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# THE CHALLENGES OF PRICING HEALTH INSURANCE FOR THE 2014 EXCHANGES

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Health actuaries are experts at building analytic models to account for multiple factors expected to affect future health care spending. Their job has grown more difficult of late, however, due to changes in a large number of important pricing factors introduced by the Affordable Care Act (ACA) starting in 2014. In order to explain these new challenges, I briefly describe how actuaries price today and identify some of the key risks introduced by the ACA, then discuss the consequences for health plans and consumers if rates end up being set too high or too low.

## HOW ACTUARIES PRICE TODAY

When developing premiums for a future rating period, actuaries apply trend factors to claims data from a prior experience period (Figure 1). For example, if the most recent claims data cover the experience period from July 1, 2011 through June 30, 2012, an actuary would apply 18 months of trend to project the medical spending expected for the calendar year 2013 rating period. The trend factor recognizes changes in both the use and cost of hospital care, physician care, pharmacy and other components of the benefit package. Additional factors are needed to adjust the experience data for other changes expected to occur between the experience and rating periods. These adjustments account for things like changes in the benefit package and changes in the composition of the risk pool, due either to shifts in the demographic profile of the enrollee population or to changes in its health status arising from adverse or favorable selection.

In making these calculations, actuaries usually must choose between using more complete data from an older experience period or more recent data that do not yet reflect all claims incurred during the period. Using more recent data is generally the preferred approach, but this requires estimation of total completed claims using only the claims reported to date. Eighteen months of trend is common due to the time required to obtain the experience data, perform the calculations, and provide a typical 60-day notification regarding new rates.

## CHANGES INTRODUCED BY THE ACA

The ACA introduces changes in 2014 that require actuaries to use much more complex models to develop premiums. First, the ACA will expand private insurance coverage by requiring guaranteed issue, mandating coverage and making premium subsidies available to lower-income people through the insurance exchanges.[1] While some people entering the exchange will have previously held non-subsidized private coverage from the individual market, a large proportion will have been previously uninsured and others may move from employment-based coverage. Predicting entry into the exchanges by these various populations is an uncertain endeavor, requiring actuaries to assess the extent to which younger and healthier people will elect to pay the small initial penalty rather than purchase coverage and what percent of employers will stop providing health insurance. Pending state decisions about Medicaid expansions may also affect predictions about the demographics of this market. A further challenge for actuaries will be to predict the morbidity levels of the new exchange populations, especially for the previously uninsured.

Second, the ACA requires new benefit designs to be offered in 2014, including the four "metal levels" corresponding to different levels of actuarial value for a benchmark package of essential health benefits. Decisions about benchmark plans for 2014 have been left to the states, with additional guidance to come from the federal level for some benefit components. This approach adds implementation flexibility but also creates uncertainty for actuaries who need to know what products they will be pricing in order to adjust the experience data to account for benefit changes. In particular, final benchmark plans may be more comprehensive than the high deductible, high coinsurance plans that are designed to keep rates lower and are often purchased in today's individual market. A recent analysis found, for example, that more than half of those with individual health insurance in 2010 were in a plan that would not meet the minimum actuarial requirements of the 2014 exchanges.[2] The resulting "rate shock" of moving to the minimum level of actuarial value may contribute to adverse selection in the exchange risk pool.

Third, the law eliminates premium differentials by health status and gender and restricts age variation to a 3-to-1 ratio. Actuaries must determine how to bring existing age factors, which can be as high

as 5- or 6-to-1, into line with the new 3-to-1 range and how to account for the adverse selection that may result when younger people see their rates increase and older people find coverage more affordable. Because current rating rules vary by state, these selection effects will also vary by state, complicating the task for actuaries who are computing premiums for health plans operating in multiple states.

Fourth, the ACA contains three risk mitigation strategies.[3] The temporary reinsurance program will be funded by levies on all medical benefit plans and will subsidize plans in the individual market that experience catastrophic claims. Risk corridors are intended to provide for the sharing of gains and losses between the federal government and the insurance companies for individual and small group business for three years starting in 2014. The permanent risk adjustment program will transfer payments between insurance companies depending on each company's risk pool characteristics in comparison to its competitors in each state. While these three programs provide some financial protection to insurance companies participating in a major new program, they also add uncertainty and complexity to pricing since the full design parameters are not yet known and actuaries have only limited data with which to model their expected impacts.

A final challenge is the ticking clock. Premiums for exchange products must be established by the October 2013 open enrollment period, implying rate filings by early- to mid-2013 in many states.

## CONSEQUENCES OF PRICING MISTAKES

Faced with these considerable uncertainties, plans may set premiums that turn out to be too high or too low. Pricing missteps will affect not only the financial results of insurers but will also impact consumers and taxpayers. And if the pricing errors are so extreme that the ACA risk mitigation strategies prove to be inadequate, the exchanges may be destabilized, jeopardizing improved access to health insurance.

