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The 10 percent problem: Future health insurance marketplace premium increases likely to reach double digits

Executive summary

Health plans setting their premiums for the public health insurance marketplaces have faced one of the most challenging pricing scenarios in recent history. A new set of rating rules, a competitive environment, and ambiguity around enrollee populations collided to create unprecedented uncertainty. While the Affordable Care Act (ACA) established three programs – risk adjustment, risk corridors, and reinsurance – to address some of this uncertainty, two of the programs will expire after 2016. The end of the risk corridors and reinsurance programs – coupled with growing health care utilization and higher costs due to the increasing annual, non-deductible fee on health plans – could make significant premium increases inevitable in the future.

Deloitte's health actuarial practice modeled the effect of the risk corridors and reinsurance programs' expiration on health plan premiums over the next three years. The analysis was based on simulations using Deloitte's Health Care Reform Premium Stabilization Projection (HCRPSP) model, which incorporates multiple variables affecting premiums, including cost trend, policy, and marketplace factors.

The bottom line: Premium increases of 10 percent or more could be likely as health plans prepare for the end of the two programs after 2016 and respond to other factors raising costs, even for health plans that priced their policies to anticipate first-year marketplace costs.

The analysis looked at scenarios for a health plan that bid high enough to cover its costs and earn a small profit and a health plan that bid too low (potentially to gain market share) and lost money:

- For a health plan that bid accurately in the first year of the marketplaces, average increases of 10 percent over the next three years could be needed to maintain profitability in 2017.
- For a health plan that bid too low, the increases could be significantly higher; average increases of 15 percent could be needed to reach profitability by 2017.

Additional uncertainties could raise premiums even more and affect pricing strategy. State and federal policies around rate reviews may limit a health plan's ability to obtain large premium increases, and rules about network standards could raise costs. If Congress were to extend the risk corridors and reinsurance programs beyond 2016, premium increases may be kept in check, but this would require legislative changes that may be challenging to pass, especially given the political landscape.

Health plans should consider a multi-year strategy for setting their marketplace premiums. Waiting until the two programs expire to raise premiums could lead to very large increases, which could be problematic for regulators and consumers.

Risk adjustment, risk corridors, and reinsurance keep premiums stable

The ACA created new rules for health plans that have brought uncertainty to the process of setting premiums in the new health insurance marketplaces. Three programs – risk adjustment, risk corridors, and reinsurance – aim to provide a stabilizing effect on premiums. These programs were designed to address concerns by health plans that they might attract enrollees with higher-than-average spending patterns. The risk adjustment program is permanent; the risk corridors and reinsurance programs will expire after 2016 because, presumably more will be known about enrollee spending patterns and marketplace competitive dynamics, and the process for setting premiums will likely be more certain. The ACA's market reforms required the three programs to be implemented separately, but they are interconnected (See Appendix 1). The success of these programs is critical to making sure that ACA insurance market reforms (e.g., guaranteed issue, elimination of pre-existing condition exclusions, essential health benefits, and rating rules) support competition and stability inside and outside the marketplaces (See Appendix 2).

Despite health care cost increases and other factors that may drive up premium rates, health plans face scrutiny over premium increases. In 2011, the U.S. Department of Health and Human Services (HHS) began a rate increase disclosure and review program to determine whether a substantial increase is unreasonable, excessive, unjustified, or unfairly discriminatory. This program applies to most health plans offering coverage in the individual and small-group markets. While the program's federal threshold is rate increases of 10 percent or more, states can set other thresholds.[1]

The 10 percent problem

Even though the federal threshold triggering rate review is 10 percent, Deloitte's health actuarial practice found that, in many cases, premium increases above this threshold are likely to be needed for health plans to reach profitability by 2017. The practice used the HCRPSP model, which accounts for a host of economic and policy factors affecting health plan premiums, to examine several scenarios and pricing strategies for sample plans, with a specific focus on the expiration of the risk corridors and reinsurance programs. In each scenario, the practice also looked at the potential effect on a health plan's profit before federal income taxes, as this factor can influence whether a health plan continues to participate in the marketplaces.

