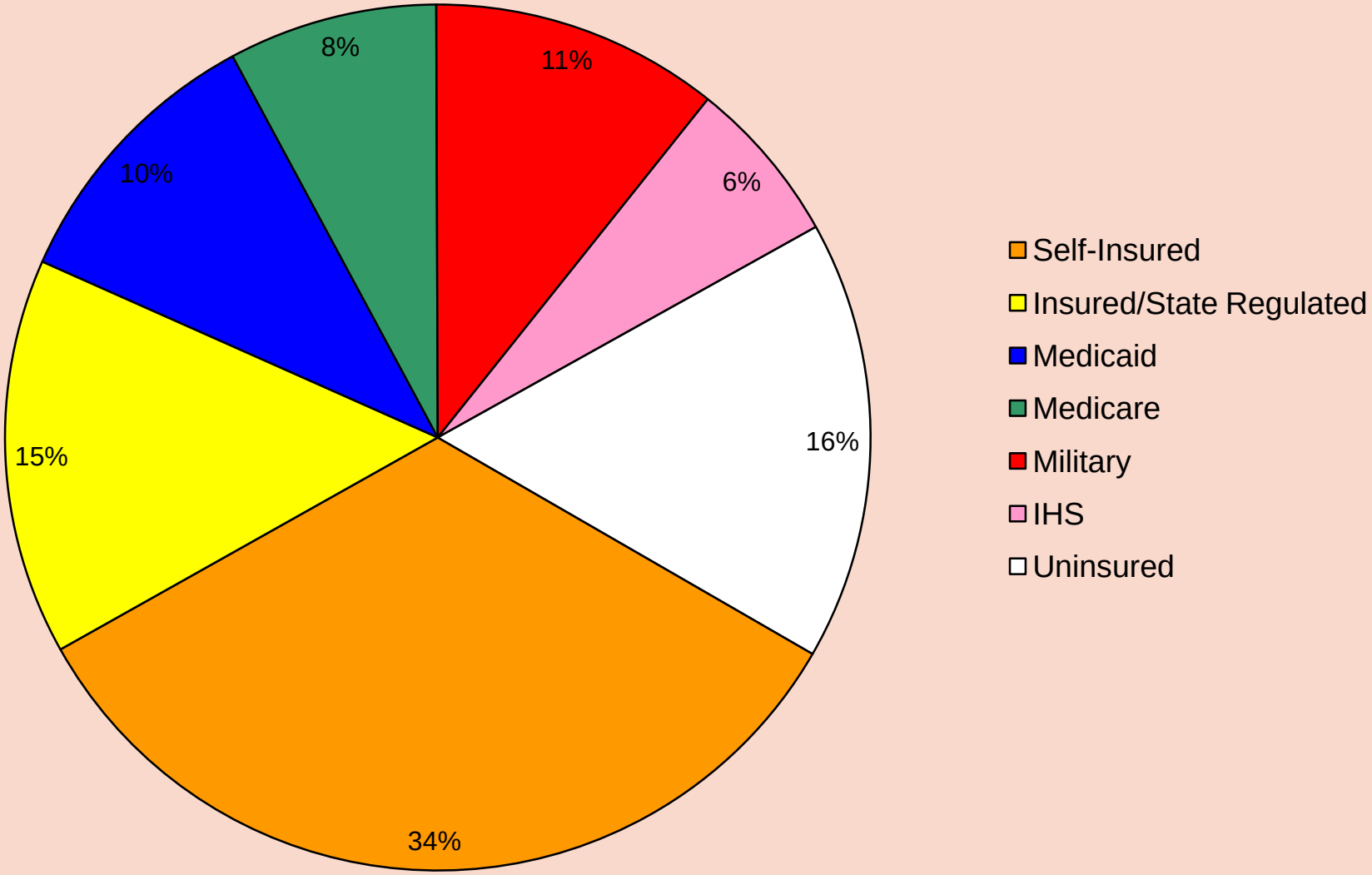
Health Care Insurance Rate Review in Alaska 2012

State Of Alaska

Division of Insurance

Health Coverage of Alaska Population



Discussion outline

- PPACA Impact on health rate review
- Alaska's health rate regulations
- Alaska's Comprehensive Health market share summary
- Alaska's pending health rate filings
- Critical drivers of health rate increases
- Risk adjustment, Risk corridors, Reinsurance

