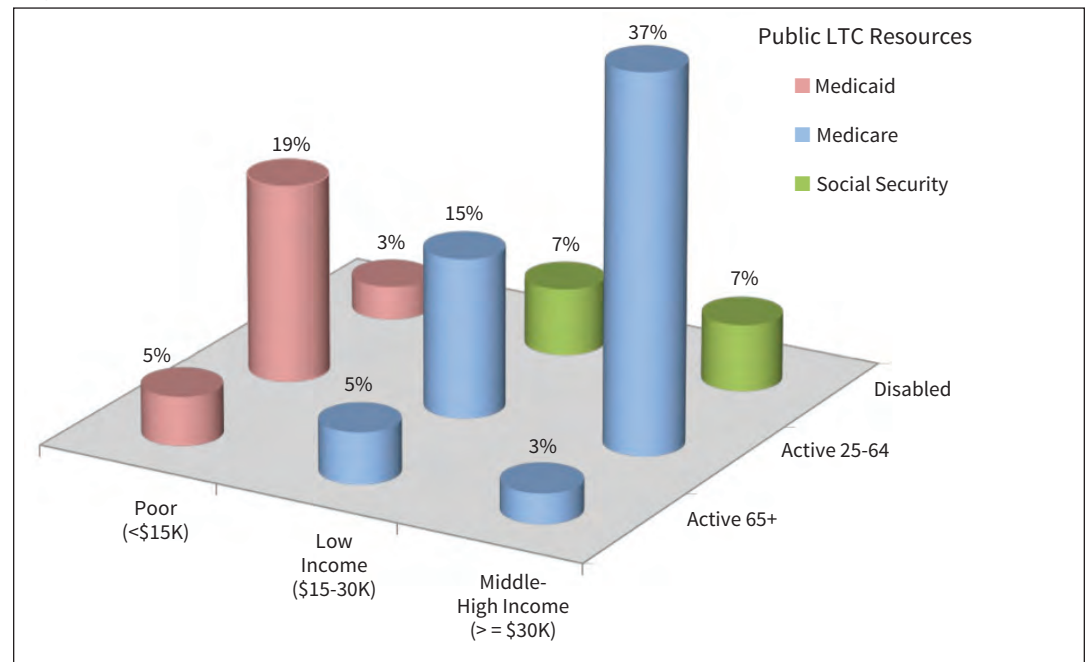
A fundamental question on LTC financing is the role of the government. Is it solely an individual's responsibility or is the government obligated to assist in the growing demand for LTC? Should LTC be considered as a basic need that warrants social support such as police and fire protection and other critical public assistance?

Perhaps a related but more practical question is whether doing nothing is an option. The need for LTC is growing as the population ages. As an indication, total LTC expenditures were 1.3 percent of the gross domestic product during 2010.⁸ This number is projected to reach 2.6 percent in 2040. In the past, workers have been paying for benefits of the old in public programs. In the future, there will be fewer workers to support

a higher proportion of seniors. The current de facto public programs for LTC will be burdensome for future workers.

Currently, there are 217 million U.S. adults age 25 and over.⁹ In order to appreciate the challenges in LTC financing, it is useful to segment this population by age and income,¹⁰ as well as by current or earmarked coverage from the public programs. (See Figure 1.)

Figure 1



An LTC social financing program should address the specific needs of the 5 groups of constituents: the poor, the low-income workers, middle-to-high-income workers, the retirees and the disabled. A 'one size fits all' method will probably not work. The poor and the disabled are currently covered by public programs. Medicaid pays for LTC services for the poor and Social Security typically pays income

and medical benefits for the disabled. An overhaul of the current systems to accommodate LTC would need to account for these two groups. If a new LTC financing program leaves the current support systems intact, then it can focus on the remaining groups: the two income classes of workers and the retirees.

on financing mechanisms that involve minimal or no monetary government support. The prevailing view, evidenced from public surveys,¹¹ is that LTC is largely an individual's responsibility and not a basic social right.

This perspective was the fundamental premise for the CLASS Act. The act emphasized long-term actuarial soundness with only incidental government

LEARNING FROM THE PAST

The most straightforward financing solution would be an expansion of the current public programs. In this era of large government deficits, there is little political appetite for this approach. Moreover, any expansion would exacerbate the increasing burden of current programs for current and future workers. Accordingly, most discussions have centered

support. The soundness requirement underscored the attention to careful premium development and proper program risk management. Despite its major failing, it had a number of salient features that a future financing program should emulate. It provided for only a basic level of benefits that struck a proper balance between minimally adequate benefits and

CONTINUED ON PAGE 60

affordable premiums for most participants. This feature allowed for the purchase of additional coverage through private insurance. From a marketing perspective, it relied on the employers to promote employee participation in the workplace.

