American Academy of Actuaries

Health Reform Implementation: Understanding the Terminology

Actuarial Value/Actuarial Equivalence: A health insurance plan's actuarial value generally refers to the average share of medical spending that is paid for by the plan as opposed to by the insureds. Actuarial values depend on the plan's cost-sharing requirements as well as the specific services that the plan covers. Two or more plans that have the same actuarial value are referred to as being actuarially equivalent. Even health insurance plans that are actuarially equivalent, however, likely will have different premiums and may be more or less valuable to any particular individual, based on his or her particular health care needs. For more information, see:

Critical Issues in Health Reform: Actuarial Equivalence

Adverse Selection: When people can choose whether to purchase insurance coverage, their decision will depend in part on how their expectations for health care needs compare to the insurance premium charged. Adverse selection occurs when individuals with higher expected medical needs are more likely to purchase coverage, thus skewing insurance risk pools. The higher premiums that result from adverse selection may lead to more low-risk individuals opting out of coverage, which would result in even higher premiums. Avoiding this premium spiral requires minimizing adverse selection and instead attracting a broad cross section of risks, especially low-risk individuals, over which the costs of high-risk individuals can be spread. Attracting healthier individuals ultimately will help keep premiums more affordable and stable. Requiring that individuals have health insurance coverage, as mandated by the Affordable Care Act (ACA), is one way to minimize adverse selection. For more information, see:

Critical Issues in Health Reform: Risk Pooling

Critical Issues in Health Reform: Individual Mandate

Comparative Effectiveness: Comparative effectiveness research offers the potential to better assess the value of health care treatment options, especially when it includes head-to-head clinical trials that compare new treatments and technologies to those already existing. Such research could result in the greater development and utilization of evidence-based treatment protocols and a reduction in provider practice variations. Comparative effectiveness research is intended to refocus the health care delivery system on the value of care received and, in doing so, could help reduce health care spending that does not correlate with better health outcomes. The new health reform law establishes a Patient-Centered Outcomes Research Institute to conduct this type of research. For more information on comparative effectiveness research, see:

Health Insurance Coverage and Reimbursement Decisions: Implications for Increased Comparative Effectiveness Research

Guaranteed Issue/Medical Underwriting: Beginning in 2014, the new health reform law requires insurers to provide insurance regardless of health status, which is referred to as *guaranteed issue*. In other words, an individual cannot be denied insurance coverage. While guaranteed issue is already required for small groups, most states do not currently require guaranteed issue

in their individual markets. Instead, they have permitted insurers to medically underwrite applicants and use health-based factors to determine whether to issue a policy. For more information, see:

The Individual Medical Insurance Market: A Guide for Policymakers

High-Risk Pools: High-risk pools provide subsidized health insurance coverage to individuals with pre-existing conditions who have been denied insurance or find individual market premiums unaffordable due to their health status. Many states operate high-risk pools. The new health reform law establishes a temporary federal high-risk pool program for individuals with pre-existing conditions who have been uninsured for at least six months.

Individual Mandate: The new health reform law requires all individuals, with a few exceptions, to have health insurance coverage. This mandate, an integral part of the new law, aims to ensure that health insurance markets enroll a broad cross section of risks to avoid the higher average premiums associated with adverse selection. In 2014, uninsured individuals not exempt from the mandate will be assessed a penalty of $95 or 1 percent of taxable income, whichever is greater. The penalty increases in 2015 ($325 or 2 percent of income) and 2016 ($695 or 2.5 percent of income). The dollar amount is indexed annually thereafter. For more information, see:

Critical Issues in Health Reform: Individual Mandate

Medical Loss Ratios: Loss ratios measure the share of premiums that a health insurer spends on medical benefits versus the share spent on administration costs (e.g., marketing, enrollment and billing). The new health reform law requires insurers in the individual market to maintain a medical loss ratio of at least 80 percent and insurers in the group market to maintain a loss ratio of at least 85 percent. In other words, for a policy in the individual market, at least 80 percent of the premium would have to go directly to coverage of medical costs and quality improvement activities. If the ratio is lower, then insurers will be required to provide a rebate to policyholders. For more information, see:

