# HEALTH CARE REFORM
## OUR UPDATE & ADVICE

MORRIS & REYNOLDS INSURANCE PRESENTS ADVICE & ANSWERS ON AMERICA'S HEALTH CARE REFORM DECEMBER 2012

## AETNA PREDICTS INDIVIDUAL & SMALL GROUP RATES TO RISE 50% TO 100%

***COMPLIANCE WITH HEALTH CARE REFORM PROVISIONS NOTES AS REASONS FOR INCREASES***

There it was. Someone finally put a price to consumers on the possible cost of healthcare reform. Last week the CEO of Aetna US Healthcare, the third-largest health insurer in America, was quoted at an investment conference in New York . CEO states insurer rates could rise dramatically in order to provide medical coverage and comply with key provisions of the new law starting in 2014.

***"In some markets increases in premiums could "go as high as 100 percent. And we've done all that math. We've shared it with all the regulators. We've shared it with all the people in Washington that need to see it. And I think it's a big concern."***
Aetna CEO Mark Bertolini

### INDIVIDUAL HEALTH (NON-GROUP) PREMIUMS ESTIMATED TO INCREASE 20% TO 50% ON AVERAGE

Asked to predict what will happen with rates in 2014, the Aetna CEO was quoted as saying:

***"Premium rate shock for 2014. Absent subsidies and everything else, is going to be in the neighborhood of 20 percent to 50 percent. And we're going to see some markets [and] in sub-segments in some markets go as high as 100 percent."***

There are many ways that healthcare reform might increase the cost of medical insurance, especially so for individuals who buy coverage on their own or their families away from a group plan.

Some key reasons insurers are will increase rates include: (1) Coverage will now be a guaranteed issue, meaning insurers will have to write every applicant, even if they are sick or injured, (2) Insurers can no longer base rates on health or for that matter age as the law requires something called 'community rating', a concept that requires younger people's rates to subsidize older people's rates, 3) "Minimum actuarial value" is a requirement that forces insurers to provide broader coverage, and (4) "Essential Health Benefits" provide for broader coverage to be offered.

*"Just one piece alone, more than half of the U.S. public [in the individual insurance market] is in a plan at 50 percent or lower actuarial benefit. If you go up to 60 percent, as required by law, you've got a huge bump already," Bertolini noted.*

*"And this is the reason why you're seeing such pressure between the states and the federal government on exchanges. Whose exchange do you want to show that price increase on? And surely, the federal government doesn't want to show that. So I think this is going to be a big debate. We're putting these things through into rate increases and we're getting them through the regulators.*

***So I think that is going to be the big story for 2014, as these rates start going to the market, probably the latter part of this year, 2013."***

### WILL NEWS OF RATE INCREASES DELAY EXCHANGES OR TEMPER INSURER'S PARTICIPATION?

In our view, the law will be implemented as of January 1st 2014.

Some suggest news of large increases could delay the start of the exchanges or that insurer's might not participate in them in a meaningful way but the political pressure to launch the core, key, part of the exchanges remains significant.

Aetna has announced that it will participate in exchanges in *"Up to 15 states in 2014, representing 65% to 70% percent of the exchange-eligible population but will "approach exchanges with caution until confident they represent a rational and stable marketplace…After a transition period, if Aetna cannot earn its cost of capital on exchanges, we will exit market areas*." A sizable insurer concern is rate regulation, what they can charge or change.

*"What are the regulators going to allow for rates when you file them?"* asked Bertolini. "*How are the 'three R's' [risk adjustment, reinsurance, and risk corridor] going to work?"*

At the same investment conference an **Aetna executive vice president of commercial (non-government) business shared that Aetna did not expect many small businesses to participate in the soon to be created exchanges because the cost of insurance on the exchanges would be quite high**.

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**Interestingly, based on initial news, Aetna's involvement in the exchanges is a bit greater than its competitors. United Healthcare has announced that it will be involved in a "few" states while Humana has stated it will be involved in just ten.**

### HOW EXCHANGE PLANS WILL PAY DOCTORS & HOSPITALS

Aetna's CEO also discussed the type of insurance that his company would offer in the exchanges:

> *"It's about having the right products at the right cost structure, [with] narrow networks, low-cost networks."*
> Aetna CEO Mark Bertolini

**Narrow means limited**. As such, in order to provide basic coverage within the exchanges this means they will be limited to a select (*narrow*) group of providers and will likely pay those providers fees for their services that are similar to what Medicare and Medicaid pays.

Using Aetna's public comments one would expect that the insurer, and their competitors offering exchange products, will offer plans in the exchanges that 'feature' low-cost doctors and hospitals to keep rate low.

For their exchange plans Aetna expects to reimburse hospitals and doctors at rates akin to government programs, rather than the much higher rates used in commercial insurance. "*We're contracting…at a rate normally between Medicare and Medicaid for the exchange population*"

Aetna's competitor **Humana** has expressed concern over whether insurers will be able to offer providers ultra low fees for their services, say fees in line with Medicaid, for exchange plans.

> *"If you go down to Nashville and you ask [hospital chain] HCA about that, they'll laugh you out of the room. This idea that it's going to be Medicaid rates—that's a joke."*
> Bruce Perkins, **Humana**

### WE'VE SEEN MUCH OF THIS BEFORE

During the Clinton Administration the State of Florida set up its **Community Health Insurance Purchasing Alliance (CHIPA)**. The CHIPA program opened 11 offices around Florida, relaxed underwriting in hopes large numbers of uninsured people would enroll and promised insurer's millions of new customers. Initially every insurer participated but a few years after it started the CHIPA program only offered the worst insurers and terrible plans. A short while later it died, closed for lack of interest and use along with poor quality and high cost.

Now that's not to say that Obama Care will suffer a similar fate as the CHIPA's but if insurer participation is limited, rates are high and the networks of doctors and hospitals are 'narrow' consumers will shy away and in fact most experts expect limited participation in exchanges by small businesses.

**If exchange fees paid to providers end near or between Medicare and Medicaid, Americans who enroll in an exchange will suffer from expensive coverage with a limited network of doctors and hospitals**. Some are already suggesting that the exchanges will fail from the start and others are pleading with the White House to offer the more market oriented exchange approach Utah uses, at least as an option to the ACA exchanges. In December Utah's Governor, Bob Herbert, wrote the President and said;

> *"I respectfully request that you instruct HHS to declare the Utah exchange model as the minimum federal standard. I am confident that if you make this change, several other states will join Utah and request certification for 'state-based exchanges' based on our model."*

**Whether the Administration will be open to such an idea is not known but the early signs on exchanges suggest options are needed to make them more attractive and affordable.**

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