02/17/16

PRESENTA-
TIONS:
ALASKA
HEALTHCARE
MARKETPLACE

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ALASKA HEALTHCARE
MARKETPLACE</SUBJECT><COMM>SHSS29</COMM></TARGET>

Senate Health and Social Services Committee | **Alaska's Health Insurance Market**
Sheela Tallman | February 17, 2016

- Thank you, Chair Stedman and members of the Committee, and thank you for the opportunity to provide comments today
- For the record, I'm Sheela Tallman with Premera Blue Cross
- Premera has operated in Alaska since before statehood in 1952 and provides coverage to **over 109,000 Alaska residents.** We offer coverage to individuals/families, small employers, and large employers as well as offering services to larger self-funded employer groups
- I'm going to provide comments regarding:
  - **changes to the market** that are impacting Premera's individual plan premiums,
  - describe our **overall individual pool experience and**
  - **a policy approach to stabilize the individual market**
- With health reform, in 2014, the **major change** to the insurance market was **guaranteed issue** to all individuals without preexisting condition exclusions. This provided access to several thousands of individuals
  - And, Premera priced products estimating the impact of the uninsured purchasing coverage for the first time
  - We experienced a significant influx of new enrollees with very high medical costs **leaving the high risk pool** and the **federal preexisting condition pool** (much more than expected) and Premera lost more than $13 million in the individual market
- For 2015 and 2016, Premera had approximately 37%-39% average rate increases **for the individual metallic** plans, impacting **6,000 enrollees**.
  - For 2015, we are expecting to have the same or more in financial losses even with these premiums
- To say it differently, Premera is taking in on average $713 in premium PMPM and paying claims at $919 PMPM, demonstrating the very high claims costs in the individual pool
- Individual purchasers are also older--- **on average around 40 years old** compared to before 2014 (35 years)
- The changes are having a dramatic impact on the individual market

- Guaranteed access to private healthcare coverage regardless of health status is available

- But, in a very small sized market like Alaska, **there are not enough healthy individual purchasers to offset the costs of enrollees with very high medical needs.** And, we now have an unsustainable market with **two years of almost 40% rate** increases for the two insurers.

- Premium for a 40 year old in Anchorage purchasing Silver or Gold plan is between $860 to almost $1000 per month

- And, while majority are receiving subsidies in the Exchange, Premera has approximately 1,600 individuals purchasing coverage off the Exchange who are not getting subsidies. And, these premiums are significant (85% of Exchange getting subsidy)

- The federal 3Rs programs (federal risk mitigation programs) which were designed to minimize the effects of adverse selection and stabilize premiums in the individual market—are **insufficient at the very high end of the claims costs which is what we are experiencing** and **are not able to help spread the risk in a market that is too small.** And, 2 of the 3 Rs are sunsetting after 2016.

- So, what can be done? The key to addressing this situation is to create a **large enough pool to spread the costs of members with the significant medical needs**

- Premera and Moda are supporting the concept of a **state reinsurance program** to help stabilize the individual market from these significant premium swings. We've also met with legislators to discuss this approach

- The reinsurance concept would **spread the claims** from **highest cost medical conditions** (long term, chronic conditions- heart failure, kidney disease) across the entire insured market using the state's high risk pool- ACHIA to administer the program

  - Claims costs from the individual market would be **spread across a larger base** and paid for using the current ACHIA assessment which is assessed on insured plans. Spreading these costs across a broader base will help lower individual premium increases

- This reinsurance solution was implemented by ACHIA in 2013 to ensure that child-only health policies were available in the individual market. By spreading the costs of very sick patients across a broader pool, insurers were able to continue to offer policies

- Using ACHIA, the reinsurance program for the individual market today could be implemented efficiently given ACHIA's experience and with minimal to no administrative costs, since the infrastructure already exists

- Premera and Moda has submitted data to the **Division of Insurance and ACHIA on a study to evaluate the impact of this proposal on individual premiums as well as the assessment**

- A reinsurance program would not only help address premium increases, but also stabilize the market which can **potentially attract new competitors** into the individual market

  - It also will **provide more financial certainty to consumers about health coverage**

- We are very concerned that these **continued rate increases to cover the rising medical costs** are **driving healthier individuals out of the market-** resulting in an ever shrinking pool to cover these very high costs –and, this is just not sustainable

- Premera is committed to the individual market in Alaska and we look forward working with you to create a sustainable market for Alaska residents

- Thank you

ACA Metallic Plan Comparison By Year

Age	Lowest Cost-Anc						Lowest Cost-Anc						Lowest Cost-Anc					
	2016						2015						2014					
	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold
0-20	288	322	340	402	418	487	197	245	243	295	313	352						
25	455	510	537	636	661	771	311	388	384	466	496	557	243	287	299	340	385	399
35	553	620	654	774	804	938	379	472	467	568	603	678	296	349	364	414	469	486
45	654	733	772	914	950	1108	447	558	552	671	713	801	350	412	430	489	554	574
55	1010	1132	1193	1412	1468	1711	691	861	852	1036	1101	1237	540	637	664	756	856	887
64	1359	1523	1605	1899	1974	2302	930	1159	1146	1394	1481	1664						

