The ACA@10

By Joan C. Barrett and Kurt Wrobel

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March 23, 2010, the day the Affordable Care Act (ACA) was signed into law, was a day of great promise for everyone without health insurance—it promised access to affordable health care. Ten years later, the question is: Was that promise kept? Certainly, it is an achievement that there are now 20 million more people insured than there were in 2010. Yet, there are still 30 million Americans[1] who are uninsured, and many more who are struggling with paying premiums and the cost-share on their existing coverage. As the 2020 U.S. election draws near, we need to be able to understand the ACA's real-world application more fully, as the electorate decides where we want to go from here. Should we "repair" or "replace" the ACA?

To help us answer this question, the Health Section Council (the Council) of the Society of Actuaries (SOA) launched the ACA@10 Strategic Initiative last year. This initiative consisted of a data-driven research project, entitled "Fifty States, Fifty Stories: A Decade of Health Care Reform Under the ACA." This research, which was authored by Paul Houchens, FSA, MAAA; Lindsy Kotecki, FSA, MAAA; and Hans Leida, Ph.D., FSA, MAAA, looks at measures of success for the ACA from a number of different perspectives.

In addition to the research, the Council commissioned several articles examining specific aspects of the ACA in more depth—the result of which comprise this web-exclusive series. In each case, the authors are health actuaries who work with government agencies, health plans and providers at a detailed level on a daily basis, and they bring a practical perspective to the table.

Authors and topics of these articles include:

- David Dillon, FSA, MAAA; Michael Lin, FSA, MAAA; and Matthew Damiani; Successes of the ACA
- Greg Fann, FSA, FCA, MAAA, The Elusive Paradoxes of the ACA
- Ryan Mueller, FSA, MAAA, The ACA's Impact on Rural Areas
- Joan C. Barrett, FSA, MAAA, Managed Care 3.0

AN ACA OVERVIEW

The primary goals of the ACA were to make affordable health care available to more people, and to support innovative medical care delivery methods designed to lower the cost and improve the quality of health care. To make affordable health care more available, the ACA provided for an expansion of Medicaid to include those making under 138 percent of the federal poverty level (FPL) and a new "marketplace" or "exchange" infrastructure. A tax penalty was imposed on people who were not covered by "minimum essential health coverage."[2]

The hallmark of the exchange infrastructure was the ability for consumers to choose from a set of plan designs that were roughly equivalent in benefit value for a given "metal level." The metal levels group plans based on benefit richness, with the plans with the lowest cost-share falling into the platinum level and plans

with the highest cost-share falling into the bronze level. To keep costs affordable, consumers at certain income levels are entitled to subsidies in the form of advance premium tax credits (APTCs) to offset the monthly premium costs and cost-sharing reduction (CSR) subsidies to offset expenses associated with deductibles, coinsurance and copays. The ACA also provided for a safety net system using risk adjustment to make sure health plans competed only on factors like price, provider access and customer service, and not on risk selection.

To lower the cost of health care and improve the overall quality, the ACA also provided for the Centers for Medicare & Medicaid Services (CMS) Innovation Center, which is now focusing on its Quality Payment Program and Advanced Alternate Payment Programs, as well as evaluating and advancing best practices.[3]

The ACA has gone through a number of changes since it was originally passed in 2010, including:

- In 2012, the Supreme Court ruled the federal government did not have the authority to mandate Medicaid expansion.
- The tax penalty for the individual mandate was repealed effective 2019.[4]

OUR ANALYSIS AND FINDINGS

Several keys themes emerged as a result of our analysis and research, including:

- **The uninsured rate.** Although the reduction in the uninsured rate was impressive and nearly on par with projections, the source of the reduction was unexpected. The Congressional Budget Office (CBO) originally estimated that by 2018, 26 million people would be covered through the exchanges. In fact, only about 10 million people were covered. Other factors influencing the reduction in the uninsured population include Medicaid expansion and the overall improvement in the unemployment rates.[5]

- **Medicaid.** Originally, the CBO projected that Medicaid enrollment would increase by 11 million beneficiaries by 2018 as a result of Medicaid expansion and additional enrollment of the existing Medicaid-eligible population. The latest numbers show that Medicaid enrollment expansion was closer to 16 million beneficiaries.[6] After the passage of the ACA, CMS became much more involved in the program, with an emphasis on delivery system and payment reform.

