PROPOSAL FOR THE STATE OF
WEST VIRGINIA
ACTUARIAL REVIEW AND CONSULTING
SERVICES FOR HEALTH INSURANCE RATE
FILINGS
RFQ #INS11006

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DIVISION
STATE OF WV

PROPOSAL FOR THE STATE OF WEST VIRGININA

REQUEST FOR QUOTATION
INS11006

Actuarial Review and Consulting Services for Health Insurance Rate Filings

Prepared by

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December 16, 2010

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I. FIRM PROFILE

Lewis & Ellis, Inc. is among the leading actuarial firms in the country. For over 40 years, we have served clients from coast to coast in all facets of life, health, employee benefits and property and casualty insurance. We strive to provide innovative and cost-effective answers to our clients' questions. We use our technical training and specialized knowledge to help identify the clients' needs and analyze immediate or potential problems. Using imagination and available resources, we develop creative and workable solutions to solve the identified problems. All during the working relationship, we communicate with the client giving them a basis for effective decision-making.

Services provided to various clients over the past several years have included actuarial examinations and assistance in connection with examinations of insurance companies conducted by state insurance departments, as well as actuarial services and management consulting for other regulatory agencies, life and health insurance companies, related financial institutions, employers, and property and casualty insurance companies. In addition, we are a leading purveyor of illustration software for insurance companies around the country.

Lewis & Ellis, Inc. operates as a corporation and is incorporated in the state of Texas. We have offices located in Kansas City, Baltimore and Dallas. The firm employs approximately 60 people, including 21 Fellows of the Society of Actuaries (FSA) and 5 Associates of the Society of Actuaries (ASA). All of the FSA's and ASA's are also Members of the American Academy of Actuaries (MAAA). All of the consultants and employees of Lewis & Ellis operate with strict adherence to ethical and professional standards.

The Kansas City office is currently staffed by 10 FSA's and a technical support staff of 10 employees consisting of a combination of ASA's, actuarial technicians and computer systems personnel. Our professional needs are regularly reviewed and appropriate staff is added as necessary. We are committed to having sufficient resources to respond in a professional and timely manner to all examinations and other projects that might arise. An additional staff of 7 provides the resources for insurance illustration software development. Actuaries are also important in this area of practice.

Lewis & Ellis, Inc. has extensive experience in conducting actuarial examinations, rate reviews and providing other assistance to state insurance departments, including the states of Wisconsin, Michigan, Kansas, Missouri, Arizona, Rhode Island, Connecticut, Pennsylvania, Massachusetts, Iowa, California, South Dakota, Oregon, Texas, Arkansas and Ohio.

We have also been retained by, or on behalf of, other regulatory agencies to provide actuarial services and expert testimony. These agencies include the Missouri Life and Health Insurance Guaranty Association, the Missouri Office of Attorney General, the Arizona Insurance Department, Arizona Joint Legislative Budget Committee, Michigan Office of Financial and Insurance Regulation, and the Missouri Department of Insurance.

Other clients have included employers, health plans, insurance companies and provider organizations, so we are well versed in all benefit and health care issues. This also provides us with a unique perspective as to the issues, concerns and solutions to the financing and rating of health care benefits. We understand all the perspectives and feel we are well qualified to identify the elements of data and information to develop premium rates. Some examples of our rate review experience and health insurance pricing experience are listed below.

Michigan OFIR: L&E has conducted financial examinations of insurance companies, conducted training sessions for OFIR examiners, conducted rate reviews of Blue Cross Blue Shield Michigan individual, group and Medicare Supplement insurance products. In September, 2009, Tom Handley testified in a rate hearing for the Medicare Supplement rate review which resulted in the rate increase being reduced from the proposed 31.2% to 3.8%.

Massachusetts Department of Insurance: L&E has conducted rate reviews of various insurance company product and rate increase filings. L&E is also providing actuarial assistance to the Massachusetts DOI on their rate review grant addressing specifically contribution to surplus experienced by insurers and benefit plan rate relativities.