PPACA Impact on health rate review

- In order for a state to make the determination under PPACA that a rate is reasonable or not, the state must have an effective rate review program
- If a rate increase is deemed unreasonable, HHS must post information for consumers regarding the rate increase on its website.
- Effective rate review program requires that a state:
  - Receive sufficient data and documentation to examine reasonableness of rate increases
  - Consider changes in medical cost trend, utilization, cost-sharing of major service categories, benefits, enrollee risk profile, previous estimation of trend, and medical loss ratio
  - Determine reasonableness under standard set by the State
  - Post a link to the HHS website which shows preliminary rate justifications
  - Establish a mechanism for receiving public comment
  - Report results of rate reviews to HHS

PPACA Impact (continued)

- HHS determined that Alaska had an effective rate review program as of 1/1/2012 when Alaska's rate filing requirements went into effect
- Under PPACA if an insurer's Medical Loss Ratio (80% for Small Group / Individual and 85% for Large Group) is not met in a particular year, then the insurer must pay a rebate. The Medical Loss Ratio is defined as

$$\frac{\text{Incurred Claims} + \text{Contract Reserves} + \text{Quality Improvement}}{\text{Earned Premium} - \text{Taxes} - \text{Fees (Licensing and regulatory)}}$$

- If an insurer's rate increase is greater than or equal to the10% threshold for rate increase set by HHS then the insurer must submit justification to HHS, which is posted on www.healthcare.gov
  - The threshold will become state-specific in future

