Affordable Care Act in 2015 - House Labor and Commerce

PREPARED BY THE DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT, DIVISION OF INSURANCE

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Frequently Used Acronyms and Terms

- ACA - Affordable Care Act
- APTC - Advance Premium Tax Credit (subsidy for qualifying individuals)
- CCIIO - Center for Consumer Information and Insurance Oversight
- CMS - Centers for Medicare and Medicaid Services
- Essential Health Benefits - Ten (10) mandatory benefits that each Qualified Health Plan under the ACA must contain (exceptions for grandfathered plans)
- FFM - Federally Facilitated Marketplace
- Grandfathered Plans - Health plans enforce prior to March 23, 2010
- HHS - United States Department of Health and Human Services
- Medical Loss Ratio - Proportion of premium revenues spent on clinical services and quality improvement
- Non-Grandfathered Plans - Health Plans placed after March 23, 2010
- PPACA - Patient Protection and Affordable Care Act (full name of legislation)
- QHP - Qualified Health Plan (compliant)
- Three Rs - Risk Assessment, Risk Corridor and Reinsurance

State of Alaska – Division of Insurance

Mission:

The mission of the Division of Insurance is to regulate the insurance industry to protect Alaskan consumers.

Affordable Care Act (ACA)

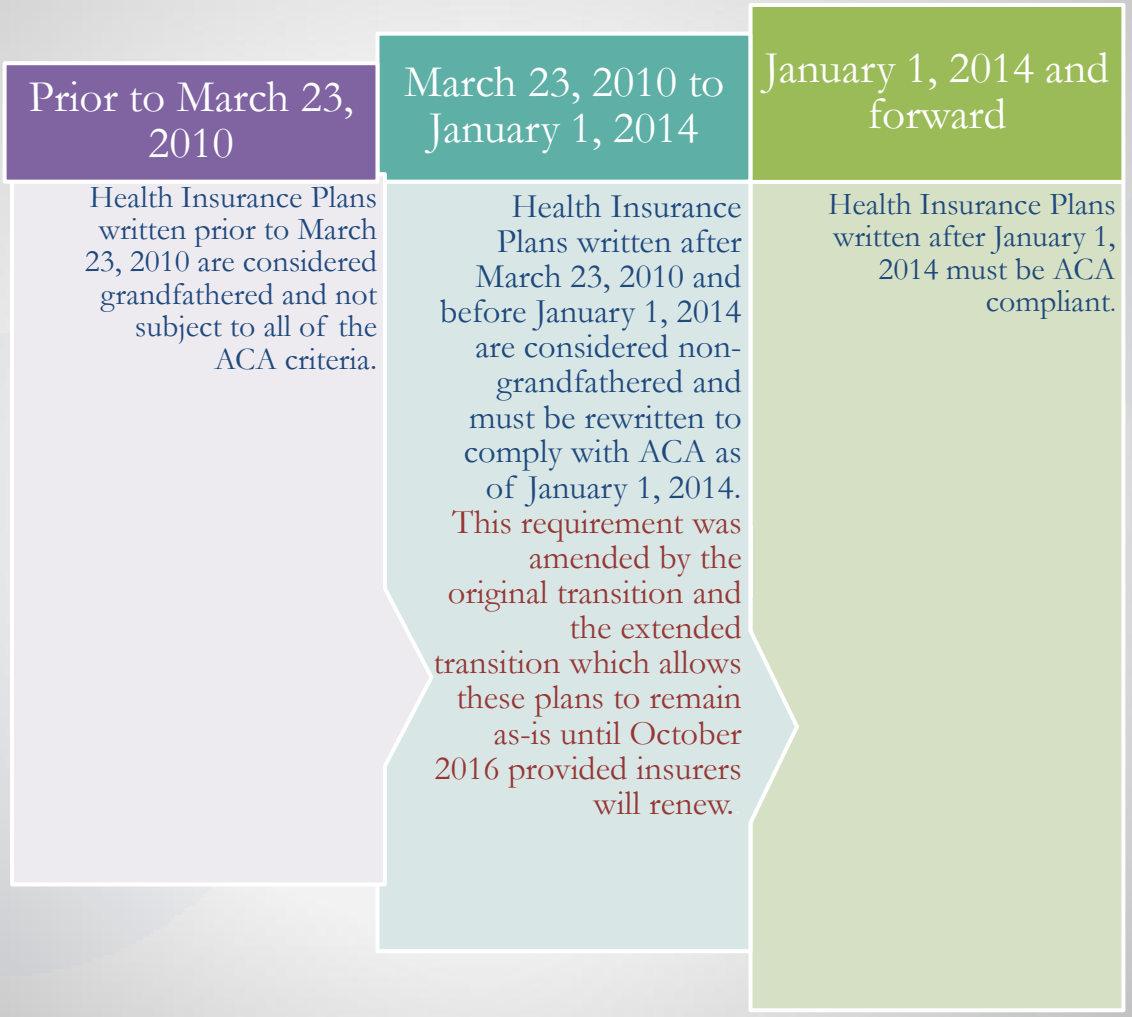
A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the Obama administration.

Signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.

Timeline

- March 23, 2010 – Patient Protection and Affordable Care Act signed by President Obama
- Fall of 2013 – Many Americans receive cancellation notices on non-grandfathered plans effective January 1st, 2014. These plans are to be rewritten as QHPs
- October 1, 2013 – Open enrollment into the ACA begins for millions of Americans
- November 2013– President Obama acknowledges substantial issues with the FFM and provides states the option to allow insurers to renew or rewrite the non-grandfathered plans
- November 2013 – President Obama announces the online small business insurance marketplace would be delayed one-year until November 2014
- December 2013 – State of Alaska issues Bulletin 13-09 allowing insurers to cancel and rewrite non-grandfathered plans effective Dec 31st, 2013 for a period of one year. Moda and Premera accepted and allowed for early renewals (others, including Aetna, Time and Celtic did not)
- March 5, 2014 – Due to high costs of QHPs and continued substantial issues with the FFM, President Obama provides states the option to allow insurers to renew non-grandfathered plans until October 2016
- March 28, 2014 – State of Alaska issues Bulletin 14-03 allowing insurers (Moda and Premera) to continue renewing the non-grandfathered plans until October 2016
- June 2, 2014 – Due to expected cost and administrative burden to small employers, State of Alaska petitions HHS to opt out of employee choice for the FFM SHOP for 2015
- June 27, 2014 – Insurers file their 2015 FFM rates for individual and small employers
- September 4, 2014 – Rate filings for Premera and Moda are approved

Timeline - continued



Looking back at 2012 and 2013
All Insurers

2012

Individual	Small Group	Large Group
13,561	18,616	34,484

2013

Individual	Small Group	Large Group
13,561	18,616	34,484

Looking back at 2012 and 2013 Premera and Moda

2012

	Individual	Small Group	Large Group
Premera	9,284	9,533	23,923
Moda	967	1,281	470
Total	10,251	10,814	24,393

2013

	Individual	Small Group	Large Group
Premera	8,764	15,393	16,949
Moda	1,237	1,123	565
Total	10,001	16,516	17,514

2014 – All Insurers in Individual and Small Group

	Individual	Small Group
Premera	13,327	13,541
Moda	8,396	746
Time	1,002	1,846
All Other	103	2,523
Total	22,828	18,656

Includes Grandfathered, Non-Grandfathered and ACA compliant plans.

Premera and Moda - 2014

Individual Market

	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	2,837	3,410	7,080
Moda	0	800	7,596
Total	2,837	4,210	14,676