Age	Lowest Cost-FBK+						Lowest Cost-FBK+						Lowest Cost-FBK+					
	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold
0-20	288	339	340	423	418	512	197	240	243	289	313	345						
25	455	536	537	668	661	810	311	380	384	457	496	546	243	281	299	334	385	391
35	553	652	654	813	804	986	379	463	467	557	603	664	296	342	364	406	469	476
45	654	770	772	961	950	1165	447	547	552	658	713	785	350	404	430	480	554	563
55	1010	1190	1193	1484	1468	1799	691	844	852	1016	1101	1212	540	624	664	741	856	869
64	1359	1601	1605	1997	1974	2420	930	1136	1146	1366	1481	1631						

Age	Lowest Cost-SE						Lowest Cost-SE						Lowest Cost-SE					
	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold	Moda Bronze	Premera Bronze	Moda Silver	Premera Silver	Moda Gold	Premera Gold
0-20	288	331	340	412	418	500	197	231	243	278	313	331						
25	455	523	537	652	661	790	311	365	384	439	496	524	243	27	299	320	385	376
35	553	636	654	794	804	962	379	444	467	534	603	638	296	328	364	390	469	457
45	654	752	772	938	950	1137	447	525	552	631	713	754	350	388	430	460	554	540
55	1010	1161	1193	1448	1468	1755	691	811	852	975	1101	1164	540	599	664	711	856	835
64	1359	1562	1605	1948	1974	2361	930	1090	1146	1312	1481	1566						

Notes:

Premera will offer 2 Gold, 4 Silver and 3 Bronze on the exchange: premiums in chart are for the lowest cost plan within metal level
Moda will offer 2 Gold, 3 Silver and 4 Bronze on the exchange: premiums in chart are for the lowest cost plan within metal level
Both will offer substantially similar plans off the exchange

Moda will also offer one lower cost "catastrophic" plan for those who qualify. "The catastrophic plan is available to people under age 30, or people over 30 who qualify for a hardship exemption (which means that due to economic hardship, the person would not be required to have health insurance or pay a penalty for failing to do so). Regardless of age or income, catastrophic plans are also available for people whose health insurance policy is being cancelled because it's not ACA compliant. Catastrophic plans are available both in and out of the ACA's health insurance exchanges, but hardship exemptions for those 30 and older must be obtained from the exchange."

Alaska: the cost of health care

Becky Hultberg, President/CEO
Senate Health & Social Services Committee
Feb. 17, 2016

Together
Shaping Our Future

ASHNHA
ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Alaska State Hospital and Nursing Home Association (ASHNHA)

OUR VISION

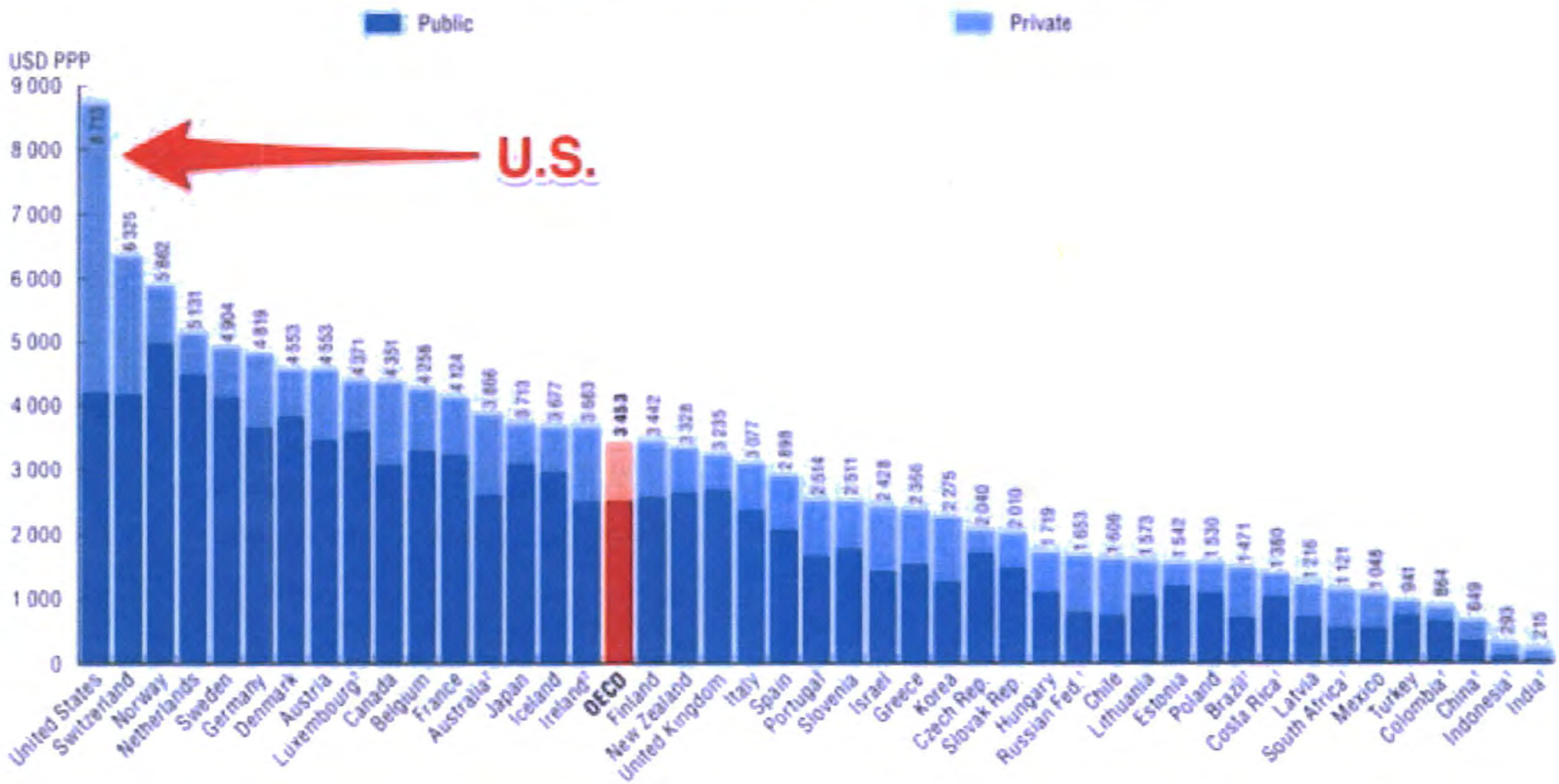
A unified Association providing effective statewide leadership to address health care delivery challenges affecting all Alaskans.

OUR MISSION

To be the premier provider advocate bringing unity to the health care community in addressing health care issues and to support our members' goal to improve Alaskan's health.

Not just an Alaska problem

9.1. Health expenditure per capita, 2013 (or nearest year)



Note: Expenditure excludes investments, unless otherwise stated.

1. Includes investments.
2. Data refers to 2012.

Source: OECD Health Statistics 2015, *http://dx.doi.org/10.1787/health-data-en*; WHO Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888933281252

Why does health care cost more in Alaska?

THE SIMPLE REASONS….

- Workforce costs are higher
  - Recruitment is more difficult
  - Licensing is more difficult
  - Thus, labor pool is smaller and wages are higher
- Geography: the cost of transporting goods, services and people
- Scale: fewer people to spread high fixed costs
- Provider payments are higher
  - Hospitals and primary care are higher than Pacific Northwest
  - Specialist costs are significantly higher than Pacific Northwest
- Regulatory environment

"For every complex problem there is an answer that is concise, clear, simple and wrong."
- H.L. Mencken

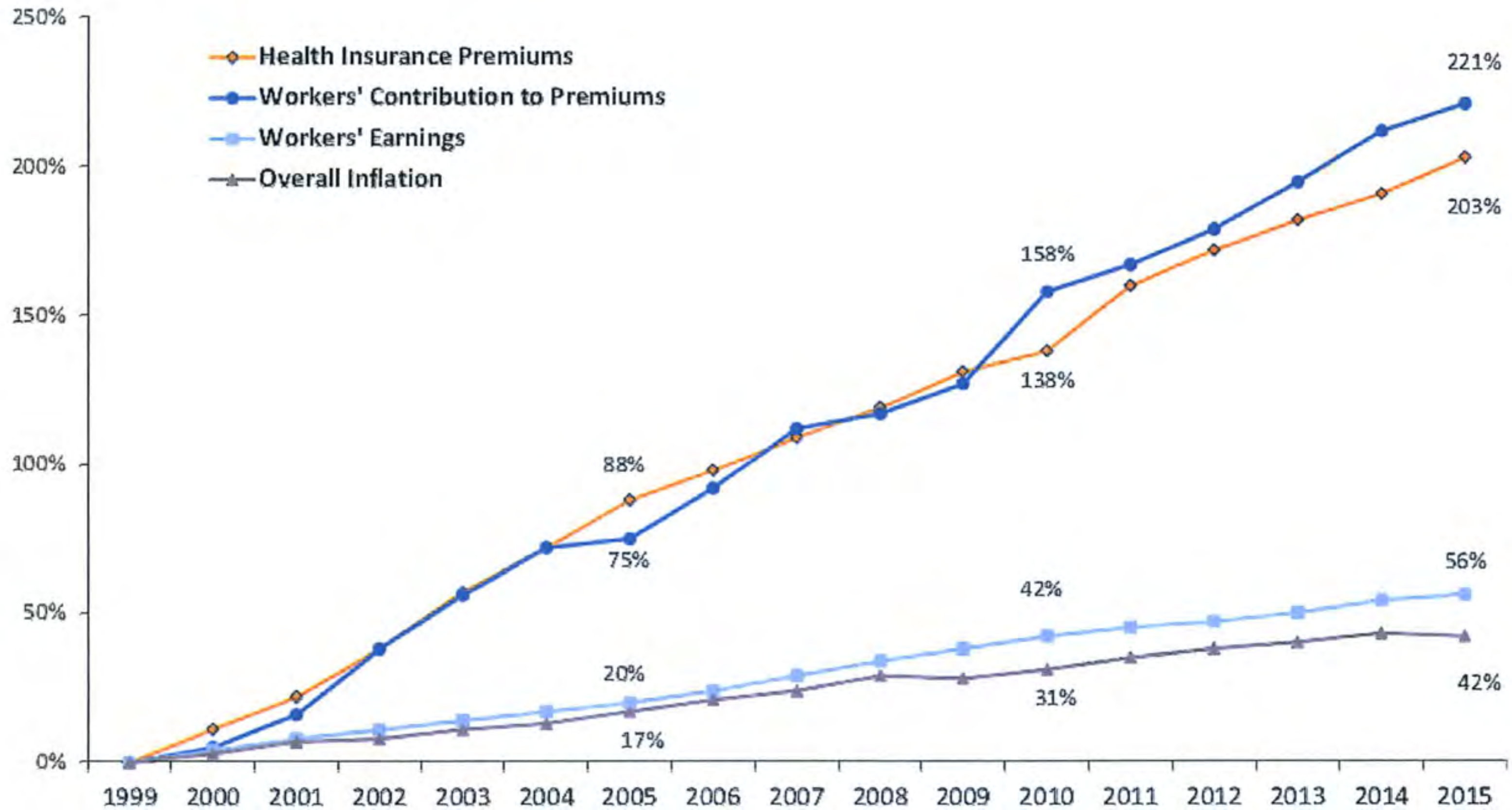
MORE COMPLEX, BUT ACCURATE REASONS…..

