

Learning from Medicare Advantage and Part D: Lessons for the individual insurance market under ACA



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Commercial issuers of non-grandfathered individual insurance plans face new challenges under the Patient Protection and Affordable Care Act (ACA)—especially if they plan to provide those plans through state health exchanges as qualified health plans (QHPs). What can they learn from Medicare Advantage and Medicare Part D to help them reduce risk and plan for the future?

MEDICARE PART D AND ACA: THE FAMILY RESEMBLANCE

The Patient Protection and Affordable Care Act (ACA) is fundamentally changing certain commercial health insurance markets—particularly for issuers of individual insurance. For those whose business practices regarding individual policies have been forged in the private, pre-ACA market, the transition will present significant challenges. Many of the instincts and axioms that have helped insurers make critical business decisions over the years will not serve them well in this new environment. They will face intensified regulatory scrutiny from new sources and function under new, complex, and changing requirements. These carriers need to control costs more tightly than ever before.

One place to look for new keys to success in the commercial market is the Medicare Advantage and Medicare Part D (MAPD) market. Although recent news coverage¹ and articles² have sought to compare the rollout of the Medicare Part D program to the implementation of ACA reforms in the commercial market, to date the focus has been on the logistical and political challenges associated with implementing any large change to the healthcare system. However, the similarities go much deeper—all the way to the very bones of the ACA law and regulations, which borrow many ideas directly from the implementation of MAPD. Because of this regulatory strategy, savvy issuers of commercial health insurance might do well to study the MAPD market to learn what their future may look like. This will help them to anticipate the challenges and risks inherent in this transformed market, and potentially identify strategies for success.

This paper explores significant parallels between the ACA regulation of the commercial market and the existing regulation of the MAPD market, and draws out some key insights that may help insurers make sense of it all.

WHY IS MAPD RELEVANT TO THE POST-ACA INDIVIDUAL INSURANCE MARKET?

Medicare Advantage is a private-public partnership in which the federal government pays private insurers to provide coverage to those seniors who choose a Medicare Advantage plan over standard Medicare coverage provided directly by the government. A related program, Medicare Part D, provides government-subsidized private plan options where seniors—both those enrolled in a Medicare Advantage plan and also those in original Medicare—can obtain prescription drug coverage.

As we will see, MAPD is fundamentally similar to, and was in fact used as a blueprint for, the individual market under ACA—also a public-private hybrid. The ACA does not establish a *single-payer* system in which the government pays for an entire centralized health system. However, under the ACA, the federal government is using substantial tax revenue to subsidize the premiums, co-pays, deductibles, and other costs of low-income citizens, as well as for a variety of other purposes. These subsidies add up to a lot of money—a recent Milliman report estimates that the average subsidy per subsidized enrollee will amount to approximately 40% of silver plan premium in the individual market in 2014.³ What is clear from experience with MAPD is that the hybrid model brings with it unique risks, challenges, and opportunities, which is why the comparison is so fruitful.

Of course, there are also many differences between the MAPD program and commercial coverage under the ACA. In particular, when the MAPD programs were introduced, the populations involved were generally already receiving benefits through the

1 Milliman, Jason. (2013, June 26). Medicare Part D offers lessons for Obamacare. *Politico*. Retrieved August 6, 2013 from <http://www.politico.com/story/2013/06/medicare-part-d-obamacare-93368.html?hp=r13>.
Rovner, Julie. (2013, July 12). Messy Rollout Of Health Law Echoes Medicare Drug Expansion. Morning Edition, National Public Radio News. Retrieved August 6, 2013 from <http://www.npr.org/blogs/health/2013/07/12/200401757/ACA-VERSUS-PART-D>.

2 Hoadley, Jack et al. (2013, June 20). Launching the Medicare Part D Program: Lessons for the New Health Insurance Marketplaces. Georgetown University Health Policy Institute. Retrieved August 6, 2013 from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/06/launching-the-medicare-part-d-program-lessons-for-the-new-health.html>.

3 O'Connor, Jim. (2013, April 25). Comprehensive Assessment of ACA Factors that will affect Individual Market Premiums in 2014. *AHIP*. Retrieved August 6, 2013 at <http://www.ahip.org/MillimanReportACA2013/>.

original Medicare program, and consequently much was known about their demographics and morbidity levels. Under the ACA, it is difficult to precisely predict what populations will sign up for coverage in the new individual health insurance marketplaces, and how they will differ from those currently insured.