Small Group Market

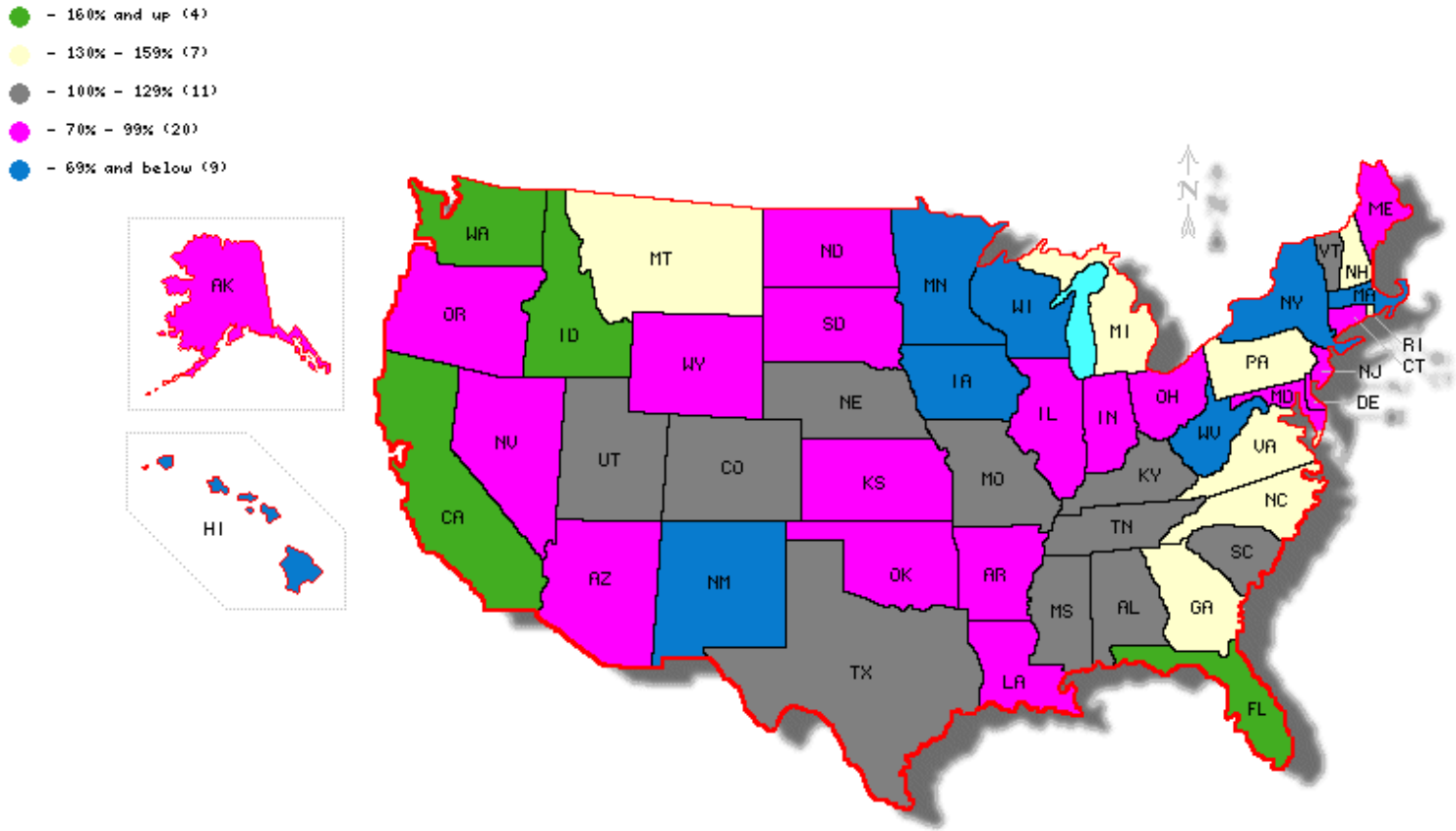
	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	4,594	7,280	1,667
Moda	0	542	204
Total	4,594	7,822	1,871

Premera and Moda - ACA QHPs in 2014

	Individual	Small Group
Premera	7,080	1,667
Moda	7,596	204
All Others	1,029	4,373
Total	15,705	6,244

- Expectations were that up to 22,000 people would enroll in the individual market under ACA.
- Currently we have close to 16,000 enrolled but there is an estimated 6,000 qualifying Alaskans that are not represented in this number.
- Even if the goal of 22,000, were accurate and 100% enrollment achieved; we are a small market and the ACA has not changed that.

