Pricing and Health Care Reform Overview

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Director, Actuarial
Agenda

- Pricing Overview

- Health Care Reform Overview
  - Major Provisions
  - Insurance Market Reforms
  - Exchange
  - Medical Loss Ratio Requirements
  - Rate Review
  - Reform Impact Scenarios
PRICING OVERVIEW
Pricing Ingredients

- Claims experience
- Current premium
- Membership
- Trend
- Retention – costs other than claims
- Adjustments from experience to projection period:
  - Network changes
  - New programs or initiatives
  - Benefit changes
- Good judgment!!!
Pricing Factors

- Age
- Gender
- Tobacco
- Area
- Risk
Trend

- Reflects expected increase in costs over time for same plan and same demographics

- 3 components:
  - Cost
  - Utilization
  - Leveraging – impact of fixed $ cost sharing
Leveraging Example

Assumptions
Pharmacy Script Cost = $100
Pharmacy Copay = $50
Cost Trend = 10%

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Cost</td>
<td>$100</td>
<td>$110</td>
</tr>
<tr>
<td>Pharmacy Copay</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Pharmacy Benefit Cost</td>
<td>$50</td>
<td>$60</td>
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</tbody>
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Benefit Trend = $60/$50 – 1 = 20%
Experience Loss Ratio = Claims / Premium

Target Loss Ratio = 1 – Retention %
### Pricing Example: Assumptions

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly claims per member</td>
<td>$150</td>
</tr>
<tr>
<td>Monthly premium per member</td>
<td>$200</td>
</tr>
<tr>
<td>Pricing Trend</td>
<td>10%</td>
</tr>
<tr>
<td>Pricing Retention</td>
<td>20%</td>
</tr>
<tr>
<td>Experience period</td>
<td>Jan to Dec 2011</td>
</tr>
<tr>
<td>Projection period</td>
<td>Jan to Dec 2013</td>
</tr>
</tbody>
</table>

Experience Loss Ratio = $150 / $200 = 75%

Target Loss Ratio = 1 – 20% = 80%
## Pricing Example

<table>
<thead>
<tr>
<th>Pricing Component</th>
<th>Value</th>
<th>Formulas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly claims</td>
<td>$150</td>
<td>(1 + 10%)^2</td>
</tr>
<tr>
<td>x Trend for 2 years</td>
<td>1.21</td>
<td>1 - pricing retention</td>
</tr>
<tr>
<td>= Trended claims</td>
<td>$182</td>
<td>Trended claims / Target loss ratio</td>
</tr>
<tr>
<td>÷ Target loss ratio</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>= Required monthly premium</td>
<td>$227</td>
<td></td>
</tr>
<tr>
<td>÷ Current monthly premium</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>= Rate increase</td>
<td>13%</td>
<td></td>
</tr>
</tbody>
</table>
Rate Filings

- All small group and individual rates must be filed and approved by Tennessee Department of Commerce and Insurance.

- Minimum loss ratio requirements in Tennessee prior to health care reform:
  - None for group
  - 55% for most Individual Under 65 products
  - 65% for Individual Medicare Supplement
HEALTH CARE REFORM
OVERVIEW
Affordable Care Act Quiz

1. When was the Affordable Care Act (ACA) passed and signed into law?

2. How many pages are in the Affordable Care Act?

3. When are most major provisions in the ACA effective?

4. The Supreme Court is holding hearings on the constitutionality of 2 ACA provisions this week. Can you name one of the 2 provisions?
Major Provisions

- **ACA accomplishments**
  - Improve access to health insurance
  - Introduce market reforms

- **Access initiatives**
  - Individual mandate
  - Medicaid expansion up to 138% Federal Poverty Level
  - Federal subsidies to assist with premiums and costs
  - Elimination of risk selection and pre-existing conditions
Major Provisions

- **Market reforms**
  - Minimum medical loss ratio requirements
  - Rate review process for “unreasonable” rates
  - Risk mitigation programs for insurers – 3 R’s – risk adjustment, reinsurance, and risk corridors

- **Funding**
  - Medicare Advantage payment reductions
  - Fraud, waste, and abuse provisions
  - Cadillac plan tax
  - Tanning bed tax
  - Penalties within the law
  - Insurance provider tax
Insurance Market Reforms Effective 9/23/2010

- Elimination of lifetime benefit limits
- Restrictions on allowable annual benefit limits
- Coverage of dependents up to age 26
- Benefits for preventive services with no cost sharing
- Pre-existing condition exclusions prohibited for children
- Rescissions prohibited – except fraud/intentional misrepresentation
- Internal and external appeals processes for enrollees
- Coverage of emergency services at in-network cost sharing
Key Insurance Market Reforms Effective 1/1/2014

- Guaranteed issue of all group and individual plans
- Elimination of pre-existing condition exclusions for adults
- Elimination of all annual limits on coverage
- Waiting periods for group plans limited to 90 days
- Minimum benefit standards for individual and group

Allowable rating factors:
- Age (limited to 3 to 1 ratio for adults)
- Tobacco (limited to 1.5 to 1 ratio)
- Area
- Family composition
Health Insurance Exchange

- ACA directs states to establish individual and small business exchanges to be operational 1/1/2014
  - HHS will establish national “fallback” exchange

- Provide one-stop insurance shopping for individuals and small businesses

- All plans sold on the exchange must cover essential benefits and meet minimum federal benefit standards
  - Four levels: bronze, silver, gold, and platinum
  - Catastrophic plans available to individuals under age 30

- Subsidies available if individual purchases inside Exchange
Essential health benefits include the following:

- Ambulatory patient services
- Maternity and newborn care
- Mental and behavioral health
- Rehabilitative services
- Preventive and wellness
- Emergency services
- Hospitalization
- Prescription drugs
- Laboratory services
- Pediatric services
Cost Share Requirements

- Health Plan Cost Share Requirements

<table>
<thead>
<tr>
<th>Metallic Level</th>
<th>Required Actuarial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze Plan</td>
<td>60%</td>
</tr>
<tr>
<td>Silver Plan</td>
<td>70%</td>
</tr>
<tr>
<td>Gold Plan</td>
<td>80%</td>
</tr>
<tr>
<td>Platinum Plan</td>
<td>90%</td>
</tr>
</tbody>
</table>

- Under ACA, issuer must offer one Silver and one Gold plan in the Exchange
Penalty is greater of two calculations

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount per Person Per Year*</th>
<th>Percentage Modified Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$95</td>
<td>1%</td>
</tr>
<tr>
<td>2015</td>
<td>$325</td>
<td>2%</td>
</tr>
<tr>
<td>2016</td>
<td>$695</td>
<td>2.5%</td>
</tr>
<tr>
<td>2017</td>
<td>Indexed</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

* Dependents are ½ the per person amount
Medical Loss Ratio (MLR) Requirements

- Minimum MLR requirements effective beginning calendar year 2011
- Applies to individual and group business
- First rebate payment due by August 2012 for calendar year 2011 results
Definition of MLR under Reform =

\[ \text{Claims + Quality Improvement Expenses} \]

\[ \text{Premium – Federal and State Taxes} \]
<table>
<thead>
<tr>
<th>Category</th>
<th>Minimum MLR Requirement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>80%</td>
<td>Excludes short term</td>
</tr>
<tr>
<td>Small Group</td>
<td>80%</td>
<td>Based on average number of employees – defined up to 100 in TN</td>
</tr>
<tr>
<td>Large Group</td>
<td>85%</td>
<td>Includes Federal Employees Program</td>
</tr>
</tbody>
</table>
Quality Improvement Expenses

Five major categories of activities considered quality improvement expenses:

- Improve health outcomes
- Prevent hospital readmissions
- Improve patient safety and reduce medical errors
- Promote wellness and health
- Health information technology expenses related to quality improvement
Quality Quiz

Which of the following expenses meet the MLR quality definition?

1. Electronic medical records
2. Wellness/lifestyle coaching programs
3. Provider networks
4. Marketing expenses
5. Chronic disease management
What Does 80% Minimum MLR Really Mean?

Sample Assumptions for Individual

- Quality expenses = 1.0% premium
- State premium tax = 1.75% premium in TN
- FIT = 1.0% premium (assumes 35% tax rate and 3% margin)

Reform MLR = \[ \text{Claims + 1.0\% Premium} \Rightarrow \min 80\% \text{ Premium} - 2.75\% \text{ Premium} \]

This equates to 76.8% minimum “unadjusted” MLR
Rate Review Overview

- **Sets a threshold** where rates will be subject to review for unreasonableness

- For rate increases filed **on or after September 1, 2011, threshold is 10%**

- Measured based on rates in current rate filing and all prior increases in preceding 12 month period

- For rate increases filed in calendar year 2012 and thereafter, HHS may set State specific thresholds
Rate Review Applicability

- Generally applies to individual and small group insurance

- Small group definition generally based on State’s rate filing laws
  - Defined as 3 to 25 employees in TN
Rate Review Authority

- State performs review if it has an effective rate review program in place

  *TN has an effective rate review program for both individual and small group*

- Otherwise, HHS performs review and will determine rate increase to be unreasonable if it is:
  - Excessive,
  - Unjustified, *or*
  - Unfairly discriminatory
Is the Rate Review Program Effective?

Requirements for an effective rate review program:

1. Sufficient data and documentation from insurers
2. Effective and timely review of data and documentation
3. Review includes examination of:
   i. Reasonableness of assumptions and validity of data
   ii. Data related to past projections and actual experience
Is the Rate Review Program Effective?

Requirements (continued):

4. Examination includes analysis of the impact of:
   
   i. Medical trend, utilization, and cost sharing changes by major service category
   
   ii. Benefit changes
   
   iii. Changes in enrollee risk profile
   
   iv. Over/underestimate of medical trend for prior year periods
   
   v. Changes in reserve needs
Is the Rate Review Program Effective?

Requirements (continued):

4. Examination includes analysis of the impact of:
   vi. Changes in costs related to quality improvement programs
   vii. Changes in taxes and fees
   viii. Medical loss ratio
   ix. Capital and surplus

5. State statute or regulation sets forth standard used to determine whether or not rate increase is reasonable
Preliminary Justification

- Required for rate increases at or above threshold

- Submit to HHS and State if rates must be filed with State prior to implementation

- Includes following:
  - Rate increase summary
  - Written description justifying rate increase
  - Rate filing documentation if HHS conducting review
Determination of Unreasonable Rate Increases

- If State conducts review, HHS adopts State’s determination
  - HHS posts final determination by State or HHS on its website within 5 days
- If rate increase unreasonable, final determination and brief explanation provided to issuer
# Illustrative Reform Impact Scenarios

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single Male Age 25</strong></td>
<td><strong>Family with 2 children</strong></td>
<td><strong>Couple Age 63</strong></td>
</tr>
<tr>
<td><strong>Age 25 Low Risk</strong></td>
<td><strong>Average Risk</strong></td>
<td><strong>High Risk</strong></td>
</tr>
<tr>
<td>Current Monthly Premium</td>
<td>Premium</td>
<td>% Change</td>
</tr>
<tr>
<td>$160</td>
<td>$894</td>
<td>$1,302</td>
</tr>
<tr>
<td>Impact of guaranteed issue and no effective individual mandate</td>
<td>$56</td>
<td>35.0%</td>
</tr>
<tr>
<td>3:1 age band limit; eliminating gender rating</td>
<td>$37</td>
<td>23.3%</td>
</tr>
<tr>
<td>Eliminating health status discount</td>
<td>$13</td>
<td>8.2%</td>
</tr>
<tr>
<td>Requiring higher benefit level *</td>
<td>$5</td>
<td>3.2%</td>
</tr>
<tr>
<td>Reinsurance tax</td>
<td>-$8</td>
<td>-5.0%</td>
</tr>
<tr>
<td>Health insurer and other taxes</td>
<td>$3</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Post-Reform Monthly Premium</strong></td>
<td>** Premium</td>
<td>% Change</td>
</tr>
<tr>
<td>$267</td>
<td>66.9%</td>
<td>$1,236</td>
</tr>
</tbody>
</table>

* Not adjusted for essential benefits other than maternity.
Questions?