One of the major pitfalls of the CLASS Act is that it attempted to cover the low-income workers and disabled individuals through subsidization. The stipulated low premium for the near-poor and low-income merely shifted the costs to other workers and subsequently made the contributions less affordable to the rest of the participants. Under a voluntary program, this creates adverse selection risk and adds to the instability of the contribution structure.

FINANCING OPTIONS

Perhaps the real downfall of CLASS is that the drafters had limited information through research and analysis for prudent program design. They underestimated the need for incentives in order to achieve the participation level that is necessary in a guaranteed issue, voluntary program. Two critical ingredients for success—namely, incentive and insurance principle—must work in unison for all constituents in the program. What follows is a discussion of a number of financing options that may enhance the chance for success in a future financing program.

As adopted in the CLASS Act, the logical direction to LTC financing is a pre-funding approach. Since not everyone will need LTC services,

an insurance program with a pre-funding feature is most efficient in this respect. However, this approach is problematic for retirees. The likelihood of needing LTC services is much greater at advanced ages and the relatively short funding period would cause the contribution level to be unaffordable to most retirees. Many of the proposals focusing on the retirees involve the trade-off concept. Retirees can trade a portion of their Social Security benefits for coverage in an insurance program. Retirees can trade equity in their homes or death benefit in their life insurance for LTC benefits. None of these proposals can curtail the rising Medicaid LTC expenditures since they do not prevent low-income retirees from becoming Medicaid beneficiaries. The lack of effective immediate coverage for retirees is a harsh reality of LTC financing. This means that any viable financing solution would have little near-term savings in government programs.

For the working population, the CLASS Act has shown that a voluntary program with no underwriting is actuarially unworkable given the anticipated low level of participation. There is also a current stigma against mandatory individual

contributions to public programs. Attention is therefore being directed toward proposals to provide incentives for working adults to participate.

One incentive is to make the access to the insurance program simple. The workplace is ideal where workers can participate through the normal benefit enrollment and payroll deduction procedures. Under the CLASS Act, companies can offer eligible employees the opportunity to participate. Employees would be automatically enrolled unless they opt out. This approach should be adopted under a new LTC social insurance program. In order to have greater participation, the offer should be made mandatory by the employers. A number of large employers are already offering LTC insurance to their employees. Like other health benefits, LTC insurance coverage should be made ubiquitous.

The use of 401(k) or individual retirement account (IRA) funds for LTC is an attractive option for middle- to-high-income workers. As shown in Figure 1, this is the largest segment (37 percent) of the current adult population age 25 and over. Approximately 40 percent of all workers have a retirement savings account and the average balance is slight-

ly over \$50,000.¹² A proposal is to allow tax-free and penalty-free withdrawals from these accounts to pay LTC service costs when they are incurred or to pay LTC insurance premiums. An example of such an insurance design is to set up an LTC subaccount in the 401(k) account where account value is allocated for LTC insurance purposes. From this subaccount, the insuring entity would annually deduct a cost of insurance for the LTC insurance coverage for that year. For most workers, this amount would only be a few hundred dollars. This cost of insurance would go up each year as the risk of LTC grows by age. The insuring entity would periodically advise the workers of the balance in the subaccount that is necessary to fund future insurance costs. The subaccount operates in a similar fashion to a universal life insurance policy but does so inside the 401(k) account.

Conceptually, LTC financial security is a part of retirement security. Out-of-pocket LTC expenses are detrimental to retirement savings. The use of funds in the account to protect the account itself serves the workers' best interest. The attraction to the workers is that the LTC premiums become practically painless since there is practically no deduction from their paychecks. This would reduce the number of opt-outs significantly and increase the level of participation in the LTC insurance program.

The potential downside of allowing such withdrawals is the loss of federal tax revenues.

Unless the current “pay-as-you-go” funding mechanism for Medicare and Medicaid is changed, LTC will put an increasingly heavy financial burden on future generations of workers.