The items on the previous slide are symptoms.
We have to stop trying to fix symptoms and start fixing systems:

- Health insurance system: disconnection of patients from the cost of their care
- Payment system: provider incentives
- Social systems: cultural/social expectations about health care
- Regulatory systems: government wants to contain costs and then continues to add administrative burden

We are getting the health care system that we want. If we want something different, it will require hard choices.

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015

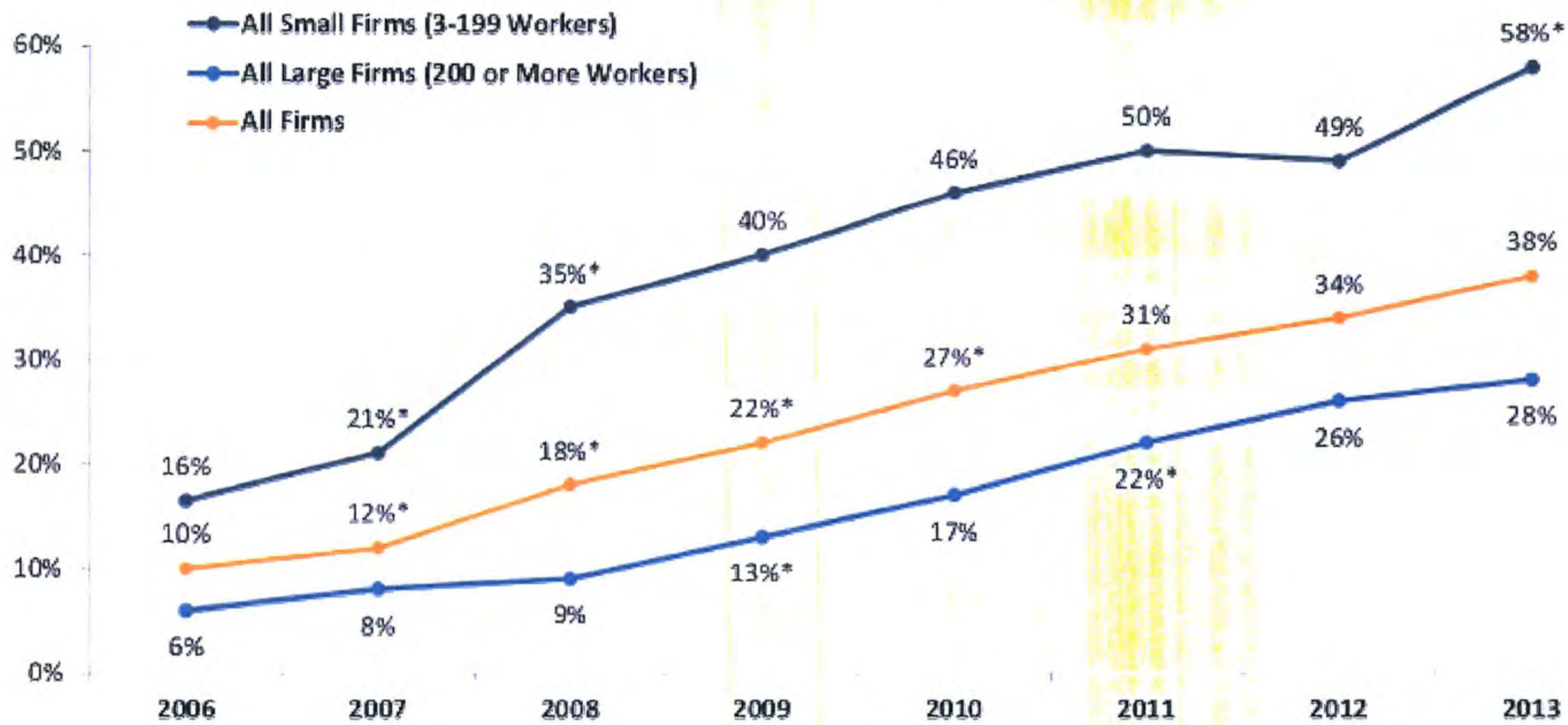


SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).

KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

A S H N H A

NATIONAL TRENDS: GROWTH IN HIGH DEDUCTIBLE PLANS



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2013.