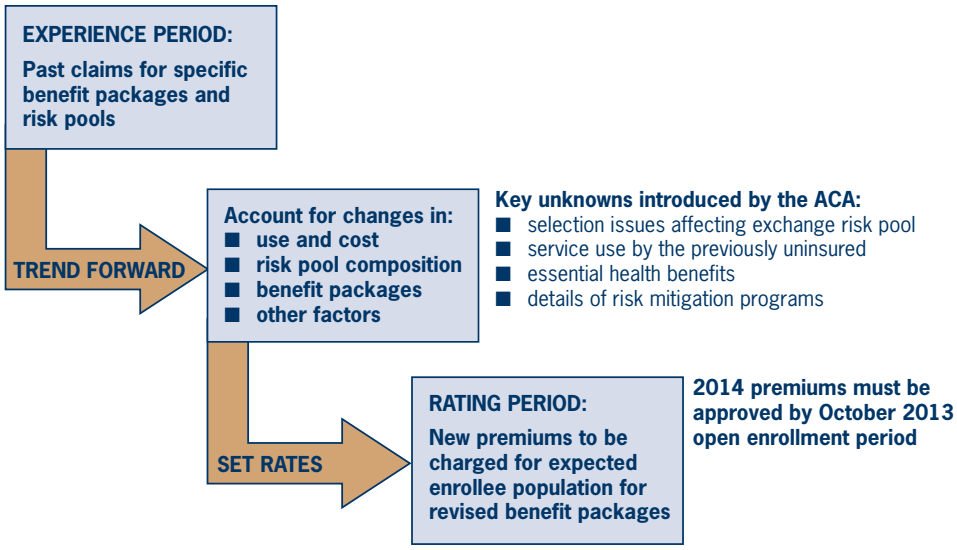
The most obvious downside if carriers set their prices too high is that consumers will face high premiums and may choose not to buy insurance, exacerbating the potential for adverse selection and threatening the longer-run viability of the exchanges. Conversely, while consumers would seem to benefit in the immediate term if the 2014 premiums are set on the low side, this boon would be short-lived if carriers experiencing large net losses stop participating in the exchanges, forcing their enrollees to change plans and leaving all exchange consumers with fewer options.

Health plans also face downside consequences from pricing too high or too low. Carriers that err on the high side in pricing are likely to lose market share, especially given what is expected to be easier comparison shopping within the exchanges. Additionally, if a carrier's actual claims experience turns out to be much lower than was expected when rates were determined, some of the profits are to be shared with the government via the risk corridor program (at least in 2014 through 2016). Higher-than-expected profits are also more likely to trigger rebates to policyholders via the ACA's medical loss ratio provisions. Thus, pricing too high could mean a relatively small profit margin with a loss of market share.

On the other hand, plans that price on the low side would likely benefit by garnering a higher market share. But low initial pricing may also bring losses that are not fully offset by the ACA's risk mitigation programs, and it may be extremely difficult to raise premiums to profitable levels in future years if regulators limit rate increases. The loss ratio requirement will likewise limit a company's ability to recover early losses in more profitable later years because profits above expectations will be refunded to policyholders. With risk corridor loss protections set to end after 2016, carriers whose rates get "stuck" on the low side may need to withdraw from certain markets, again, limiting choices for consumers and potentially disrupting the exchanges.

Taxpayers also have a lot at stake if rates are set too low or if state insurance regulators do not approve actuarially justified rates. The ACA provides no explicit funding source in the event that federal risk corridor payments due to plans with excessive losses are greater than the receipts from plans with unexpected profits. Instead these funds will have to come from general tax revenues or a new tax imposed specifically for this purpose. An additional consideration is that states that do not approve actuarially justified rates may be subsidized by other states through these risk corridor payments.

FIGURE 1. DETERMINATION OF PREMIUMS




## CONCLUSION

The stakes of pricing accurately for the 2014 exchanges are high, but with so much change occurring for these markets, current pricing models will be inadequate. Given the high stakes, it will be important for carriers and exchange personnel to have ongoing communication and to be prepared to make any needed corrections quickly as new information and results emerge.

## ENDNOTES

1 The ACA provides for separate exchanges for individuals and small businesses; states may opt to combine the two but most are expected to keep them separate, at least initially. For ease of exposition in this essay I focus on the exchanges serving the individual market. Pricing in a combined exchange or accounting for interactions between the two markets only complicates the basic considerations treated here.

2 Gabel JR, Lore R, McDevitt RD, et al. "More than Half of Individual Health Plans Offer Coverage that Falls Short of What Can be Sold Through Exchanges as of 2014." *Health Affairs*, 31:1339-48, June 2012.

3 Details for these risk mitigation strategies are not all known at the time of this writing. As final details become available, they may change the effects of these programs as described in this essay.