SIMILARITIES BETWEEN MAPD AND INDIVIDUAL INSURANCE UNDER ACA

This section covers some of the many regulatory and operational parallels between MAPD and individual QHPs under ACA. Some of these elements are designed to help insurers through the challenging early years of implementation. Others are meant to protect consumers and increase fairness or improve the overall quality of care. All of them make the prospect of selling individual health plans more complex.

The impact of earlier filing deadlines

By law, MAPD insurers must file their *bids* with the government by the first Monday in June, setting their premium rates, benefit designs, and other key assumptions for the following calendar year.⁴ The bids must be completed in a standard format set by the government and must include substantial supporting documentation. Key regulatory information, including the rates the government will pay insurers, is typically released in the spring of each year. This has several consequences for MAPD issuers:

- Due to the timing of the filing process, the bids and premium rates must be developed with data from the prior calendar year—two years prior to the year when rates will be in effect.
- Due to the timing of the release of regulatory information, bids must be developed in a compressed timeframe each spring.
- There is generally no opportunity to correct pricing until the next bid cycle—a full year away.

All three of these consequences increase pricing risk for issuers. In the early 1990s, the American Academy of Actuaries Health Organizations Risk Based Capital Task Force found that a primary driver of risk for individual health insurance issuers is the amount of time it takes an issuer to correct premium rates in the event that they are insufficient.⁵ By requiring rates to be based on older data and locking them in for a year at a time, the bid process greatly increases this risk. Medical cost trends are notoriously hard to predict, and margin of error becomes wider rapidly as the prediction goes further into the future.

4 42 U.S.C. 1395w-24 (a)(1)(A)
 5 American Academy of Actuaries Health Organizations Risk Based Capital Task Force. (1994, December). Report to the National Association of Insurance Commissioners Health Organizations Risk Based Capital Working Group, p. 31-32. Retrieved August 6, 2013 from [http://www.actuary.org/files/publications/HORBC_1994%20\(report\).pdf](http://www.actuary.org/files/publications/HORBC_1994%20(report).pdf).

What about small groups, grandfathered plans, and non-qualified individual plans?

The individual market is not the only one that faces change under ACA. Many of the challenges and comparisons described in this paper apply to small group policies, as well. Because regulations differ somewhat between individual and small group policies, this paper focuses on the former. However, insurers selling small group policies should also take note of the experiences of insurers in the MAPD market.

If an individual is covered by a plan that existed before March 23, 2010, that plan may be *grandfathered*, meaning it will be subject to a smaller subset of ACA rules. According to estimates by the Departments of Labor, Treasury, and Health and Human Services, a majority of health plans will relinquish grandfathered status in the first few years following full implementation of ACA.ⁱ Because of its comparatively high churn rate, the individual insurance market is likely to become non-grandfathered faster than other markets.

Another relevant distinction is that some individual plans are considered qualified health plans (QHPs) and are eligible to be sold on state health exchanges, while non-qualified plans cannot. Insurers can still sell non-qualified individual plans, but they are subject to somewhat different regulations and therefore not all of the comparisons made to MAPD in this paper apply. For this paper, the analysis is limited to individual QHPs in order to simplify the discussion.

i U.S. Departments of the Treasury, Labor, and Health and Human Services. (2010, June 17). Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule. *Federal Register*, Vol. 75, No. 116, 26 CFR Parts 54 and 602, 29 CFR Part 2590, and 45 CFR Part 147, p. 34553. Retrieved July 22, 2013, from <http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>.

Complicating matters is the fact that bidders do not receive advance notices from the Centers of Medicare & Medicaid Services (CMS) of possible impending rule changes until February, and do not receive final notices confirming the changes until April, by which time there is a very short window before bids are due. The result is often a mad dash to the finish line, with only weeks to create a bid that will meet the new rules and keep the insurer solvent. It also creates operational and staffing challenges, since so much work is concentrated in a small part of the year.