CMS: L&E has performed the rate reviews of the Medicare Advantage and Prescription Drug Plans on their annual filings with CMS. Tom Handley, Tony Proulx, Karen Elsom and Heather Robinson have all been involved in this activity. Some of the health plans and insurers reviewed by Tom Handley for their Medicare Advantage products have included Independence Blue Cross, Kaiser Health Plans, Empire Blue Cross Blue Shield and their Medicare Advantage products.

Healthcare Group of Arizona: L&E has prepared the rates charged by this insurer of small employers since 2008. The eligible groups are those who have not been able to obtain coverage on the open market. L&E has provided advice as to benefits offered, appropriate administrative fees for the participating provider health plans and rating strategies by group size. As a result of the L&E efforts for the last three rating periods, HGA has seen their enrollment stabilize, financial results stabilize and rate increases go from over 20% the first year to an average of 7.9% for the year beginning September 2010. This year we also provided the rate work for the PPACA changes.

Government Employees Health Association (GEHA): L&E has prepared the annual claim reserves for this large insurer of federal employees (500,000). We provide actuarial assistance on the rates for all three medical products they offer. We have provided actuarial assistance on rates for the dental products they offer. This year, L&E worked with GEHA and OPM (Office of Personnel Management) to develop the rates for the states

that selected the federal option for the PCIP (Pre-existing Conditions Insurance Plan). L&E has provided rates for 31 states. In addition to providing the rates we also furnished estimates of the subsidy that would be required from the federal government.

L&E Health Care Cost Model

The L&E Health Care Cost Model was developed back in the 1990s as a tool for evaluating benefit changes and testing the impact of utilization and network reimbursement changes for HMO and PPO products. We have continued to build a data base from client and public data sources to make updates to the values in the Model. The Model gives us a unique advantage when evaluating benefit plans and identifying changes needed to meet budget targets. The Model can be modified to fit each plan's demographics and its historical utilization rates and reimbursement levels. This provides us with a more accurate estimate of the impact of changes to benefits, utilization and reimbursement than those models that only use standard values for an 'average' group. It can also provide the means to compare a health plan's utilization to industry norms to identify those areas needing the most emphasis. Our norms are area and benefit plan specific and reflect data we have captured dating as far back as 1993. This data is from over 300 managed care plans so will reflect the possible variations in utilization and cost levels. The Cost Model is interactive which allows us to determine the impact of changes within seconds of input. Using the L&E Health Care Cost Model will help us develop recommendations as to --

a. Benefit changes in areas where utilization of services is greater than norms.
b. More aggressive management of utilization where utilization is greater than norms. The burden of this will fall clearly on the administrator to perform.
c. Review of network reimbursement levels with identification of cost per service that are greater than norm levels. We will discuss remedies for this with the network managers.

A sample of the Model is included as Appendix B.

L&E is familiar with the rate review requirements in the Affordable Care Act as we have described those rate review requirement on our website on our Health Care Reform page. L&E has recently been used by Michigan, Iowa and Massachusetts insurance departments to conduct review of health insurance rate filings. L&E does prepare the rates for several clients who provide insurance coverage to predominantly small employers. These clients include Healthcare Group of Arizona, Iowa Association of Electric Cooperatives and The League of Nebraska Municipalities. We would also use the L&E Health Care Cost Model to evaluate benefit design or benefit changes. Part of the analysis we do for the three small employer insurers mentioned includes analysis of demographic factors such as gender, age and family size.

II. STAFF CAPABILITIES

Depth of Expertise: Tom Handley will serve as the lead consultant. He has assembled a team of actuaries and consultants with significant experience in health care and health rating issues. The analysis and data work will be performed or supervised by a team of FSA's. The primary point of contact is Tom Handley. The backup point of contact will be Heather Robinson and if she is not available, Tony Proulx. Both Tom Handley and Tony Proulx are partners in the firm and the senior health actuaries in the Overland Park office.

Summary of Staff Qualifications

Following are summaries of each actuary's experience. More detailed resumes for each of the actuaries to be assigned to the rate review project are included elsewhere in this proposal.