- **Employer-sponsored insurance.** Prior to the implementation of the state exchanges, there was some speculation on how many employers would stop offering health insurance coverage and push their employees to the exchanges. There has, however, been no material change in employer-sponsored enrollment—with one exception. We continue to see a decline in coverage among employers with fewer than 50 employees, a continuation of a trend that began before the passage of the ACA.

- **The remaining uninsured.** Approximately 30 million people remained uninsured in 2018. About two million people fall into the "coverage gap," which means they make too much money to qualify for Medicaid but not enough money to qualify for subsidies in the exchanges.

- **Affordability.** Health care remains unaffordable to many Americans. In recent years, the federal government and health plans alike have focused considerable efforts on developing alternative payment methods. While these efforts are beginning to show results, they may not be sufficient to reduce the overall cost of care. One way to make care more affordable is to supplement these efforts by focusing on the underlying disease burden and the new technologies and analytical methods that help reduce the disease burden in a cost-effective way.

- **Market stability.** Premium rates in the exchanges are beginning to stabilize in many states, in large part due to mature data and more stable competition. An important factor in assessing market stability is the underwriting cycle. The underwriting cycle refers to the natural tendency of organizations, like health plans, to balance competitiveness with profitability.[7]

- **The rural population.** The ACA probably has had a greater impact on people living in rural areas than it has on other populations. Many more people living in rural areas are being covered now, but those who are not subsidized often pay a much higher premium than those living in urban areas.

- **ACA complexity.** The ACA is complex and often counterintuitive. For example, consumers in some markets find it less expensive to buy a plan at a higher metal level. Similarly, many insurers find the risk-adjustment process, which is supposed to provide some stability to the pricing process, often results in some confusion and lack of transparency.

LESSONS LEARNED

Health care is local. Each area has its own unique challenges based on its state's regulatory environment, its population, provider community and insurance availability. Whatever changes we make to the ACA, or any system that replaces it, must reflect that reality.

Change is inevitable. The delivery of health care, the provider community and the underlying demographics are constantly changing. Again, any changes we make to the ACA, or to any system that replaces it, must be able to accommodate the changes. Health care is complex. Attempts to solve one problem often end up creating new problems. Comprehensive analytics are required.

WHERE DO WE GO FROM HERE?

Health actuaries are constantly analyzing and reviewing what is going on in health care. To find out more information about our work, please visit the Health Section Council webpage or our LinkedIn subgroup page. You can also follow us on Twitter and LinkedIn using the hashtag *#soahealth*.

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ENDNOTES

1 Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029. *Congressional Budget Office,* May 14, 2019, *https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf* (accessed February 24, 2020).

2 Centers for Medicare & Medicaid Services. No Health Insurance? See if You'll Owe a Fee, The Fee for not Having Health Insurance. *HealthCare.gov, https://www.healthcare.gov/fees/fee-for-not-being-covered/* (accessed February 24, 2020).

3 Centers for Medicare & Medicaid Services. About the CMS Innovation Center. *CMS.gov,* February 14, 2020, *https://innovation.cms.gov/about* (accessed February 24, 2020).

4 Houchens, Paul, Lindsy Kotecki, and Hans Leida. *Fifty States, Fifty Stories: A Decade of Health Care Reform Under the ACA.* Society of Actuaries, March 2020, *https://www.soa.org/resources/research-reports/2020/50-states-50-stories/* (accessed March 21, 2020).

5 Ibid.

6 Ibid.

7 Ibid.

Valuation of Care Management Vendors

By Ryan Coblentz and Rick Pawelski

Once upon a time, health insurance was relatively simple: policyholders went to the doctor or the hospital, and their insurer paid the bill; nothing more to it. Straight indemnity coverage was the way of the world. Rising medical costs changed that. As an increasing part of the U.S. gross domestic product and American workers' paychecks went to medical costs, it was in the national interest to do something about it. Individuals were not in a very good position to monitor cost trends across a range of procedures and providers or to negotiate their own prices, particularly when they were already in a doctor's office or a hospital bed. It fell to insurance companies to manage health costs on behalf of the patients, so as to provide the best value in terms of covered services and provider networks. The insurers called it managed care.