The individual commercial market will now face almost the exact same set of challenges at approximately the same time. Prior to ACA, private carriers of individual insurance policies could typically file rates much later in the year, all the way up to late fall. In effect, they could file rates just a few months before implementing them, and could often re-file revised rates at any time if necessary. Now, individual markets will be on a calendar year bid schedule like the MAPD market, with most states requiring rates to be filed in mid-to-late spring of each year for plans that will be sold in the following

calendar year, with no opportunity for revision until the next *bid cycle*. There are also new federal requirements for the format of the rate filing documents and associated supporting documentation (which are in addition to any state requirements).

Having to file rates so far in advance will require major operational and strategic changes at these organizations. The change represents a fundamental shift in the risk of this line of business. Overall, this shift will create significant new pricing risk for participants in the individual market—in addition to the temporary additional risk at the early stages when there is virtually no solid data on the populations in question. Insurers who plan to sell individual policies on state health exchanges need to prepare now for the increased operational and risk management burden created by earlier filing deadlines, and need to learn to react quickly to potential regulatory curveballs that might come each spring.

Restrictions on plan design and rating

Several of the wrinkles that ACA throws into the commercial market for individuals have to do with restrictions on plan design—something that MAPD insurers are intimately familiar with. These requirements are intended to protect consumers and make it easier for them to choose from the many plans available to them. However, they also make it more challenging for insurers to balance regulatory compliance, marketability of plans, risk management, and profitability.

Essential health benefits and cost sharing

Both the medical plans under Medicare Advantage and the drug plans under Part D have a concept of *standard* and *supplemental* benefits. The federal government has set a baseline of benefits that MAPD plans must cover and complex limits on the level of cost-sharing plans can require. Supplemental benefits over and above the standard benefits are not directly subsidized by the government; instead, they must either be paid for by members out-of-pocket in the form of higher premiums, or, in some cases, they are paid for by the plan out of projected savings due to care management, narrower networks, or other cost saving initiatives.

The insurer must offer standard benefits, and is free to offer supplemental benefits—although there are also many rules governing these benefits as well. In particular, the insurer must use a government tool called the Out-of-Pocket Cost (OOPC) Model to calculate changes in average member cost sharing. Plan designs must be adjusted to meet criteria involving these OOPC values (such as meaningful difference testing and total beneficiary costs, see discussion on pages 4 and 6).

This is paralleled in the commercial market under ACA in the form of essential health benefits (EHB). Health plans are required to cover a set of EHB defined by a benchmark plan in each state. Because the benchmark plans are defined at the state level, EHB are not as uniform as standard benefits in MAPD, and there may be additional flexibility depending on state rules.⁶

6 Cosway, Robert. (2012, November). Essential health benefits: Review of the state employee benchmark plans and illustration of possible variation in essential health benefits by state. *Insight*. Retrieved August 6, 2013 from <http://publications.milliman.com/publications/healthreform/pdfs/essential-health-benefits.pdf>.

There are separate rules setting maximum cost-sharing amounts, and plan cost sharing is further restricted by the requirement to score at certain *metal levels* (platinum, gold, silver, or bronze) using a standardized tool published by the government to value member cost sharing.

Service area and network adequacy

Prior to ACA, MAPD issuers and health management organizations (HMOs) were the only commercial entities required to routinely file proof that their provider network was adequate for the needs of their subscribers. Depending on the state, commercial health plans generally had more freedom to build limited networks to meet plan design requirements.

Under ACA, participating health plans with a closed network of providers have to demonstrate to regulators that they have enough physicians and hospitals to provide adequate services for their members. As with MAPD, plans will have to include their service areas in their rate filings each year. Furthermore, service areas cannot be set in a discriminatory fashion (for instance, to carve out part of a county with a higher cost population), and networks must include a sufficient number of *essential community providers* who serve predominantly low-income individuals.

Community rating

Medicare requires that MAPD issuers take a *community rating* approach, ensuring that plan participants will not be subject to differing premiums based on health status, gender, or age. In Medicare Advantage plans, enrollee premiums typically pay for only a small share of the care received by participants, even with the additional benefits provided beyond standard Medicare. The government is already paying the largest share of costs, so community rating does not impact the market as much as it would in a commercial market where members pay a higher percent of the premium and more anti-selection can occur. Nevertheless, it does create additional risk for insurers if they enroll a greater number of more costly individuals than they expected when rates were set. This risk is mitigated somewhat by several other elements of the MAPD program (such as risk adjustment, as discussed below).