Exchange Enrollment Expectations



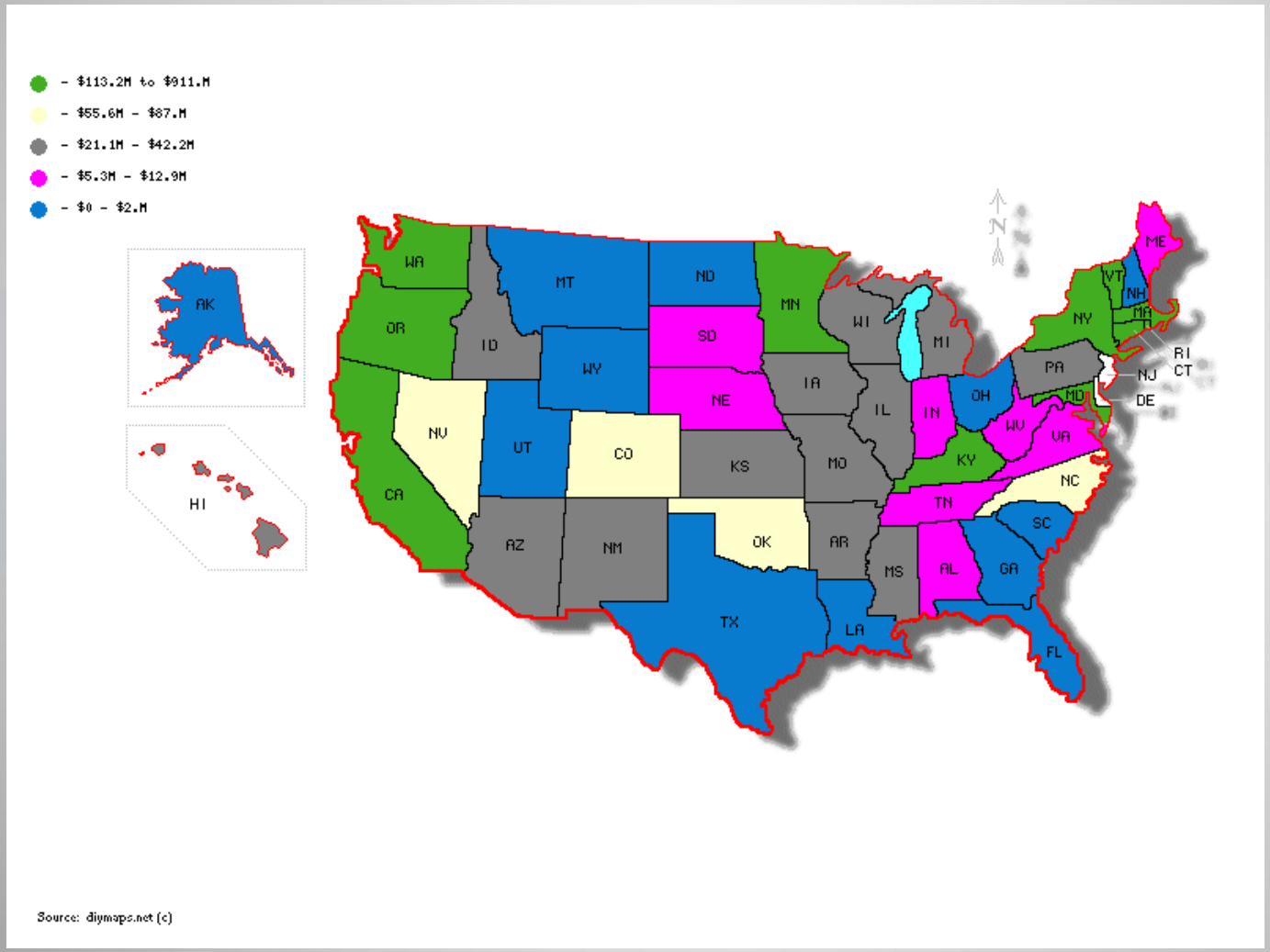
Estimates from several sources indicate that the expected enrollment ranged from 15,700 (Avalere) to 22,000 (Kaiser Family Foundation. CMS showed an expected enrollment of 21,000.

Federal Exchange and Rate Review Grants

- The ACA includes provisions intended to make health insurance more accessible and affordable.
- Included provisions for establishing health insurance exchanges in each state and enhancing processes for annual review of health insurance rates.
- The ACA created new responsibilities for states and the federal government, and provided financial resources to states in the form of federal grant funding.

Federal Exchange Grants

Alaska recognized early that designing and implementing a program to become a state based exchange would not be cost effective. Also, the grants were for a defined period of time and after being spent, the cost would be borne by Alaskans.