Tom Handley has over 35 years of life and accident and health insurance experience. He has worked with a number of Blue Cross and Blue Shield organizations, as well as employers and associations in the area of employee benefits and rating of the health coverage. He has worked for a number of different state agencies regarding accident and health coverage. This work has entailed auditing, pricing, experience analysis and product design. He has had assignments for Texas, Louisiana, Oklahoma, Kansas, Michigan and Arizona state agencies, as well as, a number of different federal government agencies (review of Medicare Advantage rates for CMS). For the first 18 years of his career, he worked for three different insurance companies in actuarial reserving, health pricing and product development and management system design. For his last insurance company employer (Blue Cross Blue Shield Kansas City) he served as Vice President and Chief Actuary.

Karen Elsom has over 20 years of life and health insurance experience, including actuarial examinations for Wisconsin Office of the Commissioner of Insurance, Michigan Office of Financial and Insurance Services, Arizona Insurance Department, Missouri Insurance Department of Insurance and the Kansas Insurance Department since 1998. She has extensive experience in pricing, rate filing, and product development of individual and association accident and health insurance.

Tony Proulx has over 30 years experience in life and accident and health insurance. He has extensive experience in Long Term Care insurance, having worked for three large LTC insurers. Tony has substantial experience in supplemental health products. He has performed almost 100 reviews of supplemental health filings for the Massachusetts Division of Insurance. Tony has worked on 5 other projects for Massachusetts including two current assignments to aid the Division in small group health regulation, funded by their rate review grant. Tony has also worked with the Michigan Office of Financial and Insurance Regulation, the Iowa Insurance Division and the Arizona legislature. He has also been involved in the review of the Prescription Drug Plans (Part D) filed with CMS.

Heather Robinson has over 15 years of experience in life and accident and health insurance. She has product development, pricing, and valuation experience. She has significant experience in analyzing experience and developing rates for individual, small group and large group plans. She has worked for four insurance companies and is very familiar with addressing state insurance department regulations with regards to rate filing and financial reporting. Heather has also been involved in the review of Medicare Advantage rates for CMS.

We believe the four people listed above will provide an adequate level of staffing for the assignment. We will also use various levels of technical support staff as needed and based on the nature of the assignment. Both Tom Handley and Tony Proulx have extensive experience in providing training in all aspects of actuarial practice including pricing, reserving and underwriting.

Tom Handley, Tony Proulx and Karen Elsom all are familiar and knowledgeable in the applicable Actuarial Standards of Practice that could apply to health insurance rating which includes Numbers 5, 8, 23, 25, 41 and 42.

Detailed resumes follow.

THOMAS L. HANDLEY, FSA, MAAA

Vice President & Principal

Consulting Actuary, Kansas City Office

Prior Positions

1994-2003: DeFrain Mayer, Overland Park, Kansas; Principal

1989-1994: The Miller Group, Overland Park, Kansas; Principal

1982-1989: Blue Cross Blue Shield Kansas City, Missouri; Vice President, Actuarial Services

1975-1982: Central Life Assurance, Madison, WI; Second Vice President - Group Actuary

1971-1975: Business Men's Assurance Company, Kansas City, Missouri; Actuary

Responsibilities and Experience

- Development and pricing of all managed care products - HMO, PPO, POS and open access
- Development and pricing of managed Medicare and Medicaid risk products
- Provider reimbursement/fee surveys and analysis
- Development and pricing of A & H individual and group products
- Individual and group A & H experience analysis and repricing
- Development of market-focused rating model for all managed care products (links utilization and reimbursement assumptions to target rates)
- State-specific certification of small employer A & H requirements
- Financial projections and forecasting
- Group underwriting policy and strategy development
- Actuarial assistance to state insurance departments
- A & H claim and contract reserves (insurance companies and HMO's)
- Gross premium valuation testing for deficiency reserves
- Rate filings with state insurance departments
- Benchmarking of utilization and costs for employers
- In depth utilization analysis of employer health plan costs
- Actuarial attestation of Retiree Drug Subsidy for CMS