Historically, in many states, private insurers have had significant freedom to rate members based on their individual characteristics, such as gender and health status. That has changed with the arrival of ACA. While ACA does not impose strict community rating requirements on the commercial market (insurers are still allowed a certain limited amount of rating variation in most states) the range is significantly compressed.

The main forms of rating compression under ACA include:

- **Age:** Insurers can only charge older people three times what they charge the youngest adult.
- **Health status:** Rates cannot vary based on differences in health status.
- **Gender:** Men and women cannot be charged different rates for the same plan, all else equal.

The transition to a more restrictive rating environment may be most difficult for people who are currently insured, who may see premiums rise as they bear a larger share of community-rated risk. Of course, other individuals (particularly older or less healthy ones) stand to gain from these changes, and many lower income members whose rates may be increasing will obtain relief through premium and cost sharing subsidies.

Hypothetically, strengthening the individual mandate with additional penalties for remaining uninsured would drive healthy individuals into the market and thus lower the cost for the community as a whole.⁷ Absent such a change, community rating can increase the possibility of adverse selection (in other words, it can create incentives for lower cost individuals to refrain from purchasing coverage). For the elderly population enrolled in MAPD, this is less of a problem, since members only pay a small portion of the cost. Furthermore, fewer seniors are willing to take the risk of delaying coverage (and there are additional penalties for those who do).

Meaningful Difference Testing

In the early days of MAPD, insurers introduced many plan designs, which were at times very similar to one another. Regulators felt that this made it difficult for seniors to distinguish among them. To address this issue, the regulators subsequently established criteria for meaningful differences between plans, leading to a significant reduction in the number of plans offered.⁸

This meaningful difference requirement has been translated from the Medicare world to the commercial world under ACA, where its intent is again to reduce consumer confusion (and to prevent issuers from taking up a disproportionate share of virtual “shelf space” on Exchanges). While they have not provided full guidance, ACA regulators have indicated that they will be evaluating plans for meaningful difference and have provided some examples of the criteria they will use.⁹ The current criteria include differences in plan type, metal level, cost sharing, provider networks, and other plan design elements. For example, if two plans offered by an issuer are identical in all respects except for their deductible level, regulators intend to question whether they are meaningfully different if their deductibles do not differ by at least \$50.

Although in theory meaningful difference testing is a reasonable approach to a real consumer need, in practice the criteria that delineate when plans are *different* from one another may appear overly complex or even arbitrary. In any case, it adds another test to the list for issuers as they design and revise their benefit plans each year.

7 To learn more, see Houchens, Paul. (2012, March). Measuring the Strength of the Individual Mandate. *Insight*. Retrieved August 6, 2013 from <http://insight.milliman.com/article.php?cntid=8039>.

8 This is one of several drivers of decreasing plan volume, see the March 2012 MEDPAC “Report to Congress: Medicare Payment Policy,” Chapter 12, pp. 291-293 for more details.

9 Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. (2013, April 5). Letter to Issuers on Federally-facilitated and State Partnership Exchanges, p. 15-16. Retrieved August 6, 2013 from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

Federal desk review

Once MAPD issuers have plans that they believe meet the requirements and restrictions imposed by MAPD, those bids are subject to *desk review*. In desk review, the federal government examines submitted bids, asks questions to clarify specific points, and may object to the bid in part or in whole. The purpose of desk review is to make sure that bids comply with laws and regulations and follow accepted actuarial standards. Much of this work is carried out by independent consultants hired by the government.

Issuers under ACA will have to undergo a similar process. While the ACA attempts to maintain the traditional role of states in reviewing and approving rates, since there is federal money involved there will be additional oversight from the federal government, even in states that have an effective rate review process. In states that do not have an effective rate review process, the federal government will perform the review in its entirety.

Guaranteed issue, community rating, and open enrollment

In MAPD, one reason that plans must file rates in the spring is that those rates must be approved in time for the fall open enrollment period (OEP). During the OEP, all participants must choose their plans for the coming year, which cannot be changed later except under certain special conditions (such as when a plan terminates). Plans cannot refuse coverage or charge different premium rates for any individual on the basis of health status or other characteristics.