There are three sources of loss. First, there is the withdrawal from the account to pay for incurred LTC expenses. This tax revenue loss is relatively minor since LTC events are rare during the working years. Second, there is the loss when costs of insurance are deducted on a tax-free and penalty-free basis. However, there is no real current loss. The tax loss would be far in the future when funds used to pay for premiums would have been distributed then. Finally, this incentive might encourage workers without a tax-deferred savings account to initiate one. Since they are likely to be workers with low income, potential tax revenue loss would be partially offset by Medicaid savings. Overall, the option of allowing the use of 401(k) funds should have minimal impact on the federal budget.

The low-income workers, at an estimated 15 percent of the current adult population, have little or no discretionary income. Incentives are not that helpful to them. They would need subsidies in order to participate. Unfortunately, there is no readily available source of subsidies unless it is from the federal or state government. An alternative is to require new workers entering the workforce to participate. Employers would be given incentives in order to subsidize their employees' premiums on a temporary or a permanent basis. This is plausible since premiums for beginning workers would be quite low. As this alternative would likely leave a sizable segment of the current low-income workers out of the program, it would

take longer for the positive effect of the insurance program on government programs to take place.

It is intuitive that a well-designed program can result in future Medicare and Medicaid savings. With proper modeling tools and techniques, such savings perhaps can be quantified in a fairly precise fashion. If this can be done, then future savings can be set aside to pay for current subsidies for the low-income working class. Since benefit claim rates are low for workers, the majority portion of the premiums in their working years would have been reserved for future claims anyway. The insurance program would be actuarially sound during the beginning years if the promise of future funds can be relied on. In order for this funding option to work, there must be proper accounting of the future savings and legislative discipline to protect such funds from other uses. As with the option of requiring new workers to participate, this option would lengthen the time period for positive impacts on government programs.

LOOKING FORWARD

Even though the LTC Commission punted on the financing issues, the momentum to search for solutions has been building. There is a recent groundswell of activities sponsored by interested groups such as the SCAN Foundation and the Bipartisan Policy Center, as well as the Office of the Assistant Secretary of Policy and Evaluation (ASPE) in the Department of Health and Human Services. Their goal is to develop estimates of

future LTC expenditures and model the impact of various potential solutions.

The significance of their efforts extends beyond the technical analysis toward viable solutions. The deliberation of the results of the analysis will continue the public discourse toward greater clarity and common understanding of the financing dilemmas. Hopefully, a number of reasonable proposals will surface. These proposals can potentially be tested in a few states.

Perhaps most importantly, a consensus may be formed with broad support from various interested groups. A consensus is crucial because LTC financing is an important public issue but not urgent. A sensible solution will necessarily be a compromise and may be in direct conflict with certain noble certainties. To push any such proposal through legislation would require the dedication of a fearless champion who will need as wide a support base as possible.

Out of respect and appreciation for our seniors, protecting them from LTC financing risk is fittingly an important element of the society's attention on retirement security. The ultimate goal is overall successful aging for seniors. To this end, governmental and private stakeholders will be continuously seeking innovative ways to deliver high-quality, individualized LTC support in conjunction with formulating financing solutions. ■

ENDNOTES

- ¹ Another acronym is LTSS, which stands for Long-Term Services and Supports.
- ² Medicare pays for the first 20 days of a skilled nursing facility stay after at least three days of hospital stay and pays for amounts in excess of \$157 per day (in 2015) for the next 80 days. It also pays for limited home health care services due to injury or illness.
- ³ *Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?* Peter Kemper, Harriet L. Komisar and Lisa Alecxih, Table 2, Inquiry, Volume 42, Winter 2005/2006.
- ⁴ Genworth 2014 Cost of Care Survey. Home care cost assumed 20 hours a week.
- ⁵ *2014 Sourcebook*, American Association for Long-Term Care Insurance.
- ⁶ These dependency ratios were derived from population projections based on the 2010 Census—U.S. Census Bureau.
- ⁷ There are approximately 10 million LTC insurance policies in force—*Long-Term Care Insurance: A Product and Industry in Transition*, Marc A. Cohen, Ph.D., LifePlans, Incorporated, November 2012.
- ⁸ *Rising Demand for Long Term Services and Support for Elderly People*, Congressional Budget Office, June 2013—Exhibit 23.
- ⁹ U.S. Census Bureau.
- ¹⁰ *Personal Income 2010 and Americans with Disability 2010*—U.S. Census Bureau.
- ¹¹ See, for example, 2014 *Survey of Long-Term Care Awareness and Planning*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
- ¹² Private Pension Bulletin—Table E20: <http://www.dol.gov/ebsa/pdf/historicaltables.pdf>.