Author: Developing Premium Rates for a Preferred Provider Organization, Transactions Society of Actuaries, 1985

Education

University of Kansas

B.A., Mathematics

Professional

Fellow, Society of Actuaries

Member, American Academy of Actuaries

KAREN E. ELSOM, FSA, MAAA

Consulting Actuary, Kansas City office

Prior Position

1988-1998: Business Men's Assurance Company, Kansas City, Missouri; Assistant Actuary

Responsibilities and Experience

- Actuarial examinations of life insurance companies for state insurance departments
- Development, pricing and filing of new insurance products
- Disability income and major medical rate increase development and state filings
- Medicare Supplement annual state filings development and preparation
- Financial reporting: GAAP, statutory, tax and management information
- Development of lapse studies
- Small group major medical certification development and preparation
- Evaluation of reinsurance treaties
- Annual statement development and preparation

Education

University of Nebraska - Lincoln,
B.S., Actuarial Science

Professional

Fellow, Society of Actuaries
Member, American Academy of Actuaries

ANTHONY G. PROULX, FSA, MAAA

Vice President & Principal

Consulting Actuary, Kansas City office

Prior Positions

1999-2000: Transamerica Occidental Life Insurance Co., Kansas City, Missouri; Director, Financial Reporting, Long Term Care

1997-1999: Conseco Companies, Carmel, Indiana; Assistant Vice President, Long Term Care

1987-1997: Unum Life Insurance Co, Portland, Maine; Director

1981-1987: John Hancock Mutual Life Insurance Co, Boston, Massachusetts; Assistant Actuary

1978-1981: Boston Mutual Life Insurance Co, Canton, Massachusetts; Associate Actuary

Responsibilities and Experience

- Financial reporting: GAAP, PGAAP, statutory, tax, dividend and management information
- Financial analysis
- Financial projections and forecasting
- Cash flow testing
- Development and pricing of new insurance products
- Policy forms compliance with state insurance departments
- Administer reinsurance agreements
- Annual statement development and preparation
- Lapse studies
- Disability income and long term care claim continuance studies
- Long term care claim cost analysis
- Implement valuation procedures and systems
- Coordination of disability income products

Education

Bowdoin College

B.A., Mathematics and Physics

Magna cum laude, Phi Beta Kappa

Professional

Fellow, Society of Actuaries

Member, American Academy of Actuaries

HEATHER L. H. ROBINSON

Senior Actuarial Associate, Kansas City office

Prior Positions

2003-2006: The Ceres Group, Mission, Kansas; Actuarial Analyst

2000-2003: DeFrain Mayer, Overland Park, Kansas; Consulting Actuary

1998-2000: American Chambers Life Insurance Co, Lenexa, Kansas; Senior Actuarial Analyst

1994-1998: Centennial Life Insurance Co, Merriam, Kansas; Senior Actuarial Analyst

1993-1994: Providian Corporation, Louisville, Kentucky; Actuarial Student

Responsibilities and Experience

- Individual and group A & H experience analysis and rate repricing
- Medicare Supplement experience analysis and rate repricing
- Dental experience analysis and repricing
- Development and pricing of Medicaid risk products
- State-specific certification of individual and small employer A & H requirements
- Financial projections and forecasting
- In-depth utilization analysis of health plan costs
- Rate filings with state insurance departments
- Benchmarking of utilization and costs for employers
- A & H claim and contract reserves
- Annual statement preparation
- State insurance department complaint response and resolution

Education

Auburn University

B.S., Business Administration, Finance; Cum Laude

Georgia State University

Post-Baccalaureate – Actuarial Science

Professional

Society of Actuaries; Courses 1 & 2 passed

III. REFERENCES

CLIENT	Michigan Office of Financial and Insurance Regulation
CONTACT	Joan Moiles
TITLE	Deputy Commissioner, Health Plans Division
ADDRESS	611 West Ottawa
CITY/STATE/ZIP	Lansing, MI 48909
TELEPHONE NUMBER	(517) 335-2053

SUMMARY OF SERVICES PERFORMED:

Provided review of the nongroup, conversion and Medicare Supplement rate filings made in 2009 and 2010. Tom Handley did provide testimony in the rate hearing for the Medicare Supplement filing. L&E has also provided analysis of various health reform proposals that were made in 2009 by Michigan legislators. L&E did a study of market competitiveness in conjunction with a proposed acquisition in 2009.