THE HENRY J. KAISER FAMILY FOUNDATION

Medicare delivery system changes

News

9 Hospitals

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, Health and Human Services Secretary Sylvia M. Burwell today announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

9

Medicare payment policies

Enacted Cuts as a Percent of Total FFS Medicare Revenue 15 year summary value	-10.0%

Cuts Enacted (2010-2024): Legislative	
ACA Marketbasket Cuts	($266,013,300)
Sequestration	(93,961,800)
Medicare DSH Cuts	(79,844,200)
Quality	(6,743,300)
ATRA Coding	(9,932,500)
Bad Debt at 65%	(2,180,700)
Total Legislative Cuts	**($458,675,800)**

Cuts Enacted (2010-2024): Regulatory	
Coding Cuts	($127,744,400)
2-Midnight Offset	(4,769,600)
Total Regulatory Cuts	**($132,514,000)**
Total Cuts Enacted	**($591,189,800)**

Cuts Under Consideration (2015-2024)	
Rural Cuts	($228,923,000)
OPD Cuts	(46,733,800)
IME/DGME Cuts	(14,218,200)
Bad Debt Elimination	(10,567,500)
CMS Coding Cut	(9,821,600)
Post Acute Cuts	(9,500,700)
Total Cuts Under Consideration	**($319,764,800)**

9 HOSPITALS

These cuts will cost Alaska hospitals $591 million over 15 years.

Cuts under consideration could reduce revenue by an additional $320 million if enacted. (This does not include recent reductions proposed in the President's budget.)

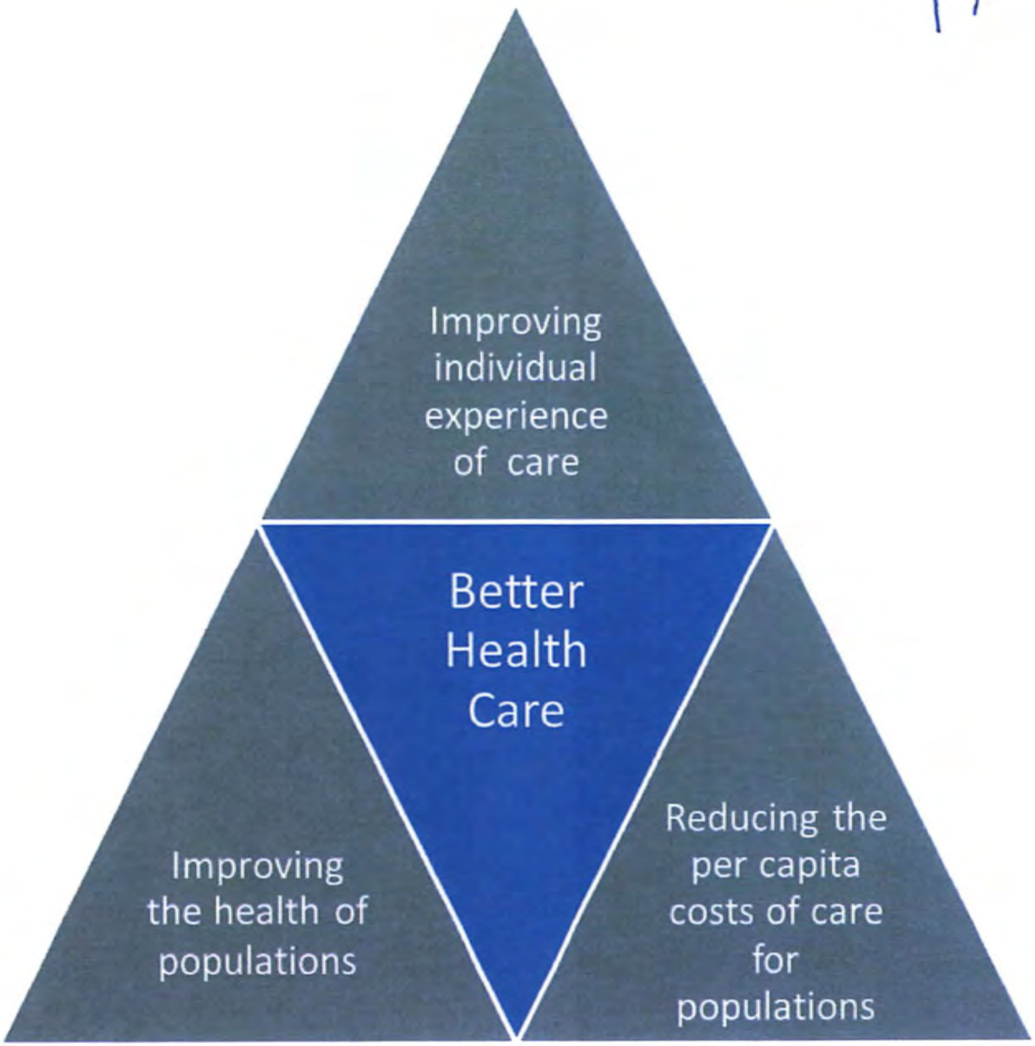
15-Year Medicare Cut Analysis, DataGen, February 2015.

Move to Population-based Payment

Payment Taxonomy Framework				
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

Volume to value: implications for the market

TRIPLE AIM



Volume to value: implications for us

Providers

Thank you.
Questions?

Together
Shaping Our Future

ASHNHA

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

THE STATE

of ALASKA

GOVERNOR BILL WALKER

DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT

Division of Insurance – Healthcare Insurance presented to Senate Health & Social Services

Director Lori Wing-Heier

February 17, 2016

Division of Insurance

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

- The division has a statutory responsibility to review and approve rules, forms and rates based on an analysis of whether they are excessive, inadequate, or unfairly discriminatory.
- The division does not have statutory authority to deny rates because of the financial impact to the consumer.

Frequently Used Terms and Acronyms

- 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 in force 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

→ SUNSETS?

Progression of ACA plan requirements

Prior to March 23, 2010	March 23, 2010 to January 1, 2014	January 1, 2014 and forward
Health Insurance Plans written prior to March 23, 2010 are considered grandfathered and not subject to all of the ACA criteria.	Health Insurance Plans written after March 23, 2010 and before January 1, 2014 are considered non-grandfathered and must be rewritten to comply with ACA as of January 1, 2014. This requirement was amended by the original transition and the extended transition which allows these plans to remain as-is until October 2016 provided insurers will renew.	Health Insurance Plans written after January 1, 2014 must be ACA compliant. Individual market non-grandfathered plans will sunset in Alaska on December 31, 2016. Small market non-grandfathered plans may continue until June 30th, 2017 or TBD Continuous changes and updates as needed /recommended by states and others

Will [illegible]
our pool

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 2014 – Individual market rate filings are approved. Premera's average increase was 37.2% and Moda's average rate increase was 27.4%
- April 2015 - Insurers file their 2016 FFM rates for individual and small employers
- August 2015 – Individual market rate filings are approved. Premera's average increase was 38.7% and Moda's average rate increase was 39.6%
- October 1, 2015 – Letter received from Kevin Counihan, CEO/Director of Center for Consumer Information & Insurance Oversight that the 2014 risk corridor payments will be paid at 12.6% requests

Looking back at the numbers

2014	Individual	Small Group
Premera	13,327	13,541
Moda	8,424	746
Time/John Alden/Assurant	1,002	1,846
All Other	387	2,523
Total	23,140	18,673

2015	Individual	Small Group
Premera	12,457	13,713
Moda	14,825	2,749
Time/John Alden/Assurant	1,430	3,447
All Other	295	1,736
Total	29,007	21,645

Includes Grandfathered, Non-Grandfathered and ACA compliant plans.

Individual Market

2014	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	2,837	3,410	7,080
Moda	0	828	7,596
Aetna	242	0	103
Assurant	0	0	1,002
Total	3,079	4,238	15,781

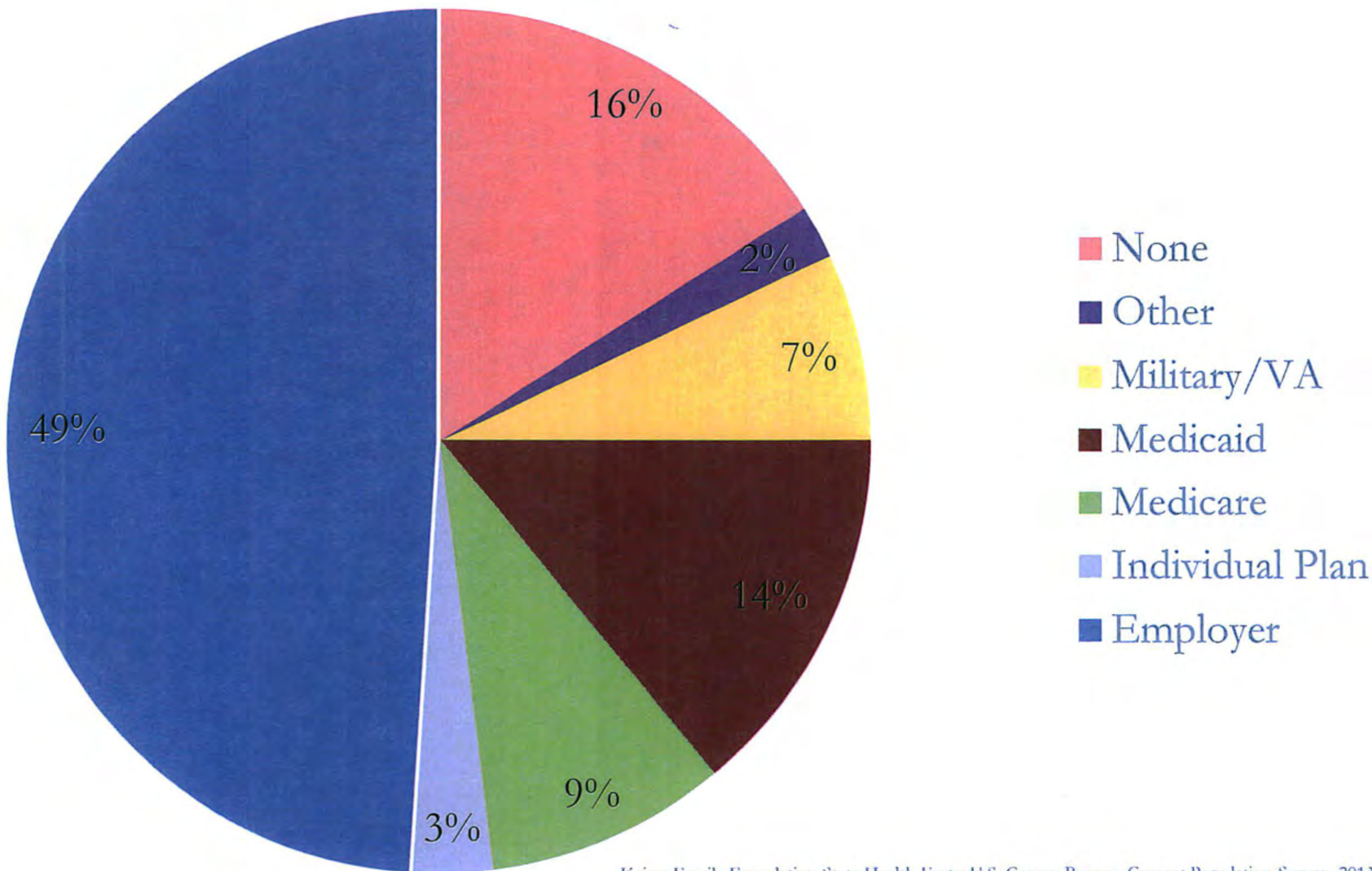
2015	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	2,274	2,345	7,838
Moda	0	0	14,825
Aetna	192	0	103
Assurant	0	0	1,430
Total	2,466	2,345	24,196