Managed care has been through many stages and iterations from the birth of the HMO to the determination of the Triple Aim, but the basic premise remains: it behooves the insurer to energetically manage the care delivered to its customers to make sure it is both medically effective and cost-effective. Meanwhile, the pace of medical change and innovation has only increased. It has become more difficult for any one organization to display best practices in the management of every type of medical care. It's hard enough to negotiate what is being paid for a typical trip to the doctor's office or a visit to each hospital in an insurer's network, let alone considering specialized segments of care delivery such as post-acute care, palliative care, treatment of end-stage renal disease, behavioral/medical comorbid diagnoses and so on. This landscape has prompted the growth of care management vendors, companies that specialize in measuring and managing the delivery of specific segments of medical treatment. These functions can be performed in-house, but insurers are also able to outsource such segments, bringing in specialized expertise and processes that would otherwise take significant time and investment to develop internally.

Picture this: within a typical health insurance organization, a conversation is going on in a typical meeting room about an external vendor that may be hired—or has been hired—to manage a segment of care on behalf of the company. Two questions always come up:

- Will this drive a better clinical outcome for the member?
- How much money can we save by doing this?

We will leave the first question to the clinicians. The answer to the second question is often "I dunno, let's ask Actuarial," which is a reasonable conclusion. With its expertise in claims and expense analysis, as well as modeling and projection, the typical actuarial department is uniquely prepared and positioned to answer this question, and that will be the focus of this article.

OK, Actuarial, what do you have for us?

WHO ARE THOSE GUYS?

First, we have to figure out what to measure. Vendors can impact medical cost in a variety of ways. Examples include the following:

- **Utilization management.** The vendor manages a specific set of medical procedures, often delineated by listed procedure codes. Management may impact utilization based on medical necessity, appropriateness of the procedure for a specific diagnosis, medically redundant combinations of procedures or other scenarios. Changes in average utilization are measured in units per thousand members but, in the case of inpatient admissions, can also be measured in average length of stay. In the latter case, bundling claims, where a decrease in length of stay may not provide any dollar savings, should also be considered.

- **Site of care.** A vendor may shift specified types of care to less expensive venues. For example, if a certain procedure could be performed just as well at home or in the physician's office as in a hospital setting, management of that procedure could shift utilization from the most expensive place (the hospital) to one of the less expensive places.

- **Diagnosis or patient type.** Some vendor arrangements identify and manage patients receiving a certain type of care as determined by diagnosis, such as end-stage renal disease, pain management, medical/behavioral health comorbidity and so on. Savings are often measured based on all covered care provided to persons under management rather than for a limited set of specific procedures or diagnoses. The goal of these services is often to reduce unnecessary inpatient admissions or emergency department visits.

- **Severity/downcoding.** Some types of medical treatment are coded by severity levels, with higher payment made for greater severity. A vendor might identify and reverse inappropriate upcoding or "code creep," leading to a utilization shift from severe/expensive procedures to those that are less so.

The type of cost savings often determines how savings are quantified.

THE BASICS

Measuring the effect of any medical savings initiative is pretty straightforward in theory: you take one group of people affected by the initiative and another group of people not affected by the initiative, then you measure the difference in total claim expenditures. All else being equal—and we'll get back to that assumption a bit later—the difference between the two groups is your savings.

Methods of various complexity may be used, often depending on the data available. These include:

- **Pre-/post-analysis.** A comparison of experience under the vendor arrangement (experience period) to a period of time before implementation (base period). In its most direct form, simple averages are calculated for each period, with an adjustment for trend between the periods. The primary shortcoming of this method of analysis is that adjustments for trend and other differences between the base period and the experience period introduce cumulative uncertainty over time, resulting in decreased confidence in measurements with each passing time period. At some point, another method may have to be used to measure savings accurately.