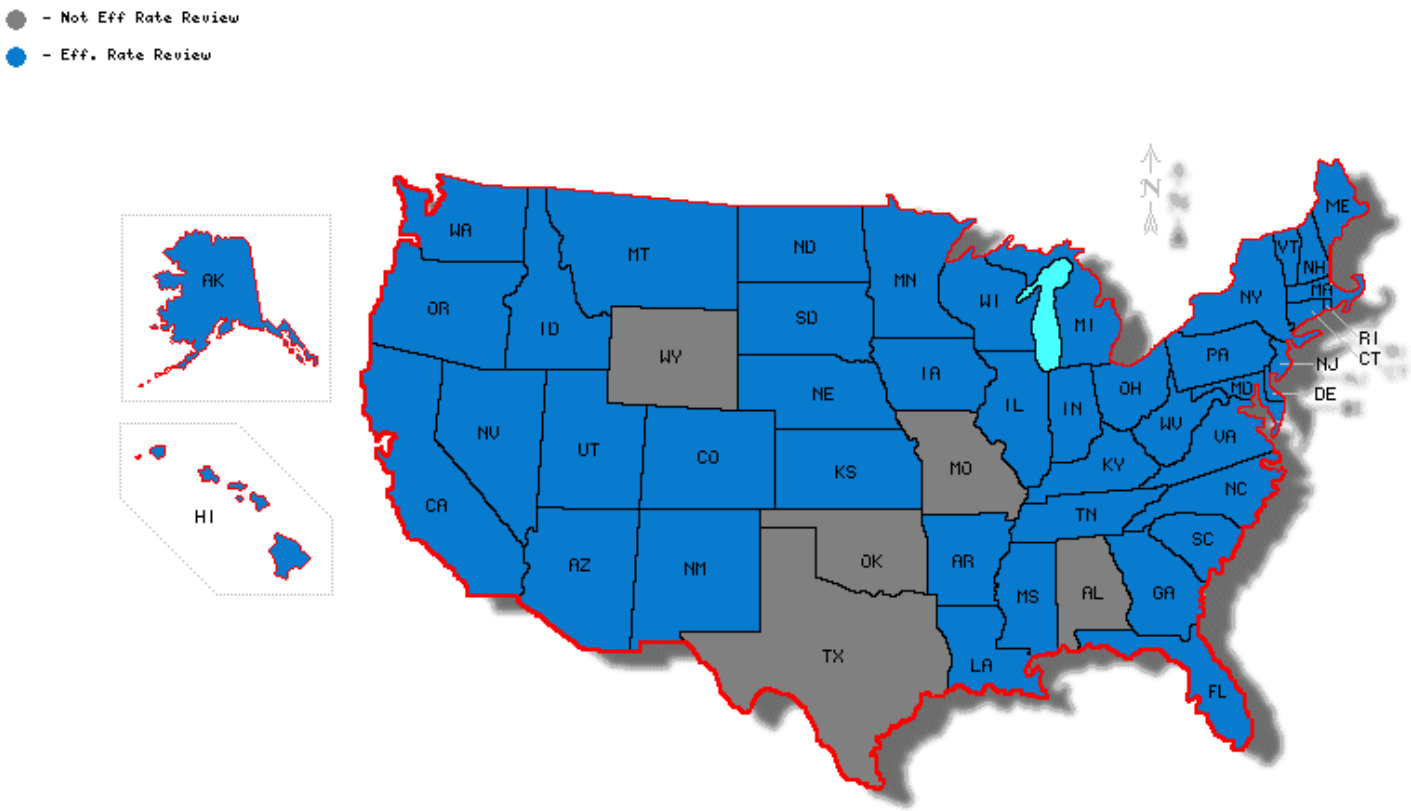
Where did the money go?

- In total, the ACA awarded grants of close to $4B to 49 states to study and, in some cases, design and implement a state based exchange. **Of the 49 states receiving HHS grant funds; 39 states are participating in the FFM in 2015**
- In 2014; **37 states, including Alaska, elected to participate in the FFM** and not implement a state based exchange
- Oregon received grants in excess of $350M to establish a state based exchange and **in 2015 will be joining the FFM**
- Nevada received grants in excess of $75M to establish a state based exchange and **in 2015 will be joining the FFM**
- Several states, including Oklahoma, Kansas, Louisiana, Maine and Wisconsin, **have returned all or a significant portion of their grants**

ACA Effective Rate Review

- **Historically the oversight of insurance rates has been a state responsibility**
- However, **the ACA established a role for HHS** by requiring the Secretary of HHS to establish a process for the annual review of unreasonable rate increases in the individual and small group market
- HHS has issued regulations requiring insurers to report on proposed rate increases (10% or more)
- The regulations also establish criteria and a process for which HHS will determine if a state has an effective rate review process

Effective Rate Review States



Source: diymaps.net (c)

ACA Criteria of Effective Rate Review

- Alaska was approved, along with 45 other states, by HHS as an effective rate review state
- Having an effective rate review system requires states incorporate very specific data into their analysis of the adequacy of the rates
- Must receive sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases

ACA v. Alaska Rate Review

ACA

- Must consider:
  - Medical cost trend changes
  - Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits)
  - Cost-sharing changes
  - Changes in benefits
  - Changes in enrollee risk profile
  - Impact of over- or under-estimate of medical trend in previous years
  - Reserve needs
  - Administrative costs related to programs to improve health care quality
  - Other administrative costs
  - Applicable taxes and licensing or regulatory fees
  - Medical loss ratio
  - Issuer's capital and surplus
- Must determine reasonableness of rate increase under standards set forth in state statute or regulation
- Must post either rate filings under review or preliminary justifications on their websites or post a link to the preliminary justifications that appear on the CMS website
- Must provide a mechanism for receiving public comments on proposed rate increases which is accomplished via the CMS website
- Must report results of rate reviews to Centers for Medicare and Medicaid (CMS) for rate increases subject to review

