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

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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

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

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

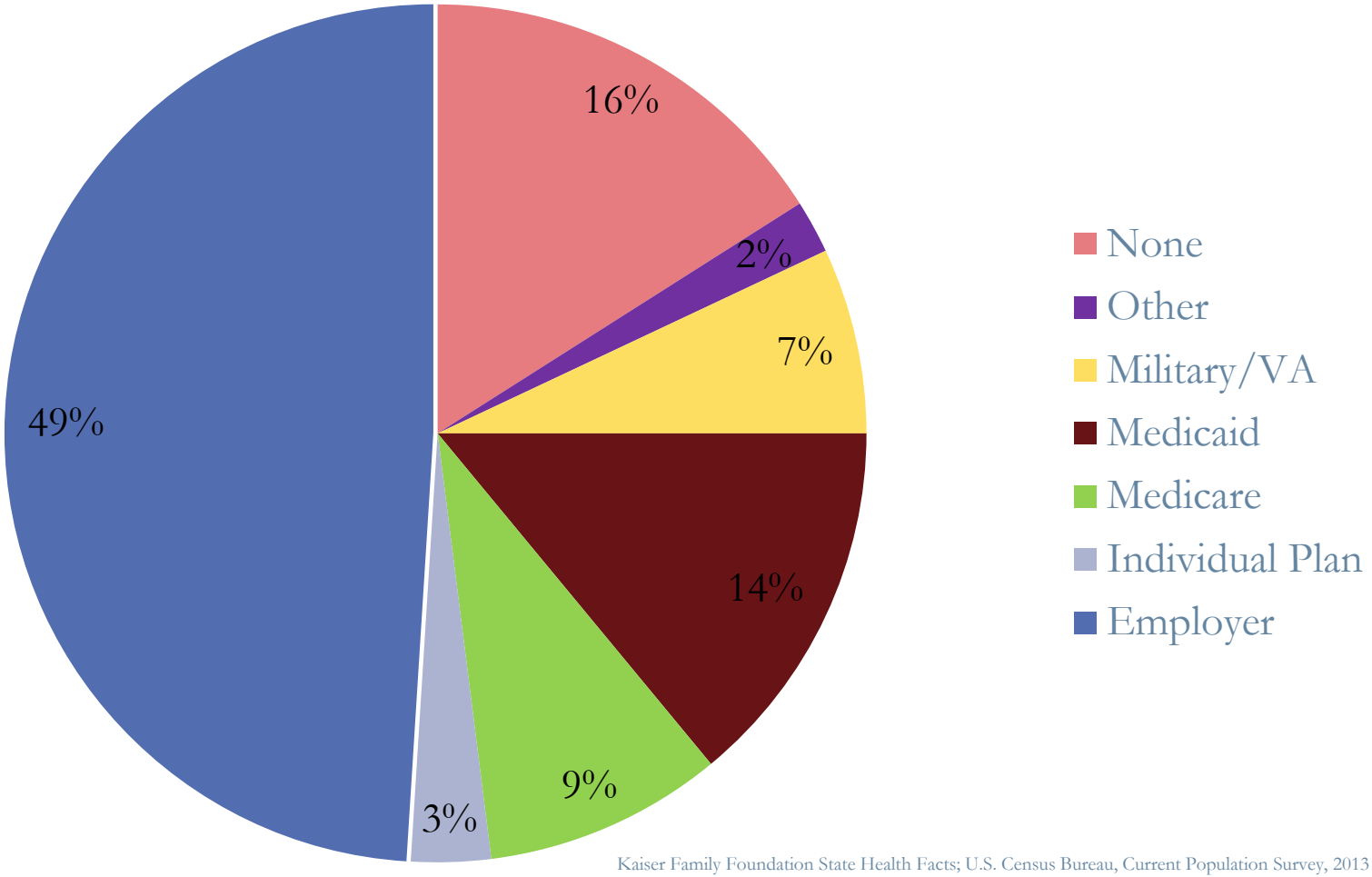
2015	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	2,274	2,345	7,838
Moda	0	0	14,825
Aetna	192	0	103
Assurant	0	0	1,430
Total	2,466	2,345	24,196

Small Group Market

2014	Grandfathered	Non-Grandfathered	ACA QHPs
Premera	4,594	7,280	1,667
Moda	0	542	204
Aetna	0	805	840
Assurant	0	0	1,846
UHC	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

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

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

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%		

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

- **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

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

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?