Small Group Market

2014	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	4,594	7,280	1,667
Moda	0	542	204
Aetna Gone	0	805	840
Assurant Gone	0	0	1,846
UHC Gone	0	0	895
Total	4,594	8,627	5,452

2015	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	3,216	7,409	3,088
Moda	0	0	2,749
Aetna	0	299	701
Assurant	0	0	3,447
UHC	0	0	736
Total	3,216	7,708	10,721

Sources of Health Insurance



Kaiser Family Foundation State Health Facts; U.S. Census Bureau, Current Population Survey, 2013

Healthcare Insurance Filings

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). The following list provides the criteria for rate reviews:

- 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.
- Filings must include a 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.
- A description of the rating formula and corresponding assumptions must be submitted.
- The methodology and actuarial justification for rating assumptions must be submitted.
- It must include a 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 are required.
- Rate revisions and implementation dates from previous 4 years must be submitted.
- The earned premiums, incurred and paid claims, and number of covered individuals and member months for most recent 48 months must be included in the filing.

Three Important Terms

Excessive – the test of an excessive rate filing is proven by reviewing the 1) expected cost of the claims, including escalating cost of medical services, submitted by the consumer and to be paid by the insurer, 2) the overhead and administrative costs of the insurer (claim administration, taxes, etc.) and 3) the expected profit of the insurer. The proposed aggregate rate must be in compliance with the benefits as provided by the ACA and include these costs but not be significantly higher than what the filing supports.

Adequate – the test for adequacy parallels that of excessive. The rate must be adequate and anticipate the 1) expected cost of the claims, including escalating cost of medical services, submitted by the consumer and to be paid by the insurer, 2) the overhead and administrative costs of the insurer (claim administration, taxes, etc.) and 3) the expected profit of the insurer. The proposed aggregate rate must include these costs but not be significantly lower than what the filing supports.

Unfairly discriminatory – the test for unfairly discriminatory is that the proposed rates do not show any discriminating factors that would be applied when rating the cost of the insurance for any one consumer.

Only following a review of all documentation and determining if a filing should be disapproved for being excessive, inadequate, or unfairly discriminatory, it is approved by the Director of the Division of Insurance. There is no provision in State or federal law that permits the burden of cost on a consumer be considered in the review of rates, although consumers do have the ability to submit comment on large proposed rate increases.

Effective Rate Review State

CMS?

Alaska had to meet federal requirements in order to review and approve Alaska rates, rather than have the federal government perform that function for the state. Along with 43 other states, Alaska was approved as an effective rate review state by the U.S. Department of Health & Human Services in January 2012. In order to be approved, the State had to demonstrate that it collected sufficient data and documentation concerning rate increases to conduct examinations of the reasonableness of the proposed increases as well as taking into consideration the following factors:

- Medical cost trend changes by major service categories
- Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits) by major service categories
- Cost-sharing changes by major service categories
- Changes in benefits
- Changes in enrollee risk profile
- Impact of over- or under-estimate of medical trend in previous years on the current rate
- Reserve needs
- Administrative costs related to programs that improve health care quality
- Other administrative costs
- Applicable taxes and licensing or regulatory fees
- Medical loss ratio; and
- The issuer's capital and surplus.

Historical Loss Ratios-Premera

Individual Market	Written Premiums	Paid Losses	Loss Ratio
2011	$39,764,513	$29,604,749	74.45%
2012	$42,119,304	$28,423,782	67.48%
2013	$40,580,188	$28,637,037	70.57%
2014	$70,921,280	$74,651,900	105.26%
Small Market			
2011	$79,710,670	$56,149,874	70.44%
2012	$74,830,099	$55,814,325	74.59%
2013	$71,886,123	$52,569,190	73.13%
2014	$73,685,279	$55,705,206	75.60%

Historical Loss Ratios-Moda

Individual Market	Written Premiums	Paid Losses	Loss Ratio
2011	$1,652,807	$1,260,090	76.24%
2012	$2,100,010	$1,022,093	48.67%
2013	$2,779,892	$2,117,312	76.17%
2014	$33,550,283	$35,064,920	104.51%
Small Market			
2011	$11,176,264	$10,589,833	94.75%
2012	$8,198,157	$7,915,547	96.55%
2013	$6,966,253	$5,441,367	78.11%
2014	$6,266,320	$4,893,758	78.10%

Historical Rate Increases-Premera

Individual Market	ACA	Transitional	Grandfathered
2009		N/A	17.70%
2010		15.10%	15.10%
2011		17.90%	15.80%
2012		12.70%	12.70%
2013		0%	0
2014	New Plans	0%	2.20%
2015	37.20%	16.65%	0%
2016	38.70%	Filing Submitted	Filing Submitted
2017	???		