State of Alaska

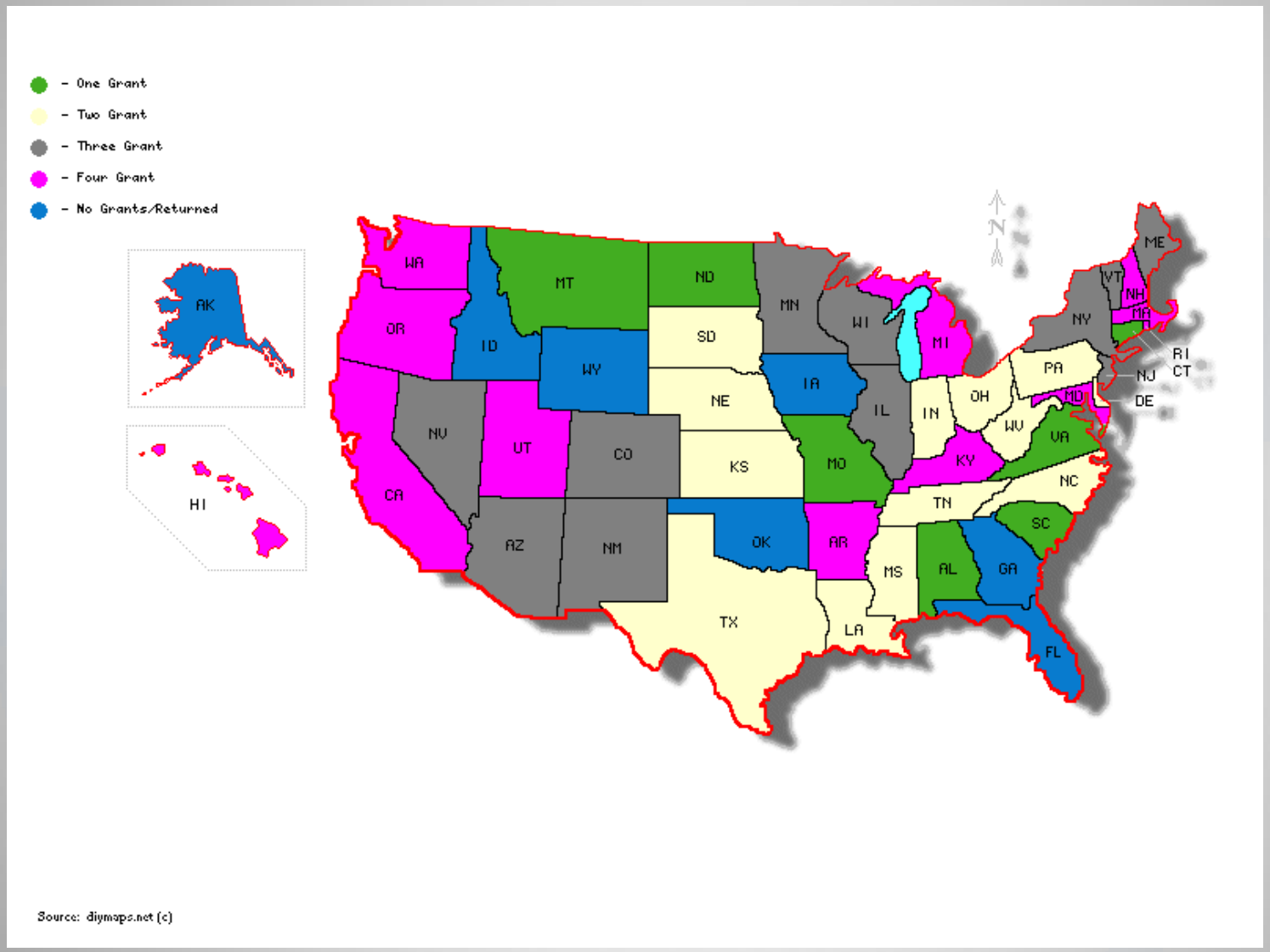
Beginning on 1/1/2012 all insurers must file rates with the division as specified in law:

- 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
- 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
- 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

Effective Rate Review Federal Grants

- Effective Rate Review grants were not meant to subsidize insurance rates or provide any relief to the premium paid by consumers
- The ACA provided $250M over five years to help states transform their review of health insurance premium increases and enhance pricing transparency. Also fund Data Centers to help the public compare prices for procedures in a given region or specific hospital, insurer, or provider
- Cycle I – Provided $1M of funding to states to help develop or enhance their rate review processes as well as processes for reporting rate increases to HHS
- Cycle II – Provided up to three years of funding to further assist states with developing or enhancing rate review and reporting processes, with the specific purpose of helping states meet HHS's criteria for effective rate review programs. To be eligible, states that at the time of the application do not have effective rate review programs in their individual or small group health insurance markets, or both, must commit to using grant funds to develop effective programs within twelve (12) months of receiving the grant

