The Actuarial Challenge

Sponsored by the Robert Wood Johnson Foundation

Announcement of Round One Results

The Actuarial Challenge, sponsored by the Robert Wood Johnson Foundation (RWJF), brings actuaries together to explore approaches to stabilize the individual health insurance market. The Challenge is administered by Milliman, Inc. and actively promoted by the American Academy of Actuaries and the Society of Actuaries. Support for the Actuarial Challenge is being provided by the Robert Wood Johnson Foundation. The views expressed here and in the papers do not necessarily reflect the views of the Foundation, Milliman, the American Academy of Actuaries, the Society of Actuaries, or the employers of the Challenge participants.

The Challenge kicked off in late September. Almost 70 participants registered, comprising 20 teams. Initial papers were submitted by December 9th. The papers each presented a proposal of various ways in which the individual health insurance market could be reformed. The proposals were not intended to be comprehensive, but to offer ideas on different ways to improve certain aspects of the current system. A panel of five judges (all actuaries) reviewed each paper and ultimately selected five papers to move on to the next round. Round Two involves the selected teams working with Milliman to model their proposals to illustrate the potential financial impact on the individual health insurance market. RWJF and Milliman would like to acknowledge and thank the Actuarial Challenge panel of judges for the significant time, effort, and diligence they devoted to select the papers on an author-blinded basis for Round Two modeling. Given the variety of interesting reform ideas presented in the papers, there was considerable discussion and deliberation when selecting finalists. The five judges include:

- Barbara Klever of the Blue Cross Blue Shield Association
- Rebecca Owen, Health Research Director of the Society of Actuaries
- Dr. Colin Ramsay, Professor at the University of Nebraska
- David Shea, Health Actuary for the Virginia Bureau of Insurance
- Cori Uccello, Senior Health Fellow with the American Academy of Actuaries

During Round Two, each team that submitted a Round One paper has the opportunity to refine its proposal for later publication, but five of the papers will be further developed by incorporating financial modeling results using the Milliman Health Care Reform Financing Model (HCRFM). The five papers selected by the panel of judges for Round Two modeling and a brief description of reformed characteristics of each are the following (in no particular order):

ROUND TWO PROPOSALS

Individual Market Redux

Revises rating to allow a wider premium range by age (5-to-1) and limited consideration of an enrollee's health status in setting premium rates via an automated process (up to an additional 50% of premium). Uses contributions to individual health savings accounts for mid/low income consumers to replace premium and cost sharing subsidies. Revises risk adjustment methodology and restores a reinsurance mitigation program. Uses Medicaid reimbursement levels and increases health cost transparency. Increases penalties for not obtaining health insurance, but allows more benefit plan

design flexibility. Reduces mandated benefits based on scientific evidence and use of an independent board. Incentivizes payment reform, integration of healthcare information, implementation of clinical best practices, and value-based care.

Why Not BE HIP?

Establishes a nationwide Basic Essential Health Insurance Plan (BE HIP) covering a core set of services/benefits set by federal regulation. Allows purchase of state regulated standardized supplemental plans (benefit riders) to offset cost sharing (i.e., upgrade to richer benefits). Automatic enrollment and/or penalty of full cost of basic plan if not enrolled. Uses a risk adjustment program and reinsurance to protect insurers. Premium equalization process to account for socioeconomic variations between insurers in a given market. Premium subsidies use similar methodology as the Patient Protection and Affordable Care Act (ACA), although percentages may differ.

The Simplifiers

All residents receive a fully publicly-funded preventive plan and must purchase an insurance plan for non-preventive services. Insurers must offer a standard plan but may offer additional plans subject to state regulations such as actuarial soundness, minimum coverage levels and loss ratios. Premiums will be limited to significantly lower and more affordable levels. A simplified, permanent publicly-funded risk mitigation program based on reinsurance formulas will result in reduced premium. Hospital costs will be reduced by payment at Medicare reimbursement levels. Drug costs will be lowered by allowing purchase from qualified international locations. Simplified low-income premium discounts will be available. Penalties equal to the lowest cost insurance plan will apply for non-coverage. Lifetime universal Medical ID cards will be used to monitor enrollment, provide electronic medical records, and act as low-interest credit cards to pay for premiums and out-of-pocket medical expenses. Exchanges will act simply as informational websites.

Panoptic

Uses auto enrollment into newly defined catastrophic plans to enforce participation, and combines the individual and small group markets (with no self-funding allowed in the small group market). Consumer can add benefits through purchase of supplemental benefit riders. Block funds for subsidies provided from federal to state for the state to administer. Elimination of dual regulation to reduce expenses. Allows wider rating for age (5-to-1) and lowers or eliminates minimum medical loss ratios. Continues risk adjustment and restores reinsurance for up to five years. The equivalent of cost-sharing reduction (CSR) funds would be deposited into a consumer's health savings account (HSA), if eligible. Use reference-based benefit pricing for provider fees. Encourages risk contracting with both upside and downside risk to the provider. Eliminates direct-to-consumer advertising. Eliminates grandfathered and transitional business. Focuses on consumer accountability by providing consumers with improved cost transparency and other resources to help them make educated decisions regarding their healthcare.

King of Carrot Flowers

Creates three pools in the individual market: (1) Over 250% FPL (federal poverty level) with state regulated underwritten market, (2) Under 250% FPL with federally funded underwritten and subsidized market, and (3) Special Needs (High Risk) Pool with a federally-funded, highly-subsidized market for individuals with persistent high costs or uninsurable conditions. Guarantee issue, but requires continuous enrollment. Incentivizes providers to manage care. Encourages tax parity between individual and group market by capping group tax deductions. Allows more tax-favored health savings account contributions.

Milliman will work with these five selected teams to model their proposals in February and March. The five Round Two teams will be able to incorporate the modeling results in their final papers. Nine other teams have the opportunity to refine their papers for possible exposure on the Actuarial Challenge website (which is hosted by the American Academy of Actuaries) or as decided by the RWJF at the end of the Challenge.

OTHER PROPOSALS

Following is a high-level summary of the other papers received (in random order):

The Mod Squad

Increases incentives to first-time enrollees, but with significant penalties for not obtaining coverage after first year (150% of lowest cost Silver plan). Extreme marketing blitz required for first year program. Institutes concurrent payment of penalties during coverage year using cell phone bill for both premium and penalty billing. Includes all individuals not eligible for Medicaid in the Individual market and prohibits withdrawal of Medicaid expansion. Creates wellness/healthy living premium subsidy and optional pharmacy coverage within ACA plans. Modifies rating to allow wider premium range for age (5.5-to-1.0). Eliminates grandfathered and transitional plans. Modifies medical loss ratio and COBRA requirements. Increases availability of premium subsidies to 600% of FPL for those in more expensive markets and areas. Restores reinsurance and risk corridor mitigation programs and requires proposed risk adjustment changes. Creates trust fund for risk corridor payments to insurers and for other federal ACA expenditures. Addresses primary care doctor shortage. Individual premiums become tax deductible to be consistent with tax deductibility of group insurance premiums.

JHU Actuarial Club

Provides enhanced benefits (e.g., gym membership, fitness classes, preventive services, etc.) in insurance coverage to encourage younger individuals to purchase. Allows health insurance plans to segment coverage of specific services to lower cost. Transforms premiums from yearly cost to longer term policies with investment opportunities and increases annual penalties for not obtaining insurance. Closes coverage gaps by expanding Medicaid, covering non-citizen immigrants, and requires more employers to cover employees. Requires health service pricing transparency.

Policy Proposal for Healthy Behavior Incentive ("HBI") Plans

Healthy Behavior Incentive Plans encourage a partnership between the insured, insurer, and health care provider to maintain well-being rather than just reimbursement for expenditures. They allow use of age-specific premium discounts upon a member's policy renewal, based on health/lifestyle choices and improvement in health status over time.

Incentive plans focus on rewarding choice-based improvements to health status, not just winners of the genetic lottery. Improvements are validated not by insurers but by trusted providers, who partner with members on their individual journeys to better health and a long-term reduction in the cost of care.

Both the proposed discounts and the proposed incentive behaviors may be a part of the state DOI's existing annual premium review, where they may be modified or rejected. But the market ultimately determines which behaviors are most effective at reducing claims costs, since insurers need not offer them and members need not buy them.

Underwriting and Premium Rating using Risk Adjustment

Focuses on improving market stability through increased enrollment of lower cost individuals by revising the rating basis to better align with expected costs. Uses uniform prospective risk scoring to place all insureds into health status rating bands. Consumers pay up to a sliding scale percent of income with subsidies filling in the difference. Additional subsidies for cost sharing applied to low income insureds. Guarantee issue with state-based assessments across insurers to help fund subsidies for highest rating bands. No individual mandate, but a reentry penalty for those who drop coverage and reapply. Every insurer must offer a state-designed benchmark plan, but no restrictions on benefit designs for other plans. Requires a funded HSA for a consumer to choose a high out-of-pocket plan. There would be no federal exchanges and no reinsurance or risk corridor programs, but would use a prospective risk adjustment program. Insurers work directly with states.

Team DC

Increases individual market penalties to encourage more enrollment by young and healthy uninsured, and mitigate developing anti-selection spiral in the individual market. Refine/extend federal government-funded backstop to insulate insurers from developing market, analogous to backstops for catastrophic losses in flood, earthquake, and severe windstorm markets. Argues that broader healthcare/health insurance economics and function will be improved, with benefits for the employer-provided and individual markets, by keeping/implementing/extending the Cadillac plan provisions/penalties in the group market.

Team ACA Version 2.0

Proposes changes to the subsidy and risk adjustment programs. In order to address the cliff created at the 400% FPL subsidy level, proposes extending the poverty threshold and providing a more tapered reduction of subsidies. In addition, considers the possibility of incorporating local income levels to account for varying cost of living across the nation. For the risk adjustment program,

proposes modifying the metallic-specific risk factors to more closely align to actual experience, thus reducing the extreme variation in risk adjustment (RA) transfer at the different metal levels. Finally, proposes using market-level paid claims per member per month (PMPM) instead of premium PMPM to better balance recoveries.

A Social Insurance Solution To Health Care Finance

Proposes to use a social insurance model to replace all current health insurance (across all markets). Covers all legal residents in the program through a payroll tax for funding. Insurance plan would cover preventive care and catastrophic care (exceeding 7.5% of income). Low income families would receive additional assistance similar to Supplemental Nutrition Assistance Program (SNAP) benefits. Routine care would be funded by individuals, but administered through a central fund, billing patients as with a credit card. Administrators must negotiate with providers, but must make all fees available to the public.

Consulting Actuaries for Sustainable Healthcare

<u>Insurance Reforms to improve actuarial soundness</u>

- Medicaid in all states <138% FPL
- Basic Benefit Plan, using Medicaid reimbursement: 138% - 200% of FPL
- Auto-enroll uninsured into Basic Benefit Plan when care needed; additional deductible of up to 12 months premiums
- 50% minimum actuarial value
- Eliminate metal levels
- Subsidies if premiums for 50% actuarial value (AV) plan >10% MAGI (modified adjusted gross income)
- Guaranteed issue for up to 10% plan value increase, at renewal
- Actuarially sound rating for age, gender, and health status (within ±20%)
- Adult children rated same as non-dependent adults
- National reinsurance for 90% of claims exceeding $250,000

<u>Provider Price & Quality Reforms, to address unsustainable underlying healthcare spending</u>

- All private fee-for-service (FFS) patients charged same
- Fees publicly available
- Billed charges = negotiated fees
- Pro-active fraud avoidance
- Direct-to-consumer (DTC) advertising restrictions
- Remove barriers for non-physician healthcare professionals
- Rigorous certificates of need
- Computer assisted diagnoses
- Expanded standards of practice
- Expanded medical homes
- Standardized electronic health records (EHRs), patient owned

True Health

Develops actuarial incentive compensation for physicians who are effective at addressing the underlying cause of patient health conditions by using the "food as medicine" concept, which has been proven to not only prevent, but reverse the chronic costly conditions faced by Americans today (including heart disease, diabetes, high blood pressure, and obesity) without any negative side effects at minimal cost. Currently, the vast majority of the population and even many in the medical and insurance fields are unfamiliar with this concept. This solution seeks to increase awareness of this approach on a much wider scale and change provider reimbursement to make treatment using this concept an option for everyone. A successful implementation of this proposal would result in lower premiums and increased access to the individual health insurance market. It would also serve as a model for the group, self-insured, Medicare, and Medicaid markets.

The above are summaries of each of the preliminary entries. Each team is in the process of refining its paper for later submission at the end of Round Two of the Actuarial Challenge. Any inquiries at this time should be directed to Jim O'Connor of Milliman, Inc. at jim.oconnor@milliman.com. A webinar to provide additional information and discussion regarding the Actuarial Challenge is scheduled for Monday, February 27th, at 2:00 pm Eastern. Additional details regarding the webinar will be forthcoming and posted on the Actuarial Challenge website at http://challenge.actuary.org.