INCREASES NOT DECREASING

Historical Rate Increases-Moda

Individual Market	ACA	Transitional	Grandfathered
2009		12.65%	
2010		21.00%	
2011		9.90%	
2012		0%	
2013		0%	
2014	New Plans	4.71%	
2015	27.30%		
2016	39.60%		

Historical Rate Increases-Celtic

DOI WANTS THEM BACK

Individual Market	ACA	Transitional	Grandfathered
2009		25.10%	
2010		23.60%	
2011		0%	
2012		25.00%	
2013			
2014	New Plans		
2015	19.40%		
2016	14.30%		

2016 - WITHDREW [illegible]

Historical Rate Increases-Aetna

Individual Market	ACA	Transitional	Grandfathered
2009			14.50%
2010			15.90%
2011		15.90%	15.90%
2012		9.50%	9.50%
2013		16.40%	19.30%
2014	New Plans		0%
2015			13.00%
2016	Withdrew		Withdrew

Historical Rate Increases-Time

Individual Market	ACA	Transitional	Grandfathered
2009			
2010			21.00%
2011			23.00%
2012		7.00%	5.00%
2013		0%	0%
2014	New Plans		20.00%
2015	36.00%		
2016			

Historical Rate Increases-John Alden

Individual Market	ACA	Transitional	Grandfathered
2009			
2010			21.00%
2011			23.00%
2012		7.00%	5.00%
2013		0%	0%
2014	New Plans		20.00%
2015			
2016			

Risk Corridor

Three Rs

- **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
  - We estimate that Alaskans paid $33,308 in 2015 and $62,453 in 2016 in fees

- **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 sunsets in 2016
  - 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
  - The cost to Alaskans $63/2014, $44/2015 and $27/2016. This is on insured and self-insured plans. Our estimated is that Alaskans paid:
    - $23,171,432 in 2014;
    - $16,183,222 in 2015; and
    - $9,930,614 in 2016

Sunsets in 2016

- **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 sunsets in 2016
  - The funds of the Risk Corridor program are based on the claims experience of the company

Low Risk to High Risk
Reverse Contract
Did not work

Health Care Costs in Alaska

- Commercial health care premiums in Alaska are approximately 130% of the average in Idaho, North Dakota, Oregon, Washington and Wyoming
- Commercial hospital reimbursement is approximately 137% of the average in the comparison states
- Average hospital costs are approximately 138% in the comparison states
- Hospital operating margins in Alaska were 13.4% in Alaska on average in 2010, compared with 5.7% for comparison states
- Physician reimbursement in Alaska is approximately 160% of the average in the comparison states
- Physicians have significant negotiating leverage relative to insurers
- Salaries for health care professionals are between 100% and 110% of those in the comparison states

Drivers of Health Care Costs in Alaska and Comparison States – Milliman, Inc. as prepared for the Alaska Health Care Commission in 2011

UTILIZATION IS A FACTOR.
ER VS. PRIMARY CARE

Ten Potential Premium Drivers in 2017

- Healthcare costs and utilization
- Changes to Essential Health Benefits and the CMS Actuarial Value Calculator
- Additional data – 3 years
- Continued migrations
- Insurers merging and exiting markets
- Ongoing uncertainty, court cases and the 2016 elections
- Transitional Reinsurance
- Risk Corridor
- Risk Adjustment
- Changes in fees and taxes

Sourced from Milliman Healthcare Reform Briefing Paper December 2015

Alaska – Potential Cost Drivers

- Cost of healthcare is amongst the highest in the nation
- Limited providers, challenges with provider networks
- Individual market remains at 20,000 – 22,000 and may have settled
- Adverse loss experience – health status of those enrolled in the individual market
- National cost drivers *do* impact Alaska – we are not immune

Section 1332 Innovation Waiver

A few states are exploring a Section 1332 Innovation Waiver which would allow the state to withdraw from the ACA if, *and subject to many provisions*, the state could provide the same benefits to consumers without any additional cost to the federal government. States that are working on 1332:

- Colorado
- Minnesota
- Hawaii
- Massachusetts

Section 1332 Innovation Waiver

- Provide coverage at least as comprehensive as under the ACA
- Provide coverage and protection against excessive out-of-pocket expenditures at least as affordable as that provided under the ACA
- Cover a number of residents comparable to the number who would be covered under the ACA
- Not increase the federal deficit

- Must be authorized by state legislation
- Developed through a public process
- A state granted an innovation waiver that restricts access to premium tax credits, cost-sharing reduction premiums or the small employer tax credit can be paid the amounts that would have been paid to its residents under these programs to finance its waiver program

Other solutions?

- Premera and Moda – Possible reinsurance program to be administered by ACHIA
- Regional exchanges – partnering with other western states?
- Combining the individual and small group markets to spread the risk amongst more enrollees?

Conclusion

Questions?

ACHIA

- MOST HAVE LEFT TO ACA.
- MEDICAL SUPPLEMENTS

80% PERCENTILE RULE

- 13 YEARS AGO (2003)
- FOR CONSUMER PROTECTION
- ALLOWS PHYSICIANS TO SET THE RATE.

Becky

DOI

SIZE LIMITATION
of AK's market