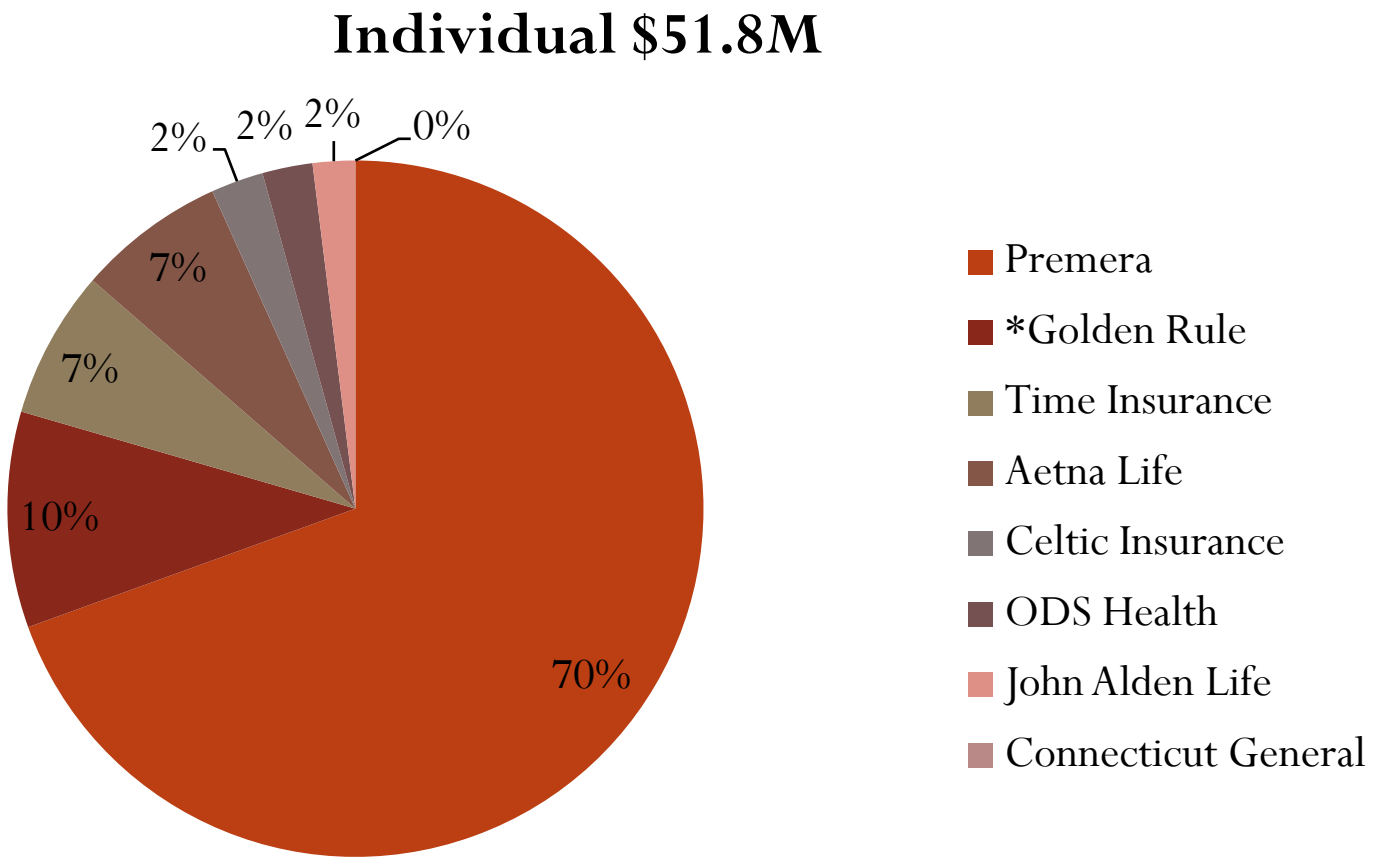
Alaska's health rate regulation

- Beginning on 1/1/2012 all insurers writing health care insurance in Alaska must file rates with the division as specified in law (AS 21.51.405 and AS 21.54.015) and the implementing regulation (3 AAC 31.235)
- General standard of review is that rates may not be excessive, inadequate or unfairly discriminatory
- Rate changes must be filed at least 45 days before but not more than 6 months before the proposed effective date of the rates
- Rates for fully experience rated large group are not required to be filed
- Requires signed certification by an actuary who is a member of the American Academy of Actuaries and actuarial memorandum demonstrating rates are not excessive, inadequate, or unfairly discriminatory
- Requires description of the rating formula and corresponding assumptions

Alaska's health rate regulation (Cont)

- Methodology and actuarial justification for rating assumptions
- Cost and utilization trend analysis by major service category
- Pricing or target loss ratio, enrollee risk profile, estimation of medical trend, projected rebates to policyholders
- Rate revisions and implementation dates from previous 4 years
- For most recent 48 months
  - Earned premiums
  - Incurred and Paid claims
  - Number of covered individuals and member-months

