SOCIETY OF ACTUARIES

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Session # 13 OF: Valuation Actuary Consideration in Health Reform

Michael J. Cellini, ASA, MAAA, FCA
Shari A. Westerfield, FSA, MAAA

Valuation Actuary Considerations in Health Reform

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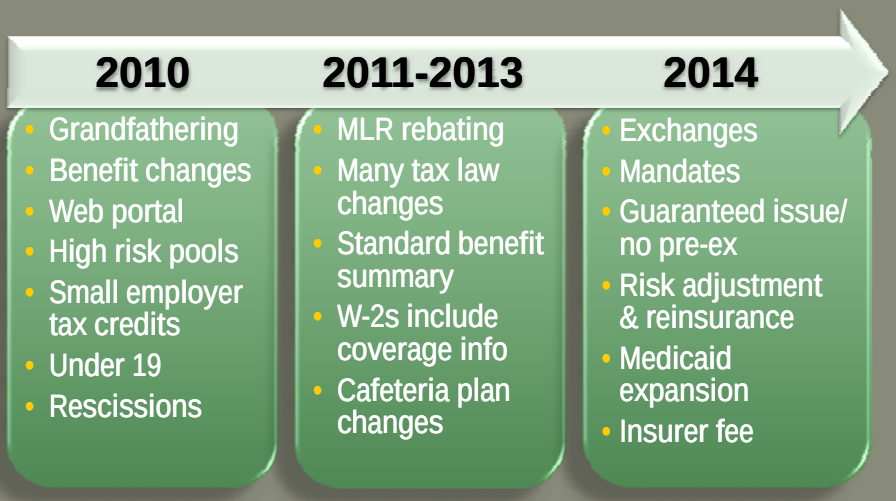
Shari Westerfield FSA, MAAA
Blue Cross Blue Shield Association

Overview of Insurance Reforms



Grandfathered Status

- Applies to both Individual and Group business
  - Policies in effect on date of enactment (3/23/10)
- Grandfathered coverage does not have to comply with various provisions
  - Essential benefits and preventive care benefits
  - Patient protections
  - Premium setting rules
- Regulations released 6/17/10

Grandfathered Regulations

- Coverage can lose grandfathered status
  - Buy new insurance policy
  - Increase deductible/cost-sharing above certain levels
  - Decrease employer contributions by >5%
  - Make certain other changes
- Carriers will have to document grandfathered status and disclose to members

MLR Federal Reporting

- No detailed regulations available yet
  - Unclear whether by line of business or total
  - May be based on NAIC recommendation that §2718(a) and (b) are the same ratio (i.e., same denominator)
  - Likely to begin when rebating begins
- To be posted to HHS website

MLR NAIC Reporting

- Annual Statement supplement for 2010
  - Due on April 1 to states
  - More detailed than law requires
  - Exhibit that builds up to an MLR calculation
  - Not same as rebate formula (ties to statement)
  - Shows all lines of business by state
  - Defines activities that improve health care quality

Medical Loss Ratio §2718(b)

Rebating Requirements

(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under 4 such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance ...) for the plan year (except as provided in subparagraph (B)(ii)), is less than

(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

MLR Rebate Regulations

NAIC Recommendations

- Comprehensive major medical only
- Calendar year basis
- By state
- By line of business:
  - Individual (includes associations / trusts)
  - Small group (state definition)
  - Large group

MLR Rebate Regulations

MLR Formula - Numerator

- Included items
  - Incurred claims
  - Quality improvement expenses
  - Contract reserves
- Excluded items
  - Cost containment expenses (CCE)
  - Other claims adjustment expenses (CAE)

MLR Rebate Regulations

MLR Formula – Numerator Issues

- Definition may create unlevel playing field
  - Fee-for-service business
  - Capitation business
  - Staff model HMO and prepaid group practices

MLR Rebate Regulations

MLR Formula – Numerator Issues

- Definition may create unlevel playing field
  - Capitation business
    - Mixture of claims and administrative expenses
    - Unbundling of costs would be artificial/subjective
    - Higher claims-over-premium ratios

MLR Rebate Regulations

MLR Formula – Numerator Issues

- Inclusion of CCE
  - NAIC “five-year historical” exhibit
    - Claims-over-premium ratios
    - CCE-over-premium ratios
  - Mitigates the “unlevel” playing field based on business mix
  - Provides some credit for CCE activities

MLR Rebate Regulations

MLR Formula – Numerator Issues

- Inclusion of CAE (or loss adjustment expenses - LAE)
  - Mitigates the “unlevel” playing field based on business mix
  - Provides some credit for administrative activities
    - Claims adjudication
    - Members services
  - NAIC Underwriting & Investment Exhibit Part 2C
    - Section C shows ratios of claims-plus-LAE to premium by product