Until the implementation of ACA, individual market insurers let individuals purchase coverage at any time during the year, and in most states they could also refuse unhealthy applicants coverage (or charge more premium). Now, they must accept anyone who applies for coverage, and rates cannot vary by health status or many other traditional rating variables (such as gender).

They must also follow enrollment period rules set out by the federal government, which includes an OEP each fall where individuals must lock in their choice of plan for the next year (again, there are limited exceptions). This compresses the work of taking on new members into a very short period, which will be even more burdensome in the first year of implementation when it is anticipated that many previously uninsured individuals will join the market.¹⁰

The three Rs: Risk adjustment, reinsurance, and risk corridors

The laws implementing the reforms discussed above recognize the plight of insurers having to face new regulatory and market conditions. Three elements of ACA—known as the *three Rs*—are designed to level the playing field, help insurers through the transition, protect against adverse selection, and keep premiums as stable as possible. All three were also implemented in MAPD in one form or another.

The first *R* is *risk adjustment*. Part of the mission of ACA is to make health coverage more equitable by eliminating rating on the basis of health status, and by eliminating or restricting other rating variations (such as by age and gender). However, in order not to bankrupt

10 For more details on the open enrollment timeline, see <http://publications.milliman.com/publications/healthreform/pdfs/aca-timeline.pdf>.

insurers that take on sicker individuals, the ACA imposes transfers of money between insurers that are intended to even out costs across issuers. These transfers are called *risk adjustment*, and are based on a complicated formula involving a risk score given to each individual based on their demographics and medical conditions. Issuers with a member base that is relatively riskier than others will be subsidized, and those with a less risky member base will be assessed. The risk adjustment program is a permanent feature of ACA.

In MAPD, the government directly varies its payments to insurers based on the risk scores of the individuals each insurer covers, and managing risk scores is a crucial key to success in that market.

Second in the government's lineup of risk mitigation strategies is *reinsurance*. Under this program, the federal government will reimburse individual market issuers for a portion of the claims incurred by high cost individuals.¹¹ A form of reinsurance for high claimants is also part of the Medicare Part D drug program, and was probably included for the same reason: to make insurers less nervous about jumping into an untested market.

While reinsurance is currently set to be phased out of commercial markets over the course of three years, it is a permanent feature (barring statutory changes) of Part D. Reinsurance does not fully protect individual market issuers from high claimants or do away with the uncertainty surrounding new market entrants, but it does materially mitigate issuer's risk during the transitional years of ACA implementation.

Third, the ACA implements another tool borrowed from Medicare Part D: the *risk corridor*. A risk corridor protects plans against mispricing by sharing profits and losses with the federal government. As usual, the details are complex. At a high level, the government reimburses a portion of losses to plans that lose money, and requires profitable plans to remit a portion of their profits to the government. The *risk corridors* are the different tiers defining the government's share of gains or losses, which starts at zero percent for small gains or losses, and ramps up to 80% for large ones.

This concept is set to apply to QHPs in the individual market for three years starting in 2014.¹² By contrast, in Part D this is again a permanent feature, although CMS has the authority to increase the amount of risk borne by Part D insurers over time, which would amount to a phase-out of the risk corridors.¹³

As with MAPD, the operation of these three programs will require significant amounts of data and reporting back and forth between issuers and the federal government. In addition to supplying the data

11 Essentially, the reinsurance program operates as a subsidy from the small and large employer group markets to the individual market, since it is funded by a fee assessed on group and individual insurance, but only non-grandfathered individual market plans are eligible for reimbursements.

12 At the time of this writing, it is still not entirely clear exactly which plans will be eligible for the risk corridor programs, if any, other than QHPs on exchanges. Proposed regulations suggest that certain plans that are the same or very similar to QHPs might also be included in the program.

13 42 CFR 423.336, Risk-sharing arrangements.

and reporting, issuers must also maintain records and prepare for federal audits of this information.

One lesson learned from Medicare Part D is that all of these risk abatement features intended to increase insurers' willingness to take part in the new market can actually be too successful. In Part D, some insurers may have seen these government subsidies as an opportunity to price aggressively in order to capture market share, since the government would bear a significant portion of losses should rates turn out to be insufficient. If this were to happen in the individual market under ACA, it is possible that the risk corridor program—which was scored as revenue neutral to the government by the Congressional Budget Office—might in fact require a significant net expenditure of federal funds.