The model took into account a number of factors that are likely to affect premiums. It assumed that the health care cost trend grows at seven percent per year and incorporated the annual, non-deductible fees that health plans are required to pay as of 2014. The Internal Revenue Service will collect $8 billion in fees from health plans in 2014; the amount will grow to $14.3 billion by 2018 and continue to rise thereafter.[2] From 2013-2022 the fees are anticipated to generate $101.7 billion in revenue to help offset ACA spending.[3] The model also assumed that risk adjustment will work as the law intended and will have a neutral effect on pricing scenarios.

The HCRPSP model produced estimates of what premiums health plans would need to charge in order to earn a profit of two percent by 2017. It looked at scenarios for a health plan that bid fairly accurately in the initial year of marketplaces – earning a two percent profit – and one that was priced too low – posting a negative five percent profit, possibly to gain market share. For the plan priced too low, the model looked at two different pricing strategies: one recoups losses all at once when the risk corridors and reinsurance programs expire after 2016; the other strategy spreads out premium increases in anticipation of the programs' end (Table 1)*.

* Refer to the methodology section for more information about the HCRPSP model and its assumptions.

Under all scenarios, health plans could need substantial premium increases:

- Rate increases higher than the 10 percent threshold are likely to be needed.
- Plans that were priced to obtain a two percent profit in 2014 could need rate increases near 10 percent over the next three years.
- Plans that were five percent underpriced in 2014 should get considerable protection from the risk corridors and reinsurance programs but are likely to need sizeable increases to reach profitability by 2017.
- Key drivers of these results are the end of the risk corridors and reinsurance programs after 2016 and the gradually increasing, non-deductible ACA fees.

Other scenarios are possible, and the modeling is simplified, but results of the following three scenarios (Table 1) indicate that health plans should consider adopting a robust, multi-year rating strategy.

Scenario 1: The price is right

Scenario 1 features a health plan that had two percent profit before federal income taxes in 2014 and wanted to maintain this level through 2017. The HCRPSP model found that, in this scenario, rate increases would need to be 12 percent in 2015, dropping to nine percent for the subsequent years in order to maintain profitability in 2017. Even in this adequate pricing scenario, the modeling suggests that health plans could require an average rate increase of 10 percent over three years, for a cumulative increase of 33 percent when the two programs expire and their protective effects vanish. If the two temporary programs did not exist to protect against losses, a health plan in this scenario would likely experience losses during the first three years. In 2014, losses could be six percent, in contrast to the two percent profit, an eight percentage point difference. Losses would drop to one percent and zero for the subsequent two years and level out in 2017.

Scenario 2: The steady road to recovery

Scenario 2 features a health plan that aggressively priced its premiums to gain market share in the early years, had a five percent loss in 2014, and began to recoup its losses through gradual premium increases over the three years. This scenario assumes the regulators would grant rate actions in excess of 10 percent. In 2014 the modeling suggests that the risk corridors and reinsurance programs prevented losses of 15 percent. This health plan could raise its premiums by 17 percent, 15 percent, and 13 percent each respective year, and in 2017 it would achieve the target of two percent profit. Combined cumulative premium increases would total 52 percent. The modeling suggests that the two temporary programs protected the health plan from a more significant loss of 20 percent in 2014. After the first year and without the programs, this plan would have had losses of 10 percent in 2015 and three percent in 2016.

Scenario 3: Out of time

Scenario 3 begins the same as Scenario 2 but this time, the health plan limits premium increases to seven percent per year in 2015 and 2016. A plan might do this because of regulatory limits on premium increases, to retain members, or to attract new ones in subsequent years. In this case, to get to the targeted two percent profit in 2017, when the risk corridors and reinsurance programs expire, the plan would have to raise premiums by 33 percent that year. Without the protective effects of the reinsurance and risk corridors programs, the health plan's losses would have been significant: as high as 20 percent in 2014 and 2015, and 19 percent in 2016.