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Epilogue

By Jim Toole and Carmen Easterwood

After five years under the new health care regime, what has changed? Maybe the easier question is what hasn't. Of course the Patient Protection and Affordable Care Act (ACA) is not perfect and important issues still need to be addressed. The ACA adds a new layer of complexity on top of an already complex system. However, on the whole the bill has done remarkably well at achieving its objectives.

Perhaps most importantly, the ACA is meeting its goal of expanding coverage. At the end of 2013, immediately prior to the opening of the health insurance exchanges, Gallup measured the uninsured rate at 17.1 percent. As of the first quarter of 2015, that rate had fallen to 11.9 percent, and is expected to fall further in the second quarter due to a special enrollment period established for those who realize while filing their taxes that they must purchase health coverage. According to Department of Health and Hu-

man Services (DHHS) statistics, that rate decline is a result of over 16 million people gaining insurance coverage. That number would be even higher if not for resistance to expanding Medicaid in some states.

The ACA has also done well from a cost perspective. The Congressional Budget Office (CBO) has revised down the expected cost of the bill by about 20 percent. Furthermore, the "rate shock" and "death spirals" that some had warned of have not only not happened, but 2015 rates were 16 percent lower than the DHHS expected. While preliminary rate filings for 2016 indicate large rate increases for some states and plans, it is too early to predict where rates will ultimately land. Similarly, there is no evidence that ACA requirements are hurting job growth, as job growth has continued for 56 consecutive months, the longest streak on record, and involuntary part-time employment has declined.

Unfortunately, the public and the political discourse have not fully absorbed these coverage and cost achievements. One reason for this is that the ACA has a minimal effect on those who already had employer-based insurance. However, the conversation surrounding the ACA is also very politically charged, and too often prioritizes an ideological position above facts. This is a major challenge going forward, and actuaries have the ability and responsibility to contribute robust, data-driven analysis of the true effects of the ACA. Put in language we all understand: We need to continue substituting facts for impressions.

As implementation of the ACA continues, the health care delivery and financing system will need to address new challenges posed by the law. For example, what can be done to address insufficient Medicaid reimbursement rates in an era of rapidly expanding Medicaid enrollment? What are the ideal role and structure of accountable care organizations, and what role should health actuaries play ensuring prudent risk management and ongoing fiscal strength? How do we adjust to the elimination of the ACA's temporary reinsurance and risk corridor schemes? Actuaries must be involved in designing the solutions to these problems. They must also be aware of broader issues in the pipeline, such as an impending shortage of primary care doctors on one end and gerontologists on the other. What effects will this shortage have on access, cost, and quality of care? More gen-

erally, how do we allocate care in a world of limited resources?

There is no magic bullet for curing the problems of the U.S. health care system. However, after years of uncontrolled cost growth and unacceptable barriers to access, the ACA has set the United States on a path toward more accessible and effective health care. Actuaries are in an excellent position to determine how these improvements can be preserved and expanded. As experts in the consequences of health risk, health actuaries must be leaders in creating a health care delivery and financing system that appropriately manages this risk, ensuring that actuarial principles and evidence-based approaches play a critical role in health policy-making. ■

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Actuaries have the ability and responsibility to contribute robust, data driven analysis of the true effects of the ACA.

Final Thoughts

By Valerie Nelson

Sometimes it just takes one idea to spark an entire publication. The idea for *The ACA@5: An Actuarial Retrospective* came from Rowen Bell. Rowen—thank you for allowing us to put your idea into motion and thank you for your contributions to this publication as well!

I would like to give a big thank you to all the authors for their time, effort and patience in contributing to this publication.

The goal for this publication was to document the last five years since the passage of the Patient Protection and Affordable Care Act (ACA) and the effect the legislation had on the health actuary. How did these reforms impact our roles as an actuary? What happened and how is our industry still changing? I hope that the readership is able to see that theme throughout the publication. Further, there are comments made in this publication that are already dated or could be taken to be an author's view of events that took place. This should not be a surprise as information continues to change as these programs mature. Please keep in mind that opinions are those of the authors.

Finally, this publication could not cover everything related to the ACA that impacted actuaries. If we did, this publication would be twice the size. However, there are many articles already written on ACA topics that this publication purposely missed. For prior publications of *Health Watch*, please check

out the publications section at www.soa.org/health/. For prior publications of *The Actuary*, please check out the link at www.soa.org/actuarmag.

It has been a pleasure to work on *ACA@5: An Actuarial Retrospective*. It will be interesting to see what the next five years bring. ■



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