

Top 10 Actuarial Issues for a Health Exchange



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As states think about developing health exchanges, it's clear that a *one-size-fits-all* approach won't work. Each state has different types of insurers and providers and varying views on the role of government. This paper discusses the top 10 actuarial concerns that a state government needs to consider when forming its exchange. The paper assumes that the state's objective is to operate a financially self-supporting exchange with as many participating members as possible. Other objectives, such as maintaining a vibrant private insurance market, might lead to different priorities.

So, that said, starting with #1...

1. Mandatory or voluntary

Should all individual and small group policies be sold through the exchange? This is one of the most significant decisions a state will make when constructing its exchange. A mandatory exchange would require all individual and small group policies to be sold through the exchange. A voluntary exchange would allow carriers the choice to offer products through the exchange or outside of the exchange.

If mandatory, all of the members in the individual and small group markets would be consolidated into two pools (i.e., one individual and one small group pool, unless the state merges these two markets—which is discussed in the next section). A mandatory exchange would minimize the potential for adverse selection (i.e., where less healthy risks gravitate to either the exchange or non-exchange markets). A voluntary exchange would likely result in most individuals and small groups purchasing insurance outside of the exchange (as it is done now), with the exchange focusing on the low-income population.

An analysis of Medicaid expansion in Indiana shows that uninsured individuals (those who will be attracted to the exchange) have higher morbidity than the currently insured population and that uninsured demonstrate pent-up demand when coverage is made available to them.¹ In a voluntary exchange environment, insurers may recognize the likelihood of pent-up demand in the exchange population and avoid participating in the exchange (at least initially) to maintain a healthier block of business. This might result in fewer newly

insured members for carriers who do not participate in the exchange, but membership growth could possibly be achieved by capturing other carriers' non-exchange business as these consumers realize they can find less expensive coverage in the non-exchange market with carriers that avoided the adverse selection that comes with the exchange. While this strategy is on the table, most carriers have indicated they will be participating in the exchange.

The government plans to implement risk adjusters, which should mitigate some of the adverse selection in a voluntary exchange. However, there's no such thing as a perfect risk adjuster. Most of them under-predict high-cost claimants and over-predict low-cost claimants. A good actuary can set up additional adjustments to partially offset this bias, but the bias will likely never completely go away.

A voluntary exchange also has benefits. For one, a voluntary exchange would create less disruption for the insurance sector because it would preserve benefit plan flexibility for insurers, who might be required to offer fewer options in an exchange environment. Voluntary exchanges also allow small employer trusts (that have earned customer loyalty over the years) to continue serving their members vs. a mandatory exchange that would potentially force such trusts out of the health insurance business.

Making the exchange mandatory would avoid the adverse selection that will likely result with a voluntary exchange. Consumers in need of a new policy would have no choice other than to purchase that coverage through the exchange. In addition,

¹ Damler, Robert. "Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured," August 26, 2009. Available at <http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf>.

a mandatory exchange might help reduce customer acquisition costs, which in turn might help a carrier meet minimum loss ratio requirements. However, this reduction in administrative costs could be offset by an increase in state fees collected to fund the exchange, which will differ from state to state.

2. To merge or not to merge

Do individuals belong in the same risk pool as small group? Individuals are more likely to buy commercial insurance policies (vs. paying the penalty) if a state merges the individual market with the small group market. This statement assumes most currently insured small groups will continue to buy health insurance in a community-rated environment (which starts January 1, 2014) regardless of their health status, resulting in a stable merged risk pool. Premiums could increase significantly and membership decline in a merged market if healthier small groups drop insurance coverage due to the significant rate increase they will receive (beyond trend) due to community rating.

If the two markets are allowed to remain separate (both inside and outside of the exchange), the individual market will likely have higher rates than small group policies, as fewer of the healthiest individuals will buy coverage and the exchange will become more susceptible to adverse selection. Such a dynamic—a more expensive individual market—is similar to what presently exists in many community-rated states. In this environment, the individual mandate is less likely to be effective, since many individuals will likely pay the penalty and purchase coverage only if they need it during the following year's open enrollment.

Presumably, merging markets in the exchange would be accompanied by a similar merging of markets outside the exchange (which assumes a voluntary exchange scenario). Why? If the markets outside the exchange were also merged, the cost shift from the individual market to the small group market would exist both inside and outside the exchange. However, if the merging only happened in the exchange, it would create new selection dynamics. Small employers in need of a small group policy could obtain lower rates outside the exchange; meanwhile, individuals purchasing coverage could obtain better rates inside the exchange.

Merging the two markets has both negative and positive consequences. On the negative side, merging the markets may create a hidden tax on small employers—this subsidy from small group to individual would keep individual policies affordable. On the positive side, merging the markets is more likely to result in fewer total uninsured individuals because it will attract better risks into the individual market and make that market—which is crucial to reducing uninsured—more affordable.

3. Implementation of risk adjusters and risk sharing

This is a matter of creating the perfect umpires. Insurers are worried about the lack of ability to assess applicants' medical conditions prior to insuring them, which goes into effect after January 1, 2014. The Patient Protection and Affordable Care Act's (PPACA's) solution to limit a carrier's risk due to a lack

of underwriting is to adjust each insurer's premium based on the health status of the individuals it insures through risk adjusters. Unfortunately, as mentioned earlier, risk adjusters are not perfect crystal balls. What computer model can predict an individual tearing an Achilles tendon while playing sports, or the need for an organ transplant after a car accident? Risk adjusters are good tools, especially when they are set up using the appropriate data and methods. But setting up a fair risk adjustment system is complex. It involves *fitting* the model to the state's specific population and making continual adjustments as results are monitored.

