Health Reform Implementation: An Actuarial Perspective

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- Medical loss ratios
- Premium oversight
- Grandfathered plans
- Individual mandate

Medical Loss Ratios (MLR)

- Medical loss ratios measure the benefits received by policyholders divided by the premiums paid
- Minimum medical loss ratios under the Affordable Care Act (ACA):
  - 85% in the large group market
  - 80% in the individual and small group markets
  - Adjustments to the individual market requirement can be made if it would destabilize the market
- Rebates required if loss ratios fall below these levels
- Requirements begin in 2011

Medical Loss Ratios (MLR)

- MLR definition in ACA varies from typical MLR definition
- MLR formula needs to be clarified
  - Specifics regarding MLR requirements to be determined by the Department of Health and Human Services with input from the National Association of Insurance Commissioners (NAIC)
- Regulations should be structured to:
  - Create fair comparisons between different types of health insurers
  - Minimize potential disruption in the individual market

Medical Loss Ratios (MLR)

- It is difficult to define claims in a way that applies consistently across different types of insurers
  - For instance, it is difficult in capitation models to split payments into claims and claims administration components
- Including cost containment expenses (the amounts insurers spend in order to manage the cost of medical claims) in the numerator would:
  - Create fairer comparisons across different types of health insurers than using claims alone
  - Encourage insurers to effectively manage the quality, efficiency, and cost of care for policyholders

Medical Loss Ratios (MLR)

- Individual market has unique characteristics that increase the potential for new MLR requirements to cause disruption
- Pricing in the individual market is typically done on a lifetime basis rather than an annual basis
  - In general, expected loss ratios of medically underwritten business will increase with policy duration
  - Meeting an annual MLR could be more difficult for insurers with newer blocks of business
- The individual market incurs higher administrative costs
  - Agent/broker compensation; lower benefit levels; fewer insureds over which to spread costs

Medical Loss Ratios (MLR)

- Options for minimizing disruption
  - Lower the 80 percent threshold for grandfathered individual business
  - Develop MLR thresholds that vary by policy duration
  - Exclude experience in the select period of underwritten business from the scope of the MLR calculation
  - Include the change in contract reserves (using a federally-defined methodology) in the numerator of the MLR calculation

Premium Oversight

- ACA requires HHS in conjunction with States to establish a process for the annual review of unreasonable increases in health insurance premiums
- Justification for unreasonable premium increases is required
- “Unreasonable” needs to be defined

Premium Oversight

- Premium increases reflect many factors:
  - Increases in medical spending
    - Increases in unit costs
    - Increases in utilization
    - Change in mix and intensity of services
  - Policyholder lapses/changes in enrollment mix
  - Leveraging effect of deductible
  - Correction of prior estimates

Premium Oversight

- Key principles for premium oversight
  - Health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges
  - Premium oversight should be done in conjunction with insurer solvency oversight
  - Premium oversight must incorporate actuarial principles (e.g., actuarial soundness)

Grandfathered Plans

- ACA exempts existing (as of 3/23/2010) individual and group plans from most insurance reforms
- Grandfathered plans are subject to certain requirements:
  - Medical loss ratio requirements
  - Prohibition on lifetime limits (and annual limits for group plans)
  - Prohibition on rescissions
  - Dependent coverage extensions up to age 26
  - Elimination of waiting periods longer than 90 days
  - Elimination of pre-existing condition exclusions (group plans)

Grandfathered Plans

- Regulatory guidance is needed to clarify what triggers the loss of grandfathered status
  - Changes in plan features?
  - Changes in insurance carrier?
- After 2014, individuals and small groups will be able to choose between existing coverage and coverage through the new system with guaranteed issue and premium rating restrictions
  - Grandfathering provisions can insulate individuals/groups from rate shock if new insurance reforms would increase premiums
  - Grandfathering provisions will put upward pressure on premiums in new system to the extent that older and less healthy individuals/groups shift to new coverage
  - Triggers need to strike a balance between allowing individuals/groups to retain their existing plans and the sustainability of the new system

Individual Mandate

- Beginning in 2014, ACA requires all individuals to have qualifying health coverage
- Tax penalty for those without coverage
  - 2014: Greater of $95 or 1.0% of taxable income
  - 2015: Greater of $325 or 2.0% of taxable income
  - 2016+: Greater of $625 (indexed) or 2.5% of taxable income
- Exemptions granted if the lowest cost plan option exceeds 8% of an individual's income, if income is below the tax filing threshold, and for certain other individuals

Individual Mandate

- The individual mandate is an integral component of health reform
- Along with the annual open enrollment period and premium subsidies, the individual mandate encourages individuals to purchase coverage before they have medical needs, thereby reducing adverse selection
- Financial penalties associated with the mandate are relatively weak
- Additional non-financial incentives could strengthen the mandate:
  - Prohibit increases in benefit categories outside of the annual open enrollment period
  - Allow individuals to move up only one benefit category per year
  - After first year, allow previously uninsured to enroll in lowest benefit category only

Bottom Line

- How the regulatory details are written will affect the law's impact on individuals, employers, and insurers