Effective Rate Review Grants-by State



Division of Insurance does not set premium rates

Insurers files their rates and the division approves

- Rates shall not be:
  - **Excessive** meaning that the rates shall not exceed expected claims and expense contribution to surplus or profit;
  - **Inadequate** meaning that the rates shall not be insufficient to cover claims and expenses and needed contribution to surplus or profit; or
  - **Unfairly discriminatory** meaning that the rates shall not be unfairly applied consistently for similar risk (age, plan, tobacco use)

2015 Rates On and Off the FFM

Key-Drivers

- Composition of the risk pool (age, gender, health, etc.) and how it changed from assumptions made by insurers in 2014
- Higher cost individuals were more likely to enroll in first year
- Lower cost individuals more likely to enroll in second and subsequent years or when the penalty for failure to enroll becomes meaningful
- Adverse loss experience - health status of those that did enroll in 2014
- Continued trend of cost of health care increasing

Essential Health Benefits (EHB)

- The ACA made a number of changes to private health insurance plans. One was establishing a minimum threshold that qualified health plans for the non-grandfathered individual and small group markets must include. These EHB's are:

1. Ambulatory patient services, such as doctor visits and outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorders including behavioral treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services including oral and vision care

- **Note that EHB's may be redefined by HSS for 2016**

Medical Loss Ratio (MLR)

- ACA requires issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR).
- Requires rebates to enrollees if percentage does not meet minimum standards.
- MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases.
- If they fail to meet these standards, the insurance companies will be required to provide a rebate to their customers.

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

Three R's

Risk Adjustment, Risk Corridor and Reinsurance

- **Risk Adjustment** transfers money among insurers to adjust for the possibility that some insurers may get more or less than their proportionate share of costly enrollees. Risk Adjustment is only:
  - Applied to the individual and small group market; and
  - Permanent program to help stabilize the costs of the ACA

- **Reinsurance** is one of the taxes associated with the ACA and is applied against health insurance policies and employer group health plans. Proceeds are used to provide the individual market plans with additional subsidies for higher-cost enrollees. The program is to only operate for three years
  - Attachment point in 2014 is $45,000 but will increase to $70,000 in 2015.
  - Coinsurance decreases from 80% in 2014 to 50% in 2015

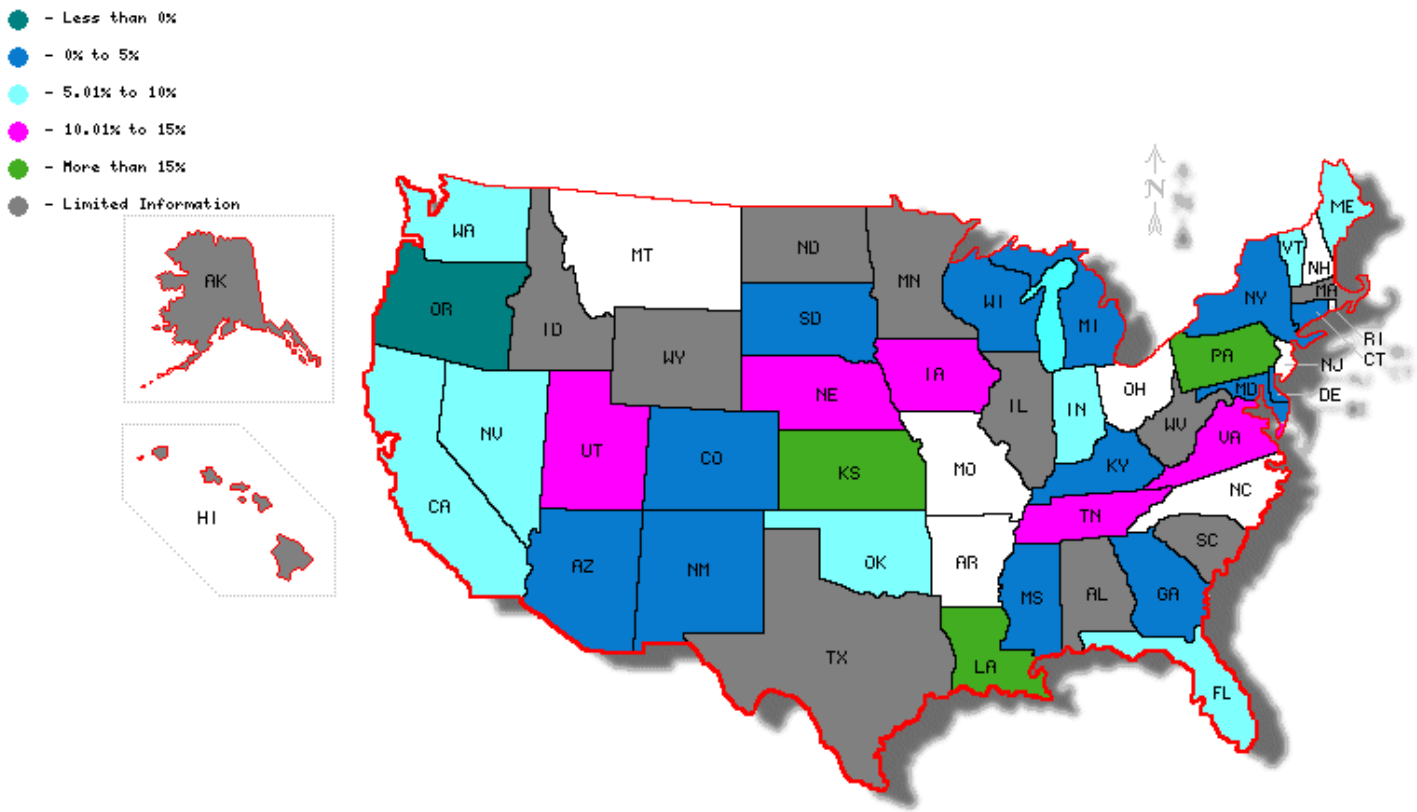
- **Risk Corridor** provides a range for profits or losses for insurance on the FFM. If an insurer has higher than expected profits, the federal government will "claw back" some of the premiums. Conversely, if an insurer has higher than expected losses, the federal government will pay the insurer additional subsidies to offset those losses. This program is to only operate for three years