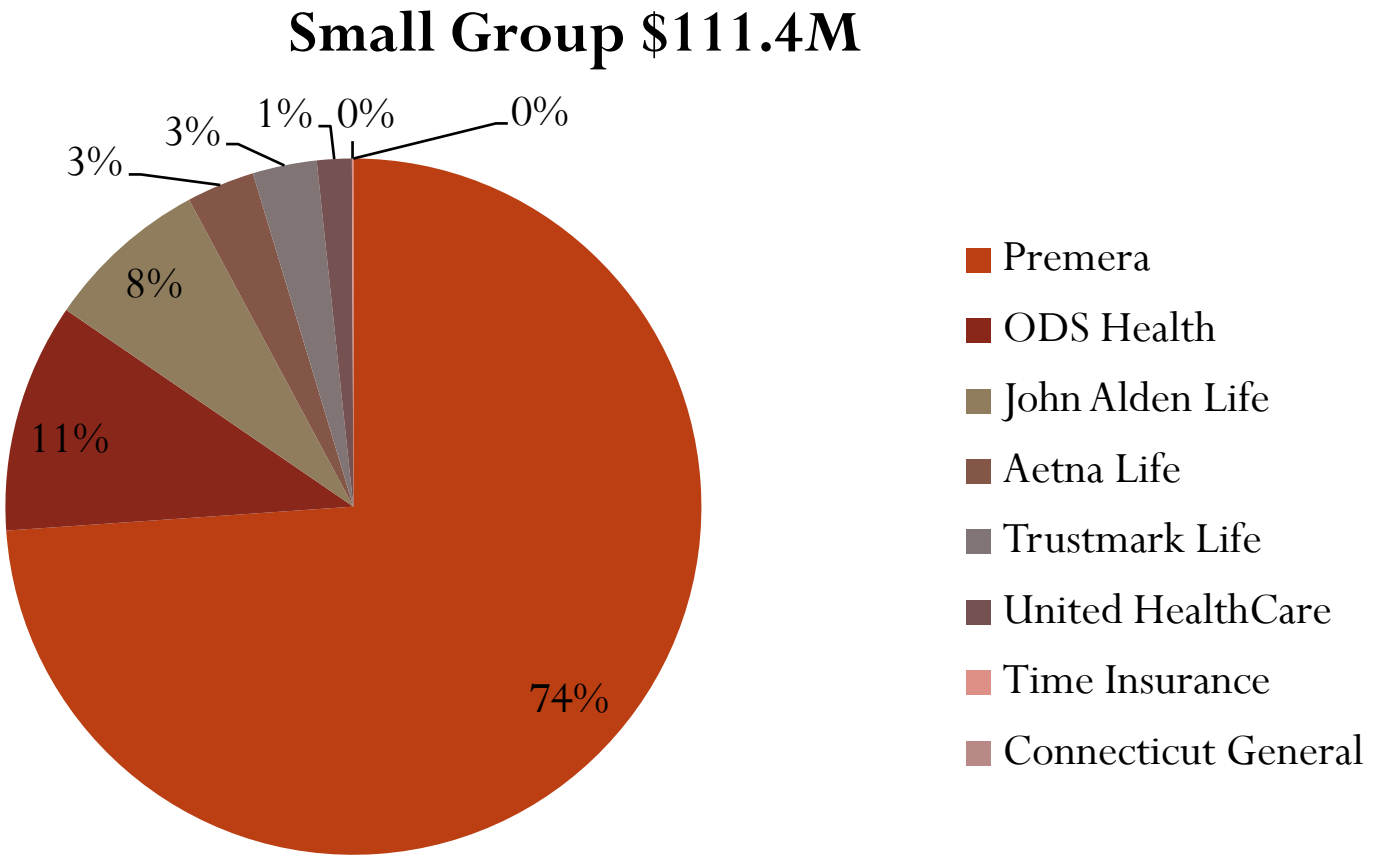
Alaska Health Market Share Summary



2011 Alaska Health Survey

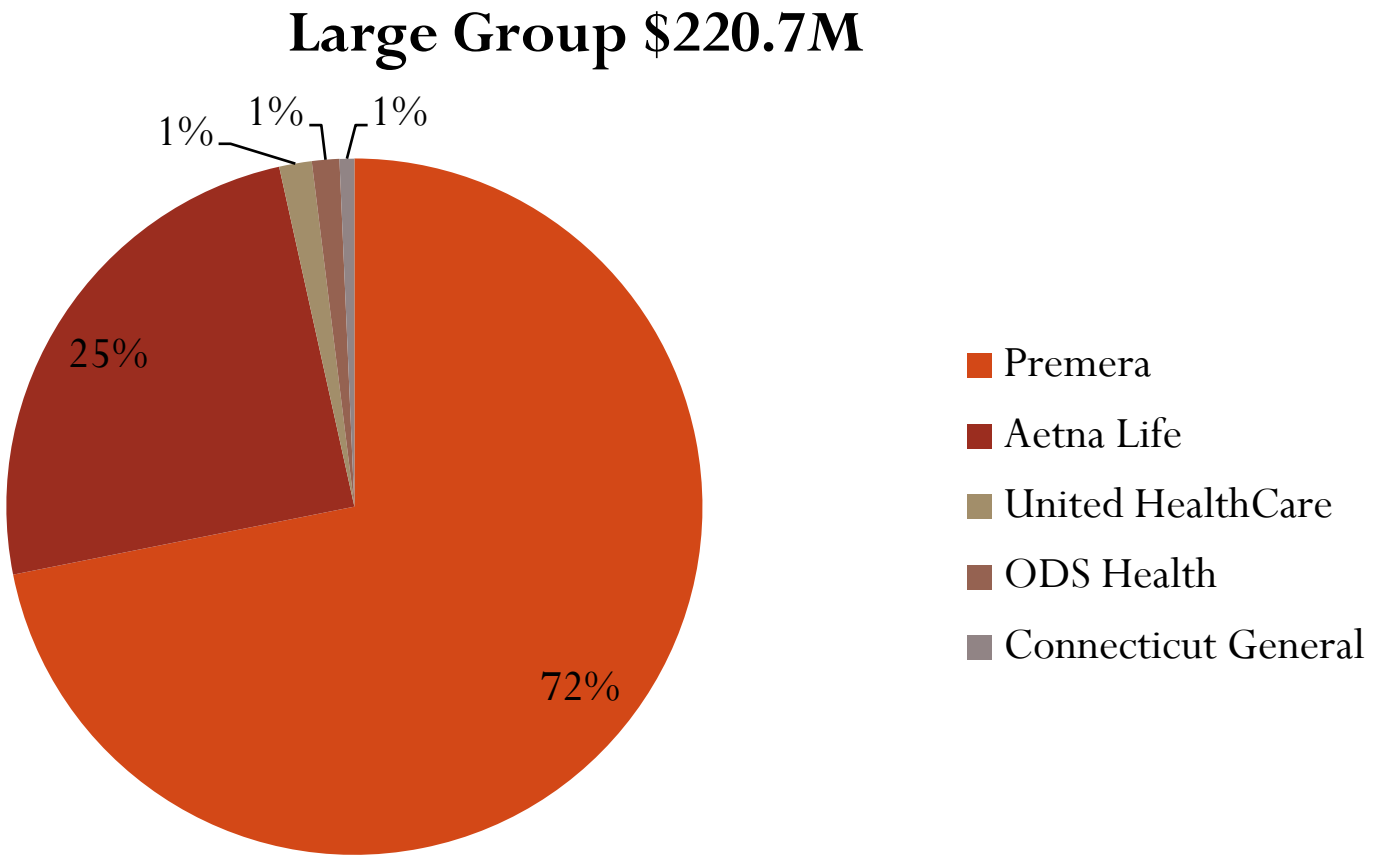
*Golden Rule will no longer offer coverage in Alaska

Alaska Health Market Share Summary



2011 Alaska Health Survey

Alaska Health Market Share Summary



2011 Alaska Health Survey

Pending Filings
ODS Health (Small Group)

- Filed with HHS on 9/30/2011 – Alaska did not have rate review authority at that time and so HHS will be making a determination of reasonableness
- Rates became effective on 10/1/2011
- Requested a 25.98% rate increase – HHS has not made a determination as of 2/16/2012
- "The primary driver of this premium increase is the high level of medical services that our Alaskan members are consuming. For example, during the base time period, roughly $10.37 million dollars in health care was consumed by 3,100 members. Just 29 members account for $4.7 million of that $10.37 million, or approximately half of total claims costs."

www.healthcare.gov

Pending Filings
Premera (Individual)

- Filed with the Division on 1/17/2012, rates effective 6/1/2012
- Requested a 12.5% rate increase – Division of Insurance still reviewing the filing
- "Here are some of the most significant increases Premera has seen the past year in the cost of medical care, specifically for serving members covered by this rate filing:
  - Costs associated with medical & professional services for inpatient hospital stays rose 11.4%.
  - Costs associated with outpatient advanced imaging (such as MRIs & CAT scans) rose 49.1%.
  - Costs associated with physician services for emergency room visits rose 28.9%."

www.healthcare.gov

Drivers of Health Insurance Rate Increases

- Provider payment levels
- Increasing cost and utilization of health care services including expensive new technologies and drugs
- Benefit levels
- Enrollee risk profile (ex: overall health, age, gender)

PPACA Risk Adjustment- 2014+

- Determination of payments to health insurers based on relative health of at-risk populations
- Because the only factors to be included will be age (Ratio limit of 3:1), tobacco status (Ratio limit of 1.5:1), location, and family size, insurers will be limited in varying premium to appropriately reflect risk
- Risk adjustment ensures that health insurers are fairly compensated for the risks they enroll

Risk Assessment

- Determine if the individual or small group represents the average risk and what the deviation is from the average risk
  - Scored using algorithm based on age, illnesses and other factors
  - Risk Score Development uses additive approach with risk markers and weights

Example

	Risk Weight
Age: 32	0.22
Diabetes	1.32
Asthma/COPD	0.96
Low cost dermatology	0.30
Total	**2.80**

Risk Adjustment Goals

- Compensate insurers appropriately
- Encourages insurers to compete on efficiency and quality, NOT the ability to select risk
- Protect financial soundness via risk based capital requirements

Outcome

- States will assess charges to plans with lower risk and provide payments to plans with higher risk

Risk Corridors

- 2014-2016 (first 3 years of Exchange operation)
- Insurer pays HHS if claims are less than 97% of target loss ratio
- HHS pays insurer if claims are greater than 103% of target ratio

- **Issues**
  - If more plans lose money than make a profit, HHS has to make up the difference
  - Companies may intentionally set rates low in order to gain market share

Reinsurance

- Only for 2014-2016 (first 3 years of Exchange operation)
- A state non-profit entity will administer a reinsurance program to compensate insurers when individual losses exceed certain threshold or aggregate losses exceed a certain level
- Insurers make annual payments to the non-profit entity to fund the program
- Pool of $20B to be paid out during 2014-2016

References

- American Academy of Actuaries Issue Briefs
  - http://actuary.org/pdf/health/premiums_mar10.pdf
  - http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf
- Alaska Health Care Commission Annual Report
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