Health Reform and Health Reserves

• Brief Summary – Reform
  > Quick review of what has and may happen
  > Implications to Payers and on Health Products

• Overview – Health Actuarial Reserves
  > Big picture – assumptions and processes
  > Similarities and differences from P&C coverage

• Implications – How Reform Changes Impact Estimates
  > New liabilities or changing landscape
  > How reform will impact estimation processes

Health Reform and Health Reserves

• Law: 2200 pages ----- Regulation: 10,000 pages?

• Potential Implications – View #1
  > Fundamental change in delivery of healthcare
  > Massive shift in how and where people get health coverage
  > Substantial change in how payers and providers are regulated
  > Evolution to a new view of cost / benefit equation

• Potential Implications – View #2
  > Emerging political reality of a reform that was pushed through
  > Legal challenges and unraveling of PPACA
  > Influence through Regulation and Funding

• Potential Implications – In Any Case
  > Change is upon us and liabilities will be impacted
Reform: First 90 Days (6/23/10)

- High Risk Pool – bridge to 2014
- Early Retiree Reinsurance – employers induced to keep plans
- Small Group Tax Credit – 35% credit to create more plans
- Crack Down on Fraud
- Regulate Loss Ratio – BCBS MLR ≥ 85%
- HHS Rate Oversight - “unreasonable” premium rate increases
- Increase funding for rural providers
- Medicaid Expansion – 133% FPL (state-option) for adults
- 10% Tax on Tanning Salons

Reform: 6-month Provisions (by 2011)

- Dependents to Age 26
- Removal of Lifetime and Annual Limits
- 100% Coverage of Preventive Care Services
- Prohibit Rescissions – except fraud and misrepresentation
- No Pre-Existing Condition Screening – Groups 2-50 EEs
- Eligibility can not discriminate based on salary
- HHS Interim Insurance Exchange Portal
- HHS to install “Effective” Appeals Process
- CLASS

Reform: 2011 - 2013

- MLR targets for all insured plans:
  - Individual & Small Group ≥ 80%
  - Large Group, ≥ 85%
- W-2 Reporting of Health Costs
- Uniform Health Plan Documents
- Payment Reform to encourage ACOs/IDCs
- Payment Linked to Quality Outcomes
- Electronic Exchange of Health Information
- FSA Contributions ≤ $2,500/Yr. (CPI)
- Medicaid PCPs paid at Medicare rates
Reform: Planned for 2014

- No Pre-Existing Limitations for Any Insureds
- Small Group rate banding
  - Age (3.0:1 Max)
  - Tobacco (1.5:1 Max)
  - Geographic
  - Family Size
- Health Insurance Exchanges
  - Standard Plans & Min Benefits
    - Cheaper/More-Safe Option
    - Risk Adjustment Mechanism
- Credits/Penalties - <400% FPL Credits / Increasing Penalties
- Medicaid Expansion to 133% FPL All Non-elderly
- Rate Review and Risk Adjustment (In & Out of Exchange)
- Temporary Risk Corridor Program

2014 Projection Member Movement – New Mix?

<table>
<thead>
<tr>
<th>Current Coverage (millions)</th>
<th>Coverage in Exchange</th>
<th>Out of Exchange</th>
<th>Total (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employer</td>
<td>Individual</td>
<td>Employer</td>
</tr>
<tr>
<td>Employer</td>
<td>154.438</td>
<td>6,708</td>
<td>6,628</td>
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<tr>
<td>Non-Group</td>
<td>14.220</td>
<td>252</td>
<td>3,520</td>
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<tr>
<td>Medicare</td>
<td>8,771</td>
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<tr>
<td>Medicare Duals</td>
<td>6,148</td>
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<tr>
<td>Medicare Baker</td>
<td>6,151</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Medicaid/SCHIP</td>
<td>61,873</td>
<td>504</td>
<td>417</td>
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<tr>
<td>Uninsured</td>
<td>48,191</td>
<td>2,358</td>
<td>7,055</td>
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</tbody>
</table>
| Total                      | 309,804  | 10,834    | 23,118   | 6,750      | 345,203           | 6,174    | 54,471
  |                           |          |           |           |            |                   | 46,146   | 19,371 |

Reform: Impact on Liability Estimates

Claims Liabilities – IBNR and ICOS
Premium Deficiency Reserves
Active Life Reserves
**Impact: Nature of Claims Liability Estimates**

- Classic Completion/Development Methodology
  - Lags: Historical lags will predict future payment pattern
  - Overrides: Most Recent 3-4 Months = substitute fully incurred estimate
  - Loss Ratios (Bornhuetter-Ferguson)
  - PMPM Incurred Cost Projections (trended fully incurred estimates)

- Processing and Speed of Payment
  - 90+% electronically submitted
  - High percentage of claims auto-adjudicated by system
  - Electronic funds transfer
  - Average Duration (Weighted Payment): 2.5 to 5 Months
  - Months in Reserve (Liability/Average Incurred) – often below 2 months

- Estimates and Metrics
  - Lag-Based Portion often <50% of Liability – but sets base for extrapolation
  - Most recent incurred month often almost ½ the Liability
  - Inventory In-house and Speed of Payment are huge issues

**Claim Liability: Importance of Overrides**

![Graph showing Total Liability vs I&P with Overrides highlighted.]

**Claim Liability: Projection of PMPM Morbidity**

![Graph showing Incurred PMPM vs Paid PMPM with Old Trend vs New Trend comparison.]

Old Trend / New Trend ??
Expansions of Public Financed Eligibility

Claim Liability: Impact of Reform - Morbidity

New State Operated Health Insurance Exchange
Claim Liability: Impact of Reform - Morbidity

Impact on Non-Group Population

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Current Policy</th>
<th>PPACA</th>
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<tr>
<td>under 19</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>19-24</td>
<td>11%</td>
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<tr>
<td>25-29</td>
<td>12%</td>
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<tr>
<td>30-39</td>
<td>16%</td>
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</tr>
<tr>
<td>40-49</td>
<td>14%</td>
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</tr>
<tr>
<td>50-54</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>55-59</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>11%</td>
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</tr>
</tbody>
</table>

- Trend Line – Historical PMPM Run Rate
- New Population = New Morbidity
- Impact of Cost-Sharing Limitations on Spend Rates
- Impact of Subsidies and Penalties
- Impact of Changes in Underwriting Slope
- Predictive Modeling or Risk/Demographic Adjustment?
- Seasonality – Monthly Patterns
- Incidence of Large Claims

Operational Impacts
- Speed of Payment – New & Different Population – Initially and Eventually
- Government Mandates – Turn-around time
- Inventories and operational turn-around

Active Life Reserve: Impact Potential

- Morbidity Reserve to Fund Shift in Morbidity by Duration
  - Underwriting and Pre-existing Limits: Initially low morbidity
  - Wear-off: Morbidity increases as insured ages and conditions appear or get covered
  - Expenses: High front-end acquisition spread to later durations
  - Actual Practice: Theory not applied in its purest form

- Impacts
  - No underwriting / no pre-existing limits after PPACA
  - MLR Limits (80% target) significantly changes distribution and loads
  - Potential change in age distribution and incidence of claims
  - Self-selection: Current HSA experience quite favorable – can it be replicated?

- Massive Changes in the Design and Operations
  - Fit under Exchanges?
  - Voluntary Product Outside Mainstream?
### Premium Deficiency Reserve: Impact Potential

**• Morbidity Reserve to Fund Shortfall in Pricing**  
- Known deficiency in emerging experience versus pricing projections  
- "Surplus Stress Test": accelerate losses on contract until remediation can occur  
- Set up at valuation date and release ratably until remediation date  

**• Impacts**  
- Huge disconnection in the markets may make pricing difficult  
- Emergence of experience may make recognition difficult  
- HHS "unwarranted increase" limitations may limit pricing remediation  
- Current treatment: Required conversion and extension products often denied PDR  

**• Open Issues**  
- Will government allow Medicaid or Medicare Advantage to set up PDR  
- Similarly, will Exchange products be allowed to have PDR?  
- Can Surplus Levels of Carriers Sustain PDR?