Impact of Market Reforms on Affordability

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Section 1 | Age Rating Limitations
Purpose of Our Work on Age Rating

- Article published in the January/February 2013 issue of *Contingencies* magazine
  - Publication of the American Academy of Actuaries
  - Co-authored with my colleague Kurt Giesa

- Unintended consequences of the Affordable Care Act
  - Age rating limitations (and other rating limitations) create subsidies in premiums from one subset of the population to another
  - Insurance works best when individuals are charged a rate that is consistent with their expected risk
  - “Antiselection is that annoying tendency people have of doing what’s best for themselves”
  - Younger individuals will opt out of insurance and choose to pay the mandate if the coverage does not provide them economic value
Basic Assumptions of Our Modeling

• Relied on data from the Current Population Survey (CPS) from the US Census Bureau
  – Individuals provide survey results on statistics such as household income, insurance coverage and premiums paid for insurance
  – Tested data against carrier information to verify reasonableness

• CBO estimates of other changes in premiums between now and 2016
  – CBO estimates from 2009 were that nongroup premiums would increase by 10 to 13 percent – excluding medical trend
  – This reflected +27 to +30 percent for actuarial value and essential benefits, -7 to -10 for differences in pricing (competition, price negotiation, etc.), and -7 to -10 for enrollment differences

• Subsequent studies have shown very different results
  – Primarily due to an expectation that the new enrollees will be less healthy
  – Particularly bad for states that will blend high risk pools into the individual market
Results of Our Analysis

Age Rating Compression AND Other Factors

Change in Nongroup Premiums for Single Contracts Excluding Medical Trend 2013 to 2014 400+ Percent FPL

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Results of Our Analysis

Age Rating Compression ONLY

Change in Nongroup Premiums for Single Contracts Excluding Medical Trend 2013 to 2014 400+ Percent FPL
Results of Our Analysis

**Age Rating Compression ONLY**

Change in Nongroup Premiums for Single Contracts Excluding Medical Trend 2013 to 2014 Ages 21 to 29

-44%  -27%  -15%  0%  10%  20%  30%  40%  50%  60%
138-200% 200-250% 250-300% 300-400% 400+%
Implications of Age Rating Compression

• Younger individuals that are affected by age rating have three choices
  – Purchase coverage at higher rates
  – Purchase catastrophic coverage
  – Forgo insurance and pay the individual mandate

• Pricing of catastrophic plan
  – Allows for rating factor to reflect the demographics of expected enrollment
  – Effectively removes the catastrophic plan from single risk pool as it relates to the age rating
  – No reason for non-subsidy eligible individual under the age of 30 to purchase anything but the catastrophic plan
    - Value of bronze expected to be roughly 5% higher than catastrophic
    - Price of bronze could be 35%+ higher than catastrophic due to age rating compression
    - May even be less expensive alternative for those that do qualify for subsidies, even though subsidies not available for catastrophic
Section 2  Risk Adjustment
ACA’s Risk Adjustment Model

• Beginning in 2014, transfer payments will be made from plan to plan based on risk adjusted premiums
  – Risk adjusted premium calculated relative to the average premium in the state
  – Eliminates pricing differences outside the measurement of risk, such as provider networks and administrative costs, etc.

• Will include plans both inside and outside of the exchange

• Purpose is to eliminate any incentive for plans to be discriminatory in their enrollment and outreach

• Plans with members that have higher morbidity will be receive payments from plans with lower morbidity
Comparison to Medicare Advantage

• Significant difference from the MA model

• Concurrent versus prospective model
  – Better at measuring acute cases
  – Improved risk adjustment of costly individuals

• Zero-sum game
  – Creates a system of winners and losers
  – Impossible to eliminate all “gaming” from the system
  – Based on state and market (i.e., individual or small group)

• Timing – Must complete data submission by April 30

• Multiple weights depending on age and metal tier
  – MA is 1 model
  – ACA is 15 models
Initial Findings

- Oliver Wyman has tested the risk adjustment methodology using a similar database as the one used to develop the model.
- Very preliminary results, since the ink is still wet on the final rules.
- Interesting questions:
  - Does the health of an individual change their risk adjustment score?
  - What happens when reinsurance is introduced?
  - How does duration affect the risk adjustment score?
Risk Adjustment Examples

Paid Claims Before and After Risk Adjustment by Health Status
Risk Adjustment Examples

Paid Claims After Risk Adjustment

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Risk Adjustment Examples

Risk Adjusted Claims Before and After Reinsurance
Risk Adjustment Examples

Risk Adjusted Claims After Reinsurance

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Risk Adjustment Examples

Paid Claims Before Risk Adjustment by Duration (Months)
Risk Adjustment Examples

Paid Claims Before and After Risk Adjustment by Duration (Months)
Risk Adjustment Examples

Paid Claims After Risk Adjustment by Duration (Months)
Implications of Risk Adjustment Model Testing

- Still some advantage to targeting healthy members

- However, combination of reinsurance and risk adjustment creates favorable results for most costly members
  - HHS chose not to adjust for reinsurance because of the limited existence of the reinsurance plan and they did not want to tinker with the model every year
  - Target high-risk members at your own peril

- HHS adjusted factors so that claims are spread out over 12 months
  - Results in potential concern over short term members
  - Additional models could be implemented that would look at length of enrollment period
  - Creates additional complexity to an already complex model