CLIENT	Massachusetts Division of Insurance
CONTACT	Kevin Beagan
TITLE	Deputy Commissioner
ADDRESS	100 Washington Street, Suite 810
CITY/STATE/ZIP	Boston, MA 02118-6200
TELEPHONE NUMBER	(617) 521-7323

SUMMARY OF SERVICES PERFORMED:

Review of rate filings for health products, research projects as needed by the Division and assistance on two projects related to small group regulation funded by their rate review grant.

CLIENT	Healthcare Group of Arizona
CONTACT	Kevin Nolan
TITLE	Deputy Director
ADDRESS	701 East Jefferson St., MD-1400
CITY/STATE/ZIP	Phoenix, AZ 85034
TELEPHONE NUMBER	(602) 417-6755

SUMMARY OF SERVICES PERFORMED:

L&E has performed actuarial development of rates for this state agency providing coverage to small employers in Arizona who have been without health coverage for at least 6 months. L&E has prepared these rates for each of the last three years 2008 through 2010. Our support includes not only rate development but also includes plan design advice and negotiation with the contracting provider based plans. Most recently, we prepared the rates for the benefit plans designed to comply with PPACA.

CLIENT	Government Employees Health Association (GEHA)
CONTACT	Eileen Hutchinson
TITLE	Vice President, Finance
ADDRESS	310 NE Mulberry
CITY/STATE/ZIP	Lee's Summit, MO 64086
TELEPHONE NUMBER	(816) 434-4501

SUMMARY OF SERVICES PERFORMED:

L&E has provided actuarial support for rate development for the health plans GEHA provides to federal government employees. The health plans include both medical and dental coverage. The rate support needs to be insufficient detail to comply with Office of Personnel Management (OPM) requirements. In 2010 since GEHA is the administrator for the PCIP program, we have provided rates for the states that have selected the federal option to provide this coverage required by PPACA. To date we have developed rates for over 25 states. During this process we have been involved in negotiations that have included GEHA, OPM and OCIIO representatives.

IV. SCOPE OF SERVICES

There are a number of activities described in the Scope of Services and we will address those in our discussion of how we would complete each phase of the Project Work Plan. We will list each of these activities and describe our approach to assisting on the activities.

Rate Review of Health Insurer Filings

Work collaboratively with the Office of the Insurance Commissioner (OIC) and Director of Rates and Forms in reviewing health insurer rate filings for individual, group and association products. In addition to assistance with reviews, we anticipate that we will work to improve and enhance the review process especially in compliance with the standards required by PPACA. Part of this could involve developing a plan for a more structured health premium rate review program that will enhance the current review process, develop a more robust review and analysis process, improve transperancy to consumers and assist with fulfilling PPACA requirements.

Lewis & Ellis approach:

1. We could review past filings available from the last three years (2008 through 2010) and begin building a database to identify the historical data, various rating factors and assumptions used by the carriers.
2. The database from the step above will help identify and quantify the rate and product parameters to be collected. With this information, a format can be developed to standardize the information provided in the filings.
3. With a standardized format and database, we can identify and compare acceptable levels of increase, acceptable levels of cost of health care or administration. This will provide OIC staff the information and tool to question assumption and rating components.
4. This should then trigger some correspondence with the insurer on their assumptions and/or projections.