MLR Rebate Regulations

MLR Formula – Numerator Issues

- Broader definition
  - Mitigates the “unlevel” playing field based on business mix
  - Provides some credit for CCE and CAE activities
  - Consistent with NAIC reporting statistics

MLR Rebate Regulations

MLR Formula – Denominator

- Premiums ("earned premium" versus "total premium revenue")
- Deductions from the denominator
  - State premium taxes
  - State regulatory assessments (e.g. high risk pools)
  - Federal income taxes
  - New annual fee (PPACA Sec. 9010)

MLR Rebate Regulations

MLR Formula - Individual Market

- Potential Disruption
  - Annual target MLR of 80% versus traditional pricing lifetime target MLR
  - Potential implications of business mix – old versus new policies
    - Durational cost variances
  - Difficulty with any potential reductions to non-claims costs
    - First year agency/broker fees
  - Premium deficiency reserve implications

MLR Rebate Regulations

MLR Formula - Statistical Fluctuations

- Reported MLR versus required MLR
  - Aggregation of blocks of business prior to MLR calculations
    - Reduction of random claims fluctuations
  - Statistical variations due to size of blocks of business
    - Risk adjustments for statistical tolerance
    - Tabular or continuous credibility factor tables
  - Incidence of large claims
    - Potential pooling of large claims across business segments

MLR Rebate Regulations

MLR Formula - Contract reserves

- NAIC SSAP No. 54
  - Premiums and benefits are not earned or incurred at the same incidence over the policy period
  - Gross premium structure – the PV of FB exceed PV of FNP
  - Contract provides for EOB after termination of coverage

MLR Rebate Regulations

MLR Formula - Contract reserves

- Issue-age rated policies versus attained-age rated policies
- Attained-age policies (prefund durational cost variations)
- Long term contracts (benefit or active life reserves) – lifetime-loss-ratio level pricing
- GAAP versus STAT variations
  - Methodologies (NLP w/ DAC versus 1yr & 2yr prelim term)
  - "Locked-in at issue" assumptions

MLR Rebate Regulations

Accounting for Rebates

- Reduction of premium revenue
  - Like retrospective rated group contracts
  - Consistent with regulatory rate filings requirements
  - Need for additional FS reconciliation entries
- New type of claims expense
  - Consistent with the definition of rebates as the product of premiums by the delta of target MLR to actual MLR
  - Rebates represent a numerator adjustment
  - Need for additional FS reconciliation entries
- Underwriting gain on a pre-rebate basis

Near-Term Coverage Changes

Guaranteed Issue Under Age 19

- No pre-ex limitations
- Limited to open enrollment period
- Can be a dependent until age 26

Rescissions Prohibited

- Exception only for fraud or misrepresentation
- 30-day written notice before rescission
- External review process

Near-Term Benefit Changes

Removal of Limits

- Prohibition on lifetime dollar limits
- Transition period/waiver for “restricted annual dollar limits” before 2014
- Essential benefits not defined

Preventive Services

- Specific services that plans must cover
- How may/may not apply cost-sharing
- Allowable treatment and medical management activities

Patient Protections

- Internal and External appeals
- Choice of any participating PCP, pediatrician, or OB/GYN
- No prior auth for ER; cost-sharing not greater than in-network

Implications for Reserving

New situation:

- Potential for increased adverse selection
- New benefits not in prior data
- Loss of limits as risk management

Claim liability considerations:

- Impact on claim trends
- Appropriateness of prior run-off patterns
- Change in incurral pattern of large claims

Rate Review Activity

Federal Activities	• Feds looking for more authority • Federal review of “unreasonable” increases
State Activities	• Many states adding approval authority • Federal grants to bolster rate reviews
NAIC Activities	• Rate filing guidelines • Disclosure form for “unreasonable” increases

HHS/State Review Process

Review of "unreasonable" increases

- Carriers to submit a justification for increases prior to implementation and post on website.
- Commissioners to provide HHS rate trends and recommend if carriers should be excluded from exchange due to pattern of excessive/unjustified increases.
- Starting with 2014 plan years, HHS (with states) to monitor premium increases both inside and outside of exchanges.
- Applies to all individual and group health insurance. Effective for plan years beginning 6 months after enactment (9/23/10).

Implications for PDRs

New situation:

- **Rate filings scrutinized**
- **Pressure on carrier profits**
- **MLR rebates**
- **Benefit changes**
- **Expense structure changes**

PDR assumption considerations:

- **Probability of rate approval**
- **Limited cross-subsidization due to rebates**
- **Future expected claims costs**
- **Expense patterns**

Questions?