  - Late last week, the GAO released a legal opinion that the law did not specify that the risk corridor funds could be provided to insurers in 2015 so Congress will have to pass a clarification to the law before funds could become available

Secretary of HHS

- In September of 2014, Secretary Sylvia Burwell wrote that while competition is working in the online marketplace, "it may not work as efficiently in a high cost market with a small population, ***such as Alaska***"

2015 Average Rates as of September 25th



Price Waterhouse Cooper (http://www.pwc.com/us/en/health-industries/health-research-institute/aca-state-exchanges.jhtml) as of September 25, 2014

2015 – Where are we today?

	2015 Rates	Type of Exchange	Medicaid Expansion
AL		FFM	No
AK	+22% to +40%	FFM	No
AZ	-25% to +23.5%	FFM	Yes
AR		P	Yes
CA	-3% to +28%	SBE	Yes
CO	-23% to +35%	SBE	Yes
CT	-21.5% to 25%	SBE	Yes
DE	-2.5% to +5%	P	Yes
DC	-6.1% to +7.6%	SBE	
FL	+11.6% to +23%	FFM	No
GA	-7.1% to +18.3%	FFM	No
HI		SBE	Yes
ID		SBE	No
IL		P	Yes
IN	-3.2% to +24%	FFM	Maybe
IA	+8.7% to +14.3%	P	Yes
KS	+11% to +20%	FFM	No
KY	-4.3% to +15%	SBE	Yes
LA	+9.9% to +19.7%	FFM	No
ME	-1.1% to +2.2%	FFM	No
MD	-14.1% to +16.2%	SBE	Yes
MA		SBE	Yes
MI	-21.6% to +15.4%	P	Yes
MN		SBE	Yes
MS	+1.2% to +7.3%	FFM	No
MO		FFM	Maybe
MT		FFM	No
NE	+9.6% to +10.7%	FFM	No
NV	-3.9% to +36%	FFM	Yes
NH		P	Yes
NJ		FFM	Yes
NM	-3.6% to +8.6%	SBE	Yes
NY	-15.3% to +13%	SBE	Yes
NC		FFM	No
ND		FFM	Yes
OH		FFM	Yes
OK	-9.1% to +27%	FFM	No
OR	-20.6% to +10.6%	FFM	Yes
PA	+13.4% to +19.4%	FFM	Yes
RI	-7.3% to +4.5%	SBE	Yes
SC		FFM	No
SD	+3.1%	FFM	No
TN	+7.5% to +19%	FFM	No
TX		FFM	No
UT	-11.8% to +35%	FFM	Maybe
VT	+7.7% to 10.9%	SBE	Yes
VA	+1.9% to +18.2%	FFM	No
WA	-2.9% to +26%	SBE	Yes
WV		P	Yes
WI	-17% to +13.1%	FFM	No
WY		FFM	No

FFM = Federally Facilitated Marketplace

SBE = State Based Exchange

P = Partnership