PPACA's second solution to limit a carrier's risk due to a lack of underwriting is to implement a risk-sharing arrangement between a given carrier and the government, similar to how the Medicare Part D program works. Risk sharing is based on the variation of results relative to a target loss ratio. This mechanism appears to be a popular government approach to entice insurers to participate in this market by limiting their risk in the early years.

4. Creativity

Ask yourself: Do you really want to emulate Massachusetts or Utah? It is important to look to these states and others for plans and ideas. However, many existing exchanges were established in different regulatory environments for specific purposes. Given the new environment and regulations, states need to be creative and design an exchange that specifically meets their needs. Differences among states include the level to which the various departments of insurance wield their authority, the amount of information a state requires carriers to post on their exchange (including rates and quality indicators), and many other factors. Exchanges should look into capitalizing on these state-specific information sources to build a high-quality, efficient exchange.

5. Joining forces

Should states consider forming joint exchanges with other states? There are advantages and disadvantages to this. After all, if it was easy, the federal government would have simply made one exchange. One of the reasons it didn't is because of authority. Most states wanted to control their own insurance destiny. Many states are struggling with forming their own exchanges given the various perspectives. Joining forces with another state may well be to their mutual benefit. On the other hand, adding another state to the decision-making process could result in gridlock. It's likely that this provision enabling states to form joint exchanges was written into the law to satisfy the legislators who believed there should be one federal exchange. The final law seems to say, "If it makes sense, the states will naturally find a way to work together." Some opportunities and challenges include:

Opportunities

- Economies of scale (from governing and expense perspectives)
- Collaboration leads to multiple perspectives with more creative ideas

Challenges

- Integrating two different Medicaid programs
- Two political views and authority

6. The large group factor

Starting in 2017, large groups may be invited to join the exchange. Will it be possible to overcome the selection issues and administrative obstacles that would arise? Large groups, whether insured or self-funded, typically pay rates consistent with their projected morbidity. Stated differently, the experience of those specific groups is a factor when setting rates. Assuming they were invited into an exchange where they were offered the average rate of all groups that reflects average morbidity/projected costs, which groups do you think would enter the exchange first? If you said “the less healthy,” you are right. All else equal, the less healthy large groups would pay less than warranted, driving up the average rate for all other exchange members. Additionally, many large employers are self-funded and it is unclear how self-funding would work with other exchange mechanisms, such as risk adjusters and risk sharing. The regulations could be written in a way to allow experience rating, which would require significant thought by people who understand the insurance market. For the exchange to be attractive and successful, it is clear that exchange leaders will have to overcome these obstacles and make it more efficient than the current method a large group uses to purchase coverage.

7. What if small groups elect to self-fund?

The PPACA is implementing community rating for individuals and groups up to 100 employees. This will result in healthier individuals and groups paying more for their health insurance and less healthy groups paying less. Some small groups, of course, are healthy one year, and less healthy the next, but other small groups stay healthy consistently. The consistently healthy small groups may decide to avoid paying the higher average premium by becoming self-funded. This could put upward rate pressure on the insured market as the healthiest groups exit. With that said, there are ways legislators can prevent these small groups from exiting the insured market.

8. Is actuarial value the *right* comparison?

Actuarial value is the most accurate way to compare health plans—but not the way the federal government is currently using it. PPACA defines actuarial value as the given benefit plan's expected paid expenses for all members in the plan versus paying all covered services *for that specific plan* at 100%. The problem is that they don't adjust for the services covered by the plan. Which plan is better, a health plan that charges a 10% coinsurance for essential benefits or a health plan that charges a 10% coinsurance for essential benefits plus vision hardware

(glasses and contacts) and health coaching? Both plans are considered to be platinum using the government's definition. However, they clearly are not the same. Comparing expected paid costs to a common plan is probably the better approach. (Of course, the materiality of this difference depends on how the government ultimately defines the essential benefits.)

9. Organizational considerations

Regardless of whether you house the exchange authority within government or make it an independent body, there are a number of issues to consider. First is the need for the exchange to coordinate with the state's Medicaid eligibility rules. This might suggest housing the exchange in the same governmental body that administers Medicaid (e.g., the Department of Health and Human Services). To what extent does the state want the exchange to judge a plan's rate increases and decide to include or exclude them from the exchange? The department of insurance might be a better choice if the state plans to closely govern rate increases through state filings, etc.

10. Information

What really matters when comparing health plans and benefits? There are many variables the states can rate health plans on, including, but not limited to:

- Customer service experience
- Provider network breadth, access, and quality
- Transparency of prices
- Patient blogs
- Ability to *push* information to patients
- Quality of disease management and wellness programs
- Claim payment timeliness and accuracy

The key is determining what factors matter and what the public wants while balancing the administrative burden to obtain and update these variables.

CONCLUSION

As states develop their health insurance exchanges, there are a number of items they need to consider. The most important, which will determine the popularity and ultimately the effectiveness of the exchange, are whether to make the exchange mandatory (vs. voluntary) and whether to merge the individual and small group markets. Other factors a state needs to deal with include determining the length of the open enrollment period, minimum loss ratio administration, actuarial strategies, and, more generally, finding the right fit for the exchange with the unique and specific needs of its population.

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