- **Participating/nonparticipating analysis.** Some initiatives do not affect all plausibly defined members. For example, some enrollment or opt-in process may be required, which not all members or groups will pursue. Other initiatives may be limited by region or some other category that does not affect members' risk or cost expectation. In this case one can define the control and test populations according to who is and who is not affected by the initiative. Again, in its most direct form, simple averages are used, and since both populations are measured in the same time period, trend is not an issue.

- **Regression/trend line analysis.** A more complex form of pre-/post-analysis in which a control population can be used to generate a formula, as with a regression formula; projected values are then compared to actual values and the difference between the two represents the savings.

- **Matched cohort analysis.** A more complex form of participating/nonparticipating analysis in which a number of variables that are expected to affect claims totals is generated and then used to match members of the test population to risk-equivalent members of the control population individually. The difference in costs between each matched pair represents the savings.

- **Propensity score matching.** A more advanced method of matching test and control members that estimates the predicted probability that each member receives a treatment based on observed characteristics. Bias from confounding variables is reduced, and dropped observations are minimized. However, a large sample size is required, and the selection of variables can affect the outcome.

- **Coarsened exact matching.** In this matching method, defining variables are coarsened into ranges or bins. This allows a greater degree of exact matches between test and control populations. The selection of variables is once again critical to the outcome of the exercise.

So that's it? No, I don't think so. Remember when we said, "all else being equal"? It's not. Not ever.

ADJUSTMENTS

We actuaries sometimes seem to spend more time on the complicating factors than we do on the underlying problem. How many of you have read through any of the Actuarial Standards of Practice lately? Put your hands down, it was a rhetorical question. The point is, the devil is often in the details. When comparing two populations, material differences in risk between them must be considered. Accounting for these differences can be done through the adjustment of data or application of a neutralizing factor. When matching methods are applied, the selection of variables can account for those differences. There may also be changes in population or care management over the course of time. Material changes of this type must also be considered.

Such considerations include:

- **Scope.** When a vendor arrangement is defined by specific data, such as procedure codes, the definition of included procedures can change over time as new codes are added and others become obsolete. Such changes in scope must be documented regularly, and savings analysis must account for them.

- **Trend.** Over any significant period of time, changes in average cost per service must be accounted for. Changes in average utilization must also be considered—the effect of the vendor's introduced care management should be removed by identifying market utilization based on nonparticipating membership, external benchmarks or some other source that is not significantly affected by the vendor.

- **Class of claims.** Will savings be measured in terms of billed dollars, allowed dollars, paid dollars or some combination? This may affect how calculations should be performed; for example, trend could have a higher impact on paid dollars than on allowed dollars due to copay leveraging.

- **Seasonality.** If data and/or projections do not comprise complete years, adjustments may have to be made for seasonal patterns in utilization.

- **Episodic care.** In some cases where a vendor's activities are specific to a given set of procedures, there can be a corresponding effect on associated procedures not included in the vendor contract. For example, if specific types of surgery are managed, all other claims associated with the day of an outpatient surgery, or the admitted days of an inpatient surgery, should be considered in calculating savings.

- **Care shifting.** If an insurer is going to stop paying, or pay less, for a specific type of claim, it's possible that provider behavior will respond by shifting care to other types of claims that have not been impacted by the vendor's care management. For example, if the fictitious procedure HCPCS = AAAAA has a near-equivalent procedure HCPCS = BBBBB, a certain amount of utilization that appears to have been prevented for AAAAA might simply shift to BBBBB. This possibility must be allowed for in savings projections.

- **Risk adjustment.** Average risk level may vary over time, between covered and noncovered populations, or between test and control populations. Where risk factors are available, they can be used to identify and adjust for such variance.

- **Overlap.** If multiple vendors or company initiatives affect the same types of claims for the same population, there is a risk of giving a vendor credit for savings generated, in whole or in part, by a different initiative.

- **Credibility.** Some vendor activities only affect a small number of people, or one might be analyzing a relatively short experience period. In either case, the credibility of the measured savings may be limited.

- **Delay in claim impact.** A care management initiative may not become fully effective upon implementation. It may take a while for providers' practice patterns to reach full effectiveness or to build up a managed population when active enrollment in an initiative is required. This can have a pronounced effect on savings measurement in the first year and sometimes beyond that.