Our reviews follow the approach described below.

a. Review the historical experience used to develop the projected rates. Is the experience base an appropriate period to use? Is it credible? Does it need to be adjusted for selection, duration, benefit plan changes? Are the completion factors used to get incurred claims appropriate?
b. Review of trend assumptions used. How was the trend developed? Did they compare to other industry data? We like to take the historical data provided and develop exponential regression trend projections. We find that this alternative approach is very effective in assessing appropriateness of trend.

c. We will review the various factors applied in the filing. This could include credibility, durational factors, geographical, benefit and demographic factors. We will compare their factors to factors we have developed for such things as benefit changes, demographic changes, area changes, etc. using the L&E Health Care Rate Model (see Appendix B). Comparison to this independent rate source allows us to determine reasonableness of the factors they have used.
d. We will look at the non claim components of the filing. This would include a review of the administrative expense components and profit or risk contingency components. We will compare the administrative loadings to our database of insurer expense assumptions and financial statement files. This comparison as well as comparing to other insurer filings in West Virginia will enhance the determination of expense assumption reasonableness.

The core of our review involves preparing an independent calculation of the increase and commenting on the differences. We have provided a sample report and supporting exhibits in Appendix A that demonstrates our approach.

In addition to reviewing insurer rate increases for Insurance Departments, we have also conducted reviews of insurer increases for employers. We follow a similar process and negotiate with the insurers when there are differences. We have been successful in negotiating a lower increase 93% of the time. The average proposed increase has been 16.5% and we have negotiated an average increase of 11%. This average 5.5% lower increase has been worth $35 Per Employee Per Month.

Monthly Training and Manual of Rate Review

Rate filing components to be included are:

1. Factors of the rate filing;
2. Benchmarks for the factors;
3. Trending factors;
4. Components of the medical loss ratio;
5. How medical inflation should be addressed;
6. Financial position of the carrier;
7. Impact of mandated benefits.

In the section above we described a process where we would review past filings as a means to gather and document information used in past filings. In Appendix C we have included a sample worksheet of the data and format that we have used in the past for rate filings. This worksheet clearly displays the various factors that could be part of a rate filing. You may not use this worksheet format but it could serve as a base starting point to develop your desired format. This format plus past rate filings can serve as a basis for structuring the training sessions.

Benchmarking can be accomplished by building a database of the different factors used in past filings and developing ranges of values. We could then determine what percentile the factors in the filing were and determine if they are acceptable or outside of desired ranges. We will discuss what is included and what should be included.

The trend factors and components of the factors are shown on the worksheet. Part of a filing should include not only the factors used but how they were developed. Was past experience used? Did they look at industry norms? Did they take negotiated reimbursement changes into account? How did they reflect utilization management changes into account? We will discuss how all these should be addressed in a rate filing.

The worksheet in Appendix C shows medical cost components and we have other worksheets that capture the non-medical components. We would start with these and modify based on the past rate filings reviewed with other appropriate components or range values. By comparing the filings from OIC and from other states, if available, we will have a good range of values for medical loss ratios. It will facilitate comparisons to the PPACA guidelines. We will discuss what is reasonable and how we would address differences with the insurers.

We would use the L&E Health Care Rate Model to assess reasonableness of rates used for mandated benefits. We could also compare other OIC filings where mandated benefit rates were also included. We would also review the data and assumptions used by the insurers to justify their rate levels. What is a reasonable value for mandated benefits and what assumptions are reasonable?

Lewis & Ellis approach:

a. We anticipate that we would review past filings and use them as a base to develop the different training sessions for the issues addressed above. Our description of the issues above would serve as a guide to develop the sessions.
b. We envision each session initially discussing the fundamentals of the issue being discussed. The theory behind each and how different techniques would be applied. We would then go through some case studies – actual past or current rate filings and discuss how the fundamentals are applied.
c. We anticipate that the sessions would be best if conducted onsite. It is our intent to do multiple sessions in a day to minimize travel expenses. We prefer onsite sessions to have better, more effective interaction between L&E presenters and OIC staff. L&E presenters are most likely to be Tom Handley and Tony Proulx.
d. The manual would be written in conjunction with the training sessions. We would adjust the training presentation based on questions and responses during the sessions. We would then modify the presentation to develop the manual.

L&E has conducted training sessions for the Michigan Office of Financial and Insurance Regulation (OFIR). Tom Handley has been part of the training sessions for actuarial and

underwriting for the Blue Cross Blue Shield Association. Mr. Handley has made several presentