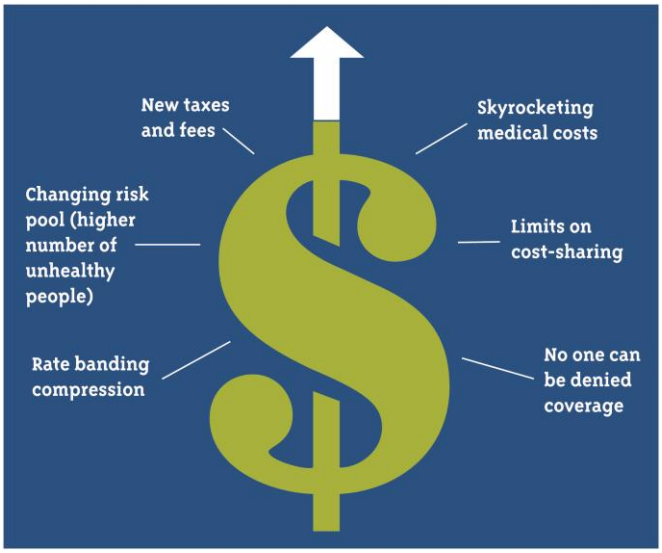
Individual and small group rates and the Affordable Care Act (ACA): What is behind the rates?

The Affordable Care Act (ACA) changes that take place January 1, 2014 will significantly alter health insurance for many Americans. The federal law expands health insurance coverage to millions who were previously uninsured (no one can be denied coverage) and makes prevention and early detection of illness a priority through enhanced preventive care benefits. New marketplaces, called exchanges, will be created where those who qualify will be able to access financial assistance to help offset the cost of coverage. The law also changes the way health insurance companies are allowed to develop rates, and assesses new federal and state fees and taxes.



We anticipate these changes will have a significant impact on premium rates charged by all health insurance companies. It is likely certain populations, particularly in the individual market, will see rates increase dramatically. Federal premium and cost sharing subsidies will provide some assistance for those who qualify, but they do nothing to address the underlying cost of healthcare.

The following information is intended to help you understand more about how health insurance rates are determined, and what is behind the increase.

How do health insurance companies determine rates?

Health insurance premium rates cover claims for medical services, health plan administrative costs, and profit (sometimes). To develop rates, health insurance companies project future costs and utilization of services (claims). This is a very sophisticated process that takes into account historical trends, medical cost inflation and use of medical services, including population health and changes and trends in diagnosis and treatment. Rates are then adjusted for each individual based on other factors including age, benefits selected, geographic location, and tobacco use. The ACA requirements have added even more complexity that must be factored into rates.

Here is a quick overview of some of the most influential factors on rates:

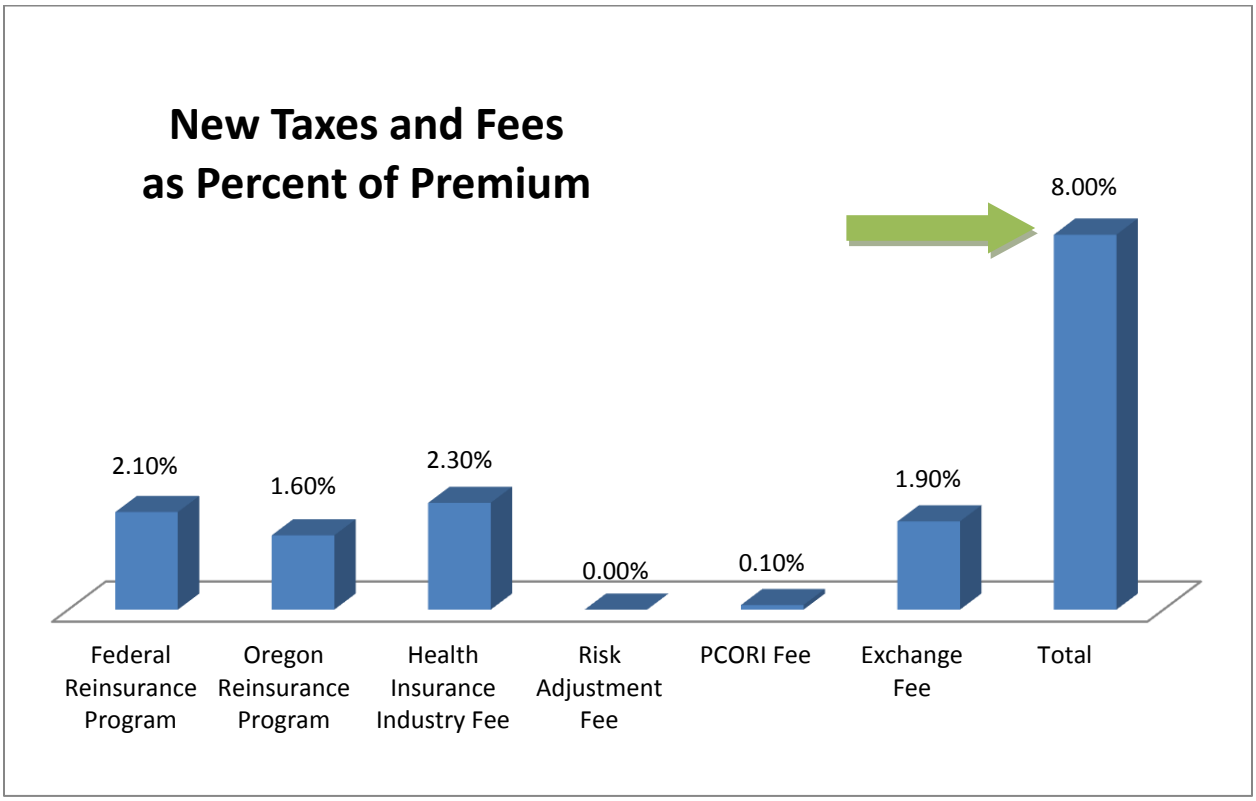
Medical costs – The biggest driver of health insurance premiums is the cost of medical care. In addition to utilization, health insurance companies must evaluate trends in medical inflation and the cost of new treatments and technologies in order to accurately project future costs. Nationally and in Oregon, medical inflation continues to outpace the cost of other goods and services.

"Guaranteed Issue" – Starting in 2014, health insurance companies may no longer deny coverage based on a person's health status at the time of application. This represents a significant change in the individual market, and will likely result in substantial cost increases.

Changing "Risk Pool" – Insurance is about pooling risks, which means that the healthier the pool, the lower the risk and, subsequently, the lower the cost. The combination of guaranteed issue and expanded coverage for millions of previously uninsured Americans will result in an overall less healthy risk pool, especially in the individual market, where members with significant medical issues have been historically denied coverage. The long-term objective of the ACA is to increase access to care and promote prevention and wellness; these are the right objectives, but it will take time to improve the populations' overall health.

Federal and State Taxes and Fees – In Oregon, health insurance companies pay fees and taxes for a variety of populations and programs, including the Oregon Medical Insurance Pool (high risk pool), Children's Reinsurance (children's high risk pool), Portability, and the Healthy Kids program. In 2014, these subgroups will merge into the Individual market. The fees and taxes will be repurposed (pending passage of Oregon legislation) to fund an Oregon supplemental reinsurance program to help offset the impact of merging these high-risk groups.

In addition to the new Oregon state reinsurance tax, various other fees and taxes will be levied on health insurance companies, including a health insurance industry fee, exchange fee, and a fee to fund the Patient-Centered Outcomes Research Institute (PCORI). In total, these state and federal fees are likely to represent 8% of premium.



Age Band Compression – Today, health insurance companies are able to charge someone who is older (i.e., 60 years old) up to five times more for the same policy as someone who is

younger (i.e., 30 years old). Health insurance companies use this practice to take into account that the health insurance needs between these two individuals are likely to be quite different. Beginning in 2014, health insurance companies will only be allowed to charge up to three times more based on age. In general, this change means healthcare will be less expensive for older Americans, but more expensive for younger Americans.

New Cost-sharing Limitations – As the underlying cost of medical care has continued to rise, employers and individuals have sought affordable coverage through policies with higher deductibles and greater cost-sharing. The ACA has placed tightly defined limits on cost sharing. Currently, about 30% of our individual members have chosen plans with higher cost-sharing than permitted in 2014, meaning that they will be forced to select a plan with richer benefits, at increased rates. These limits, combined with richer benefit requirements, contribute to the increase in rates.

Other Federal Rules – The ACA also defines limits on how much premium can be spent on things other than providing healthcare and improving quality. A ratio, called the Medical Loss Ratio, is used to evaluate health plan performance under this rule. In the Individual and Small Group markets, health insurance companies must ensure that at least 80% of the premium dollar is spent toward healthcare services, with the remaining 20% going to administration, marketing, and contribution to reserves. There are also restrictions on how much profit margin a health plan can claim. These restrictions pressure health insurance companies to manage risk as effectively and efficiently as possible, but they also foster potential instability within the health insurance system during this time of dynamic change.

Impact of Changes Difficult to Project

The early impact of the 2014 changes is difficult to project. We know many will benefit from the changes, including those who are not currently insured, are considered low income, are older, or who are less healthy. However, we are deeply concerned about the impact on people seeking to purchase health insurance in the individual market, including younger, healthier Americans who are currently insured but are likely to see rate increases that may force them out of the market. If these younger, healthier Americans choose to pay the penalty and forgo health insurance, their departure will have a negative impact on the overall risk pool by reducing the number of healthier members. This may drive up premiums even further.

What is PacificSource doing to drive down costs?

PacificSource is a not-for-profit entity with a long history of careful and ethical management of our members' premium dollars. As a community health plan, we develop strong partnerships with providers and other key stakeholders to focus on the tenets of Triple Aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of healthcare.

We will continue to bring as much stability as possible to the rate environment through our conservative rating practices, and by continuing to find innovative and meaningful ways to improve community health over time.

Here are ways PacificSource is working to drive down costs today:

Maximizing member healthcare dollars through innovative provider relationships – We are working with providers in new ways to improve the patient care experience and maximize member healthcare dollars. First, we are working with providers to establish new coordinated care networks with shared incentives for cost savings that align with our health plan designs. These incentives encourage better collaboration among providers, stronger member-provider relationships, and member engagement in healthcare decisions. Second, we are working within our existing networks to establish community health partnership agreements with providers. These agreements outline quality metrics around preventive care and condition support measures that, when met, give providers a share in resulting savings. The agreement ensures members receive the highest quality care and the potential to maximize their healthcare dollars by reducing the need for hospital stays or readmissions for the same health issue.

Designing plans that emphasize prevention and wellness – In 2014, we will launch a new plan, called Innovation (pending state approval), that places greater emphasis on prevention and wellness, and encourages members to actively participate with their providers in decisions about their care. The Innovation plan is intended to help members stay healthy and active, reducing the need for more expensive care and trips to the emergency room.

Decreasing administrative costs – Over the past two years, we have gained efficiency and reduced costs through improved contracts with vendors like Caremark, and by moving condition support and other programs in-house. We have also added services that improve access to electronic forms of communication, reducing reliance on costly printing and mailing services. For example, members can now choose paperless options for receiving Explanation of Benefits statements, bill statements, and other communications through our member web portal, InTouch.

Community Health Excellence (CHE) Program: Through this program, we make financial and other contributions to providers and organizations for initiatives that significantly improve patient care, regardless of patients' insurance status. Since the program began in 2009, the CHE program has attracted ideas from a vast array of hospital and physician group practices, and has resulted in the funding 52 initiatives across Oregon and Idaho. These initiatives have had a direct impact in improving care delivery in the domains of Infection Control, Best Practices in Acute Care, Preventive Care and Chronic Disease Management, and the Integration of Care.