YOU GET WHAT YOU PAY FOR—MAYBE

Once savings are determined for a care management arrangement, it is important to consider the price of that arrangement in determining its cost-effectiveness. Reimbursement to a vendor can take several forms, sometimes in combination:

- **Per member per month (PMPM) fee.** A fee paid for each eligible member for each month. Eligibility may be determined by line of business, participation in a program or any number of other methods.

- **Capitation.** Full risk for a specified population and/or specified types of care may be transferred from the payer to a vendor in return for a fixed payment PMPM. This payment model may limit the insurer's realization of total savings, but calculation of those savings will help to determine the cost-effectiveness of the arrangement.

When comparing two populations, material differences in risk between them must be considered.

- **Risk share.** The vendor may be awarded a percentage of savings achieved. In this case, it is important for the savings formula to be agreed upon and contractually defined in sufficient detail to preclude disagreements over what the savings figure actually is.

External vendors are often measured in terms of return on investment—the ratio of savings divided by payments to the vendor. It is important to allow for all payments to the vendor in this calculation, preferably matching any values that appear on invoices.

Getting back to that typical meeting room in the typical health insurance organization, back on the first page of this article: when someone wants to know how a vendor program is doing, they may not fully understand the risk and complexity involved in answering that question. Without proper evaluation of the savings achieved by such programs, the prices paid to their vendors would be based on, well, the charity of strangers, perhaps? There would be no way of accurately quantifying the impact of those programs on affected populations and therefore on the pricing of their insurance plans. Once quantified, that impact should feed into trending and forecasting discussions. These are all important functions for an insurer, and actuaries are uniquely positioned to participate in all of them. Consideration of the impacts, methods and considerations discussed here will help you if you're the one who picks up the phone when the people in that meeting room call. ■

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Health Care Challenges in Remote Areas: A Good Example

By Timothy Adams

When traveling westward on Nebraska's state Highway 91, a person gets a feeling of gradually increasing remoteness. Indeed, the city at its eastern terminus, Blair, which is located about 20 miles north of Omaha on the Missouri River, is easily the largest community on the entire route, with a population of about 7,000. This is farming country. The rural areas are mostly covered with grain fields, dotted by livestock pens, silos, barns and accompanying farmhouses. It is what most people think of when they think of the rural Midwest.

Blair likely has more population than all of the other towns located on Highway 91's 230-mile length put together. The route passes through only two other towns with at least 1,000 people. Albion, the second largest, has a population of about 1,600. Burwell, the third largest, reported a population of 1,210 on the 2010 census.

The change while heading west is gradual but nonetheless palpable. Farms give way to ranches, which are better suited for the lower rainfall amounts and weaker soil quality. Towns, and the accompanying services, get smaller, not to mention fewer and farther between. Once a person gets out here, maintaining enough gas and any other necessities is a must. It is easy to see why someone might refer to this as Nebraska's Outback.

Just off Highway 91, 15 miles from its western terminus, lies the village of Brewster. Population 17. This town well fits the description for being out in the middle of nowhere. Yet Brewster does have its distinctions. It is the county seat of Blaine County, making it the smallest county seat in Nebraska. What few county seats in the nation that are smaller than Brewster are unincorporated. By looking at a map, one can guess why Brewster became the county seat. Dunning, the only larger town in the county, has about 100 people. It is in the southwest part of the county. Brewster is much closer to the center. The entire county has fewer than 500 people scattered around 715 square miles.

Living here has obvious advantages. Quiet. Peaceful. Everyone knows everyone else. Everyone gets along. They are always willing to help each other. Hardly any crime. Cheap real estate.

Challenges are equally obvious. Sparse goods and services. Few activities. The nearest gas station is 20 miles away. Grocery stores, hardware stores, movie theaters and pharmacies are even farther away. Trucks that sell food to the locals visit occasionally, helping somewhat to keep refrigerators stocked. For activities, residents often like to hunt, fish and garden, further augmenting the food supply. Brewster has a mechanic, thereby helping with car repairs and maintenance. But he does not have equipment to work on newer models.

Lacking job opportunities, the young people have moved away. The remaining population is consequently much older than in most places in the U.S. Besides being the county seat, Brewster mainly serves the nearby ranches. Because the cost of county services and schools must be spread over a small population, property taxes are unusually high. This has forced many ranches to close, placing additional strain on remaining residents who now face even higher taxes. Although Blaine County supports county employees and schools, other services such as road maintenance are often neglected.

Access to medical care is among Brewster's biggest challenges. Home Health Care used to visit to provide basic medical assistance, but it no longer serves Brewster. The nearest doctor is in Ainsworth, 43 miles to the north. Because a routine visit to a physician, eye doctor or dentist takes a significant part of a day, people in Brewster try to combine doctor visits with other chores, such as shopping.

Emergencies are even more difficult. The village has a local ambulance. But whenever the ambulance is needed, it takes 15 minutes for all the people who run the ambulance to arrive at the scene. Add another 45 minutes to get to the nearest hospital. That makes it one hour before the patient gets to substantive medical help. Bad weather can make emergencies even worse. One time a person there had a stroke. The ambulance had to follow a snow plow all the way to Ainsworth. It took 12 hours

just to get this person to a hospital. If the ambulance breaks down, it further complicates matters.

Access to medical care can be downright costly for extreme cases. One resident spends about all his Social Security income on medications. His primary care doctor is in Ord, 61 miles away. On top of that, he must get specialized treatment in North Platte (91 miles), Kearney (114 miles), Grand Island (131 miles) and Hastings (152 miles). Just traveling between those places is expensive. Round-trips between Brewster and each of those cities totals 1,098 miles. That comes to $631.35 at the standard 57.5 mileage deduction rate. Sometimes he needs iron transfusions that require treatment for three days in a row. That further increases costs. Typically, he travels back and forth for each of those three days. The alternative would be to rent a motel room for the overnights.

Disasters cause their own problems. The Nebraska Emergency Management Agency (NEMA) and Federal Emergency Management Agency (FEMA) were both on hand during recent flooding. Residents do not like dealing with agency rules, but they have learned to accommodate them. At least nobody was injured in those floods.

Volunteer emergency medical technicians (EMTs) sometimes provide help via life flight. This is particularly useful when somebody needs emergency treatment not available in the cities that are within an hour's drive. The nearest trauma center is in Kearney. A medical emergency transport company claims the average out-of-pocket expense for this kind of service in Nebraska is $176. This amount can fluctuate based on several factors, such as insurance, in- and out-of-network providers, the amount of care the patient needs in transit and distance. Such companies are reluctant to provide more detailed figures because of all the factors involved.

Long-term care provides challenges, too. The facilities in the area are struggling financially. Rules and regulations aggravate the problem. The residents in those facilities do not even get the best nutrition. Their food comes prepackaged. Worse yet, activities are lacking. People need a sense of purpose. These shortcomings leave residents with a choice between staying close to friends and loved ones and moving away to get better care.

Health insurance in Brewster is a mixed bag. Employees of the county get group health coverage. Most of the other residents are on Medicare. At least one resident gets VA benefits. But because of the extreme cost, anybody who must pay for their own health insurance often has to choose between having health care coverage and eating.

Preventive care, such as inoculations, is like other services. One needs to travel to places that have doctors to get it. Occasionally, a person can go to Broken Bow (57 miles) to get a screening for stroke. For $149, they get checked for plaque, heart rhythm, abdominal aortic aneurism, peripheral arterial disease and osteoporosis risk.

All things considered, the people in Brewster are happy living there. As mentioned earlier, it has its advantages. The inconveniences are just part of the trade-off. Anybody who cannot handle the inconveniences should not live there.

Nonetheless, the people in Brewster, just as people in a myriad of small, remote towns in the United States, need access to adequate health care. This is one issue that should be considered in health care policy.

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RESEARCH & REPORTS

Read the newly released research report "Fifty States, Fifty Stories: A Decade of Health Care Reform Under the ACA," which identifies 11 key observations since the passage of the ACA. The report's data-driven observations focus on the uninsured rate, insurer competition in health exchanges and premium rate levels.

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