Quality ratings

Although the biggest changes under the ACA in the commercial market are aimed at improving access to insurance coverage, it also contains provisions intended to improve the quality of coverage and medical care. In MAPD, plans get rated over time on a 5-star quality scale based on an enormously complex and ever-changing set of criteria. In recent years, CMS has linked plan payments to quality ratings.

ACA regulators have indicated that they will develop similar ratings for commercial QHPs. The details of the system are pending; as yet, the government does not have sufficient resources or data to implement one. Given the experience of MAPD issuers, it is not inconceivable that subsidies or other financial incentives may eventually be tied to this quality rating. In the extreme case, regulators could one day require plans to maintain a minimum quality rating for participation in the exchanges—MAPD plans that consistently fail to maintain a sufficient quality rating will be terminated by the government.¹⁴

BROADER LESSONS: WHAT INSURERS IN THE INDIVIDUAL MARKET CAN LEARN FROM THE EXPERIENCES OF MAPD ISSUERS

MAPD has been profitable for many insurers, but it has never been an easy road. Although plans proved extremely popular with consumers, insurers have had to develop an entirely new approach to the market to succeed in the face of federal regulation. Private insurers can learn a few things from those experiences to be more prepared and successful providing QHPs under ACA.

Learn to embrace change

Many commercial insurance markets have already been heavily regulated in the past, and have occasionally been subjected to significant changes in market rules. However, MAPD issuers have had to adapt to a much faster pace of regulatory change, where each year brings new changes to the fundamental rules of the game. These changes are frequently driven by policy goals that have

14 Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. (2012, April 2). Rate Announcement and Call Letter, p. 87-88. Retrieved August 6, 2013 from <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2013.pdf>.

nothing to do with actuarial accuracy (and indeed, may instead be aimed at creating deliberate subsidies for certain individuals).

During the Medicare bid season, CMS holds frequent calls and issues memos and guidance whenever necessary. Any of these can be vehicles for rule changes that materially change the optimal strategy for insurers. The timing of these changes is not always convenient. In fact, it is not unheard-of for major guidance to be released after plans have already filed their rates. One example of this is the introduction of a limit on the total increase in out-of-pocket costs and premiums (*total beneficiary cost*) for MAPD participants from one year to the next, which was first introduced in the summer of 2010—well after MAPD plans had filed their bids for calendar year 2011.

Such occurrences have already become the reality of life for insurers in the individual commercial market, as well. The pace at which new ACA regulations were issued during the spring of 2013 was grueling, and the administration is continuing to make significant changes to the market rules for 2014 after many issuers' premium rates have already been set.¹⁵

Successful players in both markets will be those issuers who are nimble enough to adapt their strategies to each rule change.

Choose a service area and provider network carefully

In Medicare, the rate insurers are paid from the government has a lot to do with service area. Choosing a service area and building an efficient network of healthcare providers within that area is one of the few relatively unrestricted levers available to insurers to mitigate risk and increase profitability.

In the post-ACA commercial world, this will become increasingly true, as well. As the regulations level the playing field in other ways, plans must focus on geographic areas in which they are strong relative to competitors. Wisely choosing which doctors, clinics, and hospitals to include in a network and negotiating lower payment rates with them (including non-traditional contracts such as risk sharing arrangements) is another way commercial insurers can be more competitive under the restrictions of the ACA. This is potentially even more important in the commercial market compared to MAPD, as seniors may be more resistant to limits on which doctors they can see than younger and healthier populations.

Manage the risk score from day one

In the Medicare market, plans discovered early on that their risk adjustment score is one of the most critical success factors. The risk adjustment model assigns a score to every individual in a plan, in large part driven by what medical diagnoses are assigned to each individual. Populations that are scored as riskier than average result in higher payments to the insurance company, and populations that are less risky than average result in lower payments. If the risk score

is out of sync with the actual cost of the population, the insurer could face serious problems.

Over time, this model provided a strong incentive for insurers to improve the coding of diagnoses by providers, since a missing diagnosis could result in lower payments. In response, CMS introduced an adjustment to account for this *coding improvement* intended to prevent overall payments from increasing inappropriately. The end result is that insurers that do not “keep up with the pack” in terms of coding improvement may see their payments go down over time, making it difficult for them to remain competitive.