Table 1: Deloitte's HCRPSP model illustrates three scenarios of profit levels and annual rate increases that could be required to reach or maintain modest profitability in 2017

	2014	2015	2016	2017	Cumulative three-year increase	Average rate increase
Scenario 1: The price is right						
Profit before federal income tax (% of premium)	2%	2%	2%	2%		
Rate increase (%)		12%	9%	9%	33%	10%
Impact of temporary programs (% of premium)	8%	3%	2%	0%		
Profit without temporary programs (% of premium)	-6%	-1%	0%			
Scenario 2: The steady road to recovery						
Profit before federal income tax (% of premium)	-5%	-4%	-1%	2%		
Rate increase (%)		17%	15%	13%	52%	15%
Impact of temporary programs (% of premium)	15%	6%	2%	0%		
Profit without temporary programs (% of premium)	-20%	-10%	-3%			
Scenario 3: Out of time						
Profit before federal income tax (% of premium)	-5%	-6%	-6%	2%		
Rate increase (%)		7%	7%	33%	52%	15%
Impact of temporary programs (% of premium)	15%	14%	13%	0%		
Profit without temporary programs (% of premium)	-20%	-20%	-19%			

Source: Deloitte analysis

Critical factors could change the game

The public health insurance marketplaces are new, and many important questions remain unanswered. This is affecting health plans' ability to price their offerings with confidence. There are, of course, many game-changing issues to consider:

Will risk adjustment work?

While the HCRPSP model assumes that risk adjustment is accurate and the program controls risk liability between health plans, in reality, risk adjustment is not always completely accurate. Some health plans are concerned that the program will not offer sufficient protection from adverse risk. While they may aim to achieve a two percent profit in 2017, health plans still need to understand marketplace claim levels for 2017.

Risk adjustment is a zero sum game in each state. Consequently, health plans and other organizations (e.g., integrated health systems) that are able to more effectively and accurately capture diagnosis information could have a competitive advantage and even disproportionately benefit from the program. Providers should have the right tools to accurately diagnose patient populations. Also, claims data should be matched with diagnoses for certain populations to verify that patient risk profiles are being properly identified. This is commonly done in Medicaid and Medicare Advantage and Part D, as many health plans seek to maximize their reimbursement in those programs through risk adjustment.

The risk pool: A grab bag?

The health insurance marketplaces enrolled approximately eight million individuals during the first open enrollment period.[4] While HHS provided details into the demographic breakdown of enrollees through the federally facilitated marketplace, information on state-based marketplaces has varied. In addition, health plans have been unable to fully assess the health status of new enrollees—a critical element that is likely to affect future pricing strategies. Twenty-eight percent of total year-one enrollees (2.2 million individuals) were between the ages of 18 and 34, but this was significantly lower than the 40 percent that many predicted was necessary to outweigh the cost of older enrollees.[5]

Initial accounts of early enrollees in marketplace plans suggest that this population is less healthy and, thus, more expensive than the traditional commercially insured population. An analysis of pharmacy spending among early and late enrollees by Express Scripts, a pharmacy benefits manager, determined that marketplace enrollees had greater use of specialty medications than their counterparts in the commercial insurance market.[6] While this is an early snapshot of just one component of this population's health care spending, it could raise concern among health plans about adverse selection. Attracting more people – especially younger people who tend not to use as much health care as others – could help to moderate the spending trend and bring a meaningful reduction in medical claims—a change that could be critical to marketplace success.

State and federal factors

Role of aggressive premium reviews: Over the last 25 years, many state regulators have given their insurance department or commission rate review power. As with much regulatory power at the state level, implementation can differ by state. To date, 43 states and the District of Columbia have instated effective rate review programs. In the six states that do not have an effective rate program, HHS conducts rate reviews; Virginia's rate review program is split between the state and HHS.[7] The ACA has provided more than $44 million in grants for states to make improvements to their rate review programs.[8]

State-by-state release of information from the first year of rate reviews generated considerable media coverage. Throughout the summer and early fall of 2014, insurers disclosed rate changes that received both positive and negative reactions from consumer groups and other health care stakeholders. This component of health insurance marketplaces is critical for protecting consumers against high premiums; however, rate reviews also have other impacts. States that are more aggressive with their review policies can cause a ripple effect throughout their marketplace by approving or denying certain proposals. Health plans whose proposed increases are rejected could face three decisions: pull out of the marketplace, begin chipping away at the benefits offered on the individual plans, or find new efficiency gains to offset potential losses. Health plans are somewhat limited in their ability to take away benefits as a way to keep costs down, as all plans offering coverage in the exchanges must meet certain actuarial values. Aggressive premium reviews could ultimately decrease competition in certain marketplaces if a considerable number of plans decide to pull out after their rate increases are rejected.