Critical Issues in Health Reform: Minimum Loss Ratios

Pay-for-Performance (P4P): Also known as value-based purchasing, pay-for-performance incentive programs are intended to align medical provider reimbursements with favorable or desired improvements in health outcomes. They reward providers for meeting certain performance-based measures related to quality, safety, and efficiency. As a result, P4P can encourage higher quality care, more cost-effective care, and improved patient satisfaction. The health reform law establishes and extends value-based purchasing programs in Medicare. For more information, see:

Pay for Performance: Rewarding Improvements in the Quality of Health Care

Premium Rating Rules: Until enactment of the new law, insurers could incorporate information on many factors when determining premium rates—health status, age, gender, geography, tobacco use, industry/occupation, and family size, among others. The new law, however, limits rating factors to age, tobacco, family size, and geography. The age rating factor cannot vary by more than 3:1, which means that an older individual cannot be charged premiums more than three times the premiums for a younger individual. The tobacco rating factor cannot vary by more than 1.5:1, which means that a smoker would not pay more than 1.5 times what a non-smoker would pay.

Reinsurance: Reinsurance is essentially insurance for insurance companies. As a general rule, reinsurance reimburses eligible entities for the cost of individuals who have high claim costs. The new health care law contains two reinsurance components:

- A temporary reinsurance program that is in effect until 2014 will reimburse employers that

offer coverage for retirees between ages 55–64. Employers and insurers will be reimbursed for 80 percent of eligible claims between $15,000 and $90,000.

- A temporary reinsurance program for individual and small group markets in each state will be in effect during the first three years of the operation of the health insurance exchanges beginning in 2014. Health insurers and third-party administrators will make payments to a non-profit reinsurance entity. Those amounts would be used to reimburse insurers that cover high-risk individuals.

Risk Adjustment: Risk adjustment is a tool used to adjust payments to health plans or other stakeholders based on the relative health of at-risk populations. If insurers are limited in the extent to which premiums can vary by health status or other factors associated with health spending, risk adjustment can help compensate insurers for the risks they enroll. The new law includes a risk adjustment mechanism. For more information, see:

Risk Assessment and Risk Adjustment

Risk-Based Capital: Risk-based capital is the amount of capital that a company needs to support its operations based on the risks assumed by the company. It is needed at plan start-up and on an ongoing basis to mitigate the risk that insurance claims and expenses will exceed insurance premium revenues. In other words, risk-based capital reduces the risk that an insurance organization will not have enough funds to meet its financial obligations.

Risk Corridors: The new health reform law will extend insurance to many previously uninsured people. Insurers may find it difficult to price this coverage as they lack data on health spending of the currently uninsured. The new health reform law creates temporary risk corridors in the individual and small group markets that will limit both the downside risk and upside gain for insurance organizations. Plans will receive payments from the government if their allowable costs exceed 103 percent of the target amount; plans will make payments to the government if allowable costs are less than 97 percent of the target amount.

Risk Pooling: Health insurance risk pools are large groups of individual entities (individuals or employers) whose medical costs are combined to calculate the health insurance premium. Pooling risks together allows the costs of those individuals at higher risk of high medical costs to be subsidized by those at lower risk. The individual mandate included as part of the new health reform law is intended to increase overall participation rates—especially among low-risk individuals—and create a pool of individuals with a broader cross section of risks. For more information, see:

Critical Issues in Health Reform: Risk Pooling

Critical Issues in Health Reform: Individual Mandate

Value-Based Insurance Design (VBID): Plans using a value-based insurance design contain features intended to encourage the use of medical services with evidence of clinical benefit and discourage use of medical services with little or no evidence base. These plans essentially lower the cost barriers to high-value services that consumers otherwise might delay or avoid. For more information, see:

Value-Based Insurance Design

American Academy *of* Actuaries