Commercial insurers under ACA will face a similar challenge. Out of the *three Rs* discussed above, risk adjustment is the only one that is currently slated to be permanent. The risk adjustment model in the commercial market, while different in several ways from the Medicare model, also depends on diagnoses as a primary driver of risk score. To succeed, commercial issuers will need to meet or exceed their competitors' efforts to improve data quality and coding accuracy. Otherwise, it is likely that the risk adjustment mechanism will not appropriately reimburse them for the risk of their population.

Could total beneficiary cost limits be coming to commercial markets?

The idea behind measuring total beneficiary cost (TBC) is to limit the out-of-pocket cost increases to subscribers by restricting the *total* of premium increases and cost sharing increases rather than one or the other. TBC limits were implemented rather suddenly in the MAPD market and caused (and continue to cause) significant problems for insurers. The main issue is that TBC limits can conflict with the requirement that MAPD premium rates be sufficient for insurers to at least break even. If TBC prevents an insurer from increasing the premium or cost sharing, there may not be other levers available to return to profitability.

TBC limits have not been discussed in the commercial market, perhaps due to the wider variation in benefit plan designs allowed in the commercial market relative to Medicare, or perhaps because regulators do not have the authority to limit rate increases outright in some jurisdictions. However, a concept of *potentially unreasonable rate increases*, arbitrarily set at 10%, has been introduced into these markets.

Although the rate increase threshold does not (yet) directly incorporate a measure of any changes in member cost sharing, it may serve a somewhat similar purpose to the TBC requirement in MAPD. Increases exceeding this threshold are subject to extra scrutiny, and may be deemed unreasonable. Issuers implementing increases that have been deemed unreasonable may risk being barred from the exchanges. This rate review process may therefore become a more potent tool for state and federal regulators after the exchanges open in 2014.

Prepare to be audited (more than in the past)

For MAPD insurers, frequent audits are a way of life. Bid audits examine rate filings in great detail; major errors can result in sanctions or fines. Program audits ensure compliance with rules and

¹⁵ For example, the administration announced on July 2, 2013 that they would delay the mandate that large employers provide health insurance coverage by a year. See <http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner.aspx>.

regulations. Financial audits compare claims and enrollment data to financial records.

If the experience of MAPD issuers is any guide, the commercial insurance market will also face an ever-growing compliance burden. Plans will be audited more often by more parties, and they will have to answer to federal in addition to state regulatory bodies. They will experience federal audits for compliance with the risk adjustment and reinsurance programs of ACA. They may not have to deal with the level of scrutiny that MAPD issuers incur, but they will likely see their compliance costs grow.

Expect new incentives and penalties

In MAPD, insurers can have their contracts revoked by the federal government in certain circumstances. For example, this can happen if the insurer fails to maintain a sufficient quality rating or meet minimum loss ratio requirements for several years in a row.

The analogous power given to the federal government under ACA is exchange participation. Issuers with a history of rate increases deemed unreasonable by state or federal regulators risk being barred from the state insurance exchange. It may be that regulators will decide to link other requirements (such as quality ratings) to exchange participation in the future.

On the other hand, the way that the various programs are structured are also creating positive incentives for issuers by rewarding those that can keep administrative costs down or who are willing to participate in exchanges (where the lion's share of new business should occur, and where the greatest protections are provided by the government).

CONCLUSION: DON'T GIVE UP HOPE

While the MAPD and commercial individual markets are far from identical, they are similar enough that a comparison provides many insights to issuers hoping to succeed in a transformed individual market. In particular, issuers might expect:

- Significantly greater compliance burdens and regulatory scrutiny
- More complex rules, including last-minute changes
- More time pressure to file rates and less flexibility to change them
- Less flexibility in plan design
- Fewer ways to differentiate plans from competitive offerings

While these are serious challenges to be sure, the final lesson to be learned is that insurers can succeed in public/private hybrids. MAPD has been profitable for a wide range of insurers since its inception, despite the complexities involved, and has proved very popular with Medicare beneficiaries as well. As with ACA, MAPD provided insurers with access to vast new markets, with the federal government taking on some of the risk. So far, insurers seem up to the task. While there are many uncertainties ahead, keeping an eye on the MAPD market can provide a useful (if slightly murky) "crystal ball" for QHP issuers.

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