Another factor to consider is that while HHS may deny substantial rate increases, competitive pressures may also require health plans to keep their increases low. Consumers that are price-sensitive are more likely to choose plans with lower premiums over more expensive ones that have broader networks and more benefits.

In August 2014, the California state legislature passed Senate Bill 964, "Health Care Coverage," requiring California health plans to submit an annual report to the Department of Managed Health Care (DMHC) on new access measures related to timely receipt of care and network adequacy. The bill requires the report to include information on provider office location, area of specialty, hospital privileges, providers with open practices, the number of patients assigned to the provider, and any grievances about network adequacy that were received in the prior year.

Source: California Legislative Information, Chapter 573: SB-964 Health Care Coverage, September 25, 2014. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB964. Accessed November 3, 2014.

Limitations on narrow networks: In addition to rate review requirements, the ACA implemented standards around marketplace provider networks, deeming that they must be "sufficient in number and types of providers… to assure that all services will be accessible without reasonable delay." Health plans offering qualified health plans (QHP) also are required to make available online a provider directory and must identify which providers are not accepting new patients.[9] While the ACA imposes these basic requirements, some states require additional standards for provider networks and, more recently, certain state legislatures have attempted to increase their control over provider network standards (See above). States' and federal regulators' efforts to limit the use of narrow networks could force health plans to seek other solutions for controlling costs.

The National Association of Insurance Commissioners (NAIC) is also refreshing the Managed Care Plan Network Adequacy Model, which specifies standards around networks, including size and variety of providers. In its review of the model, NAIC is considering many issues, such as tiered and narrow networks, provider directories, and so-called "surprise bills" that patients may receive if a provider that consults on their case is out-of-network.[10] The revised model could put even greater pressure on health plans seeking to use narrow-network strategies to decrease costs.

Other uncertainties remain

Additional uncertainties continue to make premium pricing in the new marketplaces a moving target:

- *How will the enrollment patterns of populations across the available options affect pricing strategy?* The HCRPSP model considers only the individual market inside the marketplaces. Each market has a different population, which should be considered in pricing strategies.
- *How will recoveries from the reinsurance program compare to charges from HHS, which fund the reinsurance program?* The HCRPSP assumes that recoveries from the reinsurance program will average 10 percent of premiums in 2014, and that reinsurance charges will equal payouts.
- *How much protection will the risk corridors program offer?* After indicating in the Final Notice of Benefit and Payment Parameters for 2014 that the risk corridors program was not required by statute to be budget-neutral, HHS indicated in the final rule for 2015 that the risk corridors program will be implemented in a budget-neutral manner.[11,12] Many health plans remain concerned about how the program will be implemented if the administration does not have the funds required to cover potential losses. Furthermore, a report from the Government Accountability Office recently raised concerns that the Centers for Medicare & Medicaid Services (CMS) might not have authority in 2015 to issue payments for the risk corridors program.[13] This report has been used as political fodder by lawmakers in Congress seeking to delay the appropriations needed to run the program.

Implications

Certain policy levers at the state and government level are affecting health plans' pricing and participation decisions.

Three policy levers are influencing health plans' options for premium increases and decisions around participation in the marketplaces:

- Pressure on health plans that exceed the 10 percent threshold for premium increase review to keep those premiums low is keeping some health plans from obtaining the premium increases they may need.
- Increasing pressure (or requirements) to offer broader networks and discontinue other strategies to keep prices down could drive some health plans out of the marketplaces. Deloitte's 2013 *Survey of U.S. Health Care Consumers* found that around half of insured respondents are willing to accept network changes in exchange for lower-cost insurance or care.[14]
- The expiration of the risk corridors and reinsurance programs after 2016 could cause large rate increases in the marketplaces in the coming years.

Changes to these levers would require legislative and/or regulatory modifications at the federal and/or state level.

Health plan C-suite executives should plan multiple years ahead.

Health plans should consider developing multi-year, multi-prong strategies to keep spending under control and prevent large premium increases. Value-based care purchasing strategies, population health investments, and analytics to target care coordination, are among the tools and methods that health plans can use to manage costs.

However, if health care spending trends again reach historic rates and health plans have limited flexibility to use benefit and network design strategies to limit costs, they should also consider how to request premium increases in ways that are defensible, that anticipate expiration of risk corridors and reinsurance, and that spread the changes over time.

A multi-year strategy might involve actuarial modeling such as that used in the scenarios presented here. Health plans should consider using a framework (Figure 1) when developing their overall strategy and testing its execution through robust, multi-year modeling. Doing so may provide greater insight into a rate increase strategy that is workable for regulators, health plans, and consumers.

Figure 1: Rate increase strategy framework

Appendix 1: ACA premium stabilization programs

	Risk adjustment	Risk corridors	Reinsurance
Operated by	States which established marketplaces; federally facilitated marketplace	Federal government	States or federal government
Administered by	States which established marketplaces, otherwise federal government (all methods approved by HHS)	Secretary of HHS	Third-party, non-profit entity
Time span	2014 and beyond	2014 – 2016	2014 – 2016
Costs involved	Plan transfers net to zero within a market and state	TBD	2014: $12 billion 2015: $8 billion 2016: $5 billion
Plans participating	QHPs in the individual and small-group markets	QHPs in the individual and small-group markets	All major medical issuers contribute; ACA-compliant plans in the individual market (inside and outside of marketplaces) receive benefits
Protects against	Adverse selection among QHPs	Uncertainty in rate setting and costs associated with pricing for a new risk pool	Individuals with high medical claims costs

Source: Deloitte analysis of the HHS Notice of Benefit and Payment Parameters for 2014 final rule

Appendix 2: Previous insurance market reforms show stabilization programs are necessary

Previous insurance market reforms have shown the importance of risk adjustment, risk corridors, and reinsurance in stabilizing the market in times of uncertainty and in reducing the risk of adverse selection when unexpectedly higher numbers of sicker people who use more services enroll in plans. During the early 1990s, several states (e.g., California, Kentucky, New Hampshire, and South Dakota) introduced market reforms after passing community rating and guaranteed issue provisions in their states. In 1993, California created a state-run marketplace for small groups to purchase health insurance through the Health Insurance Plan of California (HIPC, now known as Pacific Health Advantage). HIPC was accompanied by market reforms such as guaranteed issue and limits on pre-existing condition exclusions. Although the HIPC was initially successful, the lack of risk adjustment within the marketplace led to adverse selection and "cherry-picking" among participating health plans. Ultimately, the HIPC failed to obtain the desired market reforms and closed in 2006.[15] There are also examples of state-based reforms related to community rating which led to adverse selection issues that resulted in most insurers leaving those markets.

Along with this historical context, the government used learnings from other U.S. health insurance system programs to inform ACA strategy around the new marketplace reforms. For example, Medicare Part D, Medicare Advantage, and Medicaid rely on (or have relied on) risk stabilization programs.

Medicare Part D

In the early 2000s, President George W. Bush and his administration understood that, in order to successfully integrate a new prescription drug benefit program into Medicare, insurers offering prescription drug coverage (a new product at the time) would need to feel confident that there would be some protection against adverse selection and uncertainty around competition and use patterns. The insurers that participated in the new program initially had no actuarial experience in pricing for plans of this nature, and they experienced considerable risk. The risk corridors program for Medicare Part D, which still operates today, helped provide the fallback mechanism that insurers needed to participate.[16]

Medicare Part D also relies on a sound, permanent risk adjustment strategy to maintain a stable marketplace for participating insurers. CMS pays monthly, capitated payments to standalone prescription drug plans using the Part D Prescription Drug Hierarchical Condition Categories (RxHCC) risk adjustment model. The model is built on Medicare beneficiaries' diagnoses from claims for services. The program was updated in 2011 to incorporate data from prescription drug events in addition to the demographic and diagnosis information that has been put into hierarchical condition categories (HCC).[17]

Medicare Advantage

The Medicare Advantage program pays capitated payments to participating health plans each month. These payments comprise a base rate calculated for enrollees with average risk and a risk score that reflects each enrollee's risk compared with the average beneficiary. The risk score reflects individual demographics and medical conditions, which are sorted into one of 70 HCCs. CMS has improved the performance of this model over time.[18]

Medicaid

During the 1990s, states began to move their Medicaid populations into managed care organizations (MCO). Because many health plans had no experience with pricing and managing the new populations, many states required MCOs to have reinsurance, sometimes referred to as stop-loss arrangements, in order to protect them. Other states used part of the capitated monthly payments to finance a public reinsurance program for their Medicaid programs.[19]

Medicaid has also used risk adjustment to support competition by reducing the financial effects of adverse risk selection for plans. States have opted for different approaches to risk adjustment, such as systems that use individual or aggregate calculations, prospective and concurrent risk adjustment, and a number of different risk adjustment models (e.g., CDPS, ACG, DxCG, and ACG). Some states incorporated temporary risk corridor provisions to further help stabilize the market.[20]

Methodology

Deloitte's Health Care Reform Premium Stabilization Projection (HCRPSP) model analyzes the potential impact of the premium stabilization programs on health plan profit before federal income taxes and after paying the non-deductible ACA fees. The HCRPSP model assesses the potential effects these programs could have under three scenarios and what rate actions could be required to obtain a two percent profit before federal income tax by 2017.

The health care actuarial team at Deloitte Consulting LLP built the HCRPSP model using the most current data and assumptions as of fall 2014 (prior to the second open enrollment period for the health insurance marketplaces).

The HCRPSP model relies on the following simplifying assumptions:

- **Reinsurance program:** The model assumes that an average of 10 percent of premiums for any individual health plan will be eligible for the reinsurance program in 2014. This is based on the parameters outlined in the final rule for the reinsurance program, which set the attachment point for 2014 at $45,000 and capped the program at $250,000. All insurers will pay a per-member-per-month (PMPM) contribution to the reinsurance pool, which will be an estimated $5.25 PMPM in 2014, totaling an estimated $12 billion for the pool. The pool is distributed through reinsurers to plans on the individual market based on their claims as of April following the end of the plan year.
- **Claims trend:** The HCRPSP model assumes a seven percent care cost trend, which is consistent with a "normal" base trend, but also includes adjustments for previously uninsured individuals entering the market. The model does not assume any changes in provider reimbursement, health care utilization, network structures, etc. Changes in these and other factors could cause the outcomes of future modeling outputs to vary.
- **Risk adjustment:** The risk adjustment program operates by collecting fees from non-grandfathered plans in the individual and small-group markets, both inside and outside the exchanges. For the 2015 benefit year, HHS estimates that the cost to operate the risk adjustment program on behalf of the states will be approximately $27.3 million. Thus, for the year, HHS will apply a user fee of $0.96 PMPM to operate the program. The model assumes that risk adjustment begins in 2015 for the 2014 year and that the program is accurate and spreads the payment to plans in a manner consistent with their differentiated risks.
- **Competitor pricing:** The model assumes that competitors' relative price point is held constant. This model does not account for or build in competitive factors that should be considered by health plans.

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Contacts

To begin a discussion or for further information on Deloitte's Life Sciences and Health Care practice please contact:

Bill Copeland
Principal
U.S. Life Sciences and Health Care Leader
Deloitte LLP
bcopeland@deloitte.com

Gregory Scott
Principal
National Health Plans Sector Leader
U.S. Life Sciences and Health Care
Deloitte Consulting LLP
grescott@deloitte.com

Kevin Kenny
Director
U.S. Life Sciences and Health Care
Deloitte Consulting LLP
kekenny@deloitte.com

Authors

Sarah Thomas, MS
Research Director
Deloitte Center for Health Solutions
Deloitte Services LP
sarthomas@deloitte.com

James Whisler, FSA, MAAA
Principal
Health Actuarial Practice Leader
Deloitte Consulting LLP
jwhisler@deloitte.com

Lee H. Resnick, ASA, MAAA
Principal
Deloitte Consulting LLP
lresnick@deloitte.com

Claire Boozer Cruse, MPH
Health Policy Specialist
Deloitte Center for Health Solutions
Deloitte Services LP
cboozer@deloitte.com

Sean Chin, FSA, MAAA
Senior Consultant
Deloitte Consulting LLP
sechin@deloitte.com

Contact information

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Deloitte Center for Health Solutions
555 12th St. NW
Washington DC 20004
Phone 202-220-2177
Fax 202-220-2178

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The source for health care insights: The Deloitte Center for Health Solutions (DCHS) is the research division of Deloitte LLP's Life Sciences and Health Care practice. The goal of DCHS is to inform stakeholders across the health care system about emerging trends, challenges, and opportunities. Using primary research and rigorous analysis, and providing unique perspectives, DCHS seeks to be a trusted source for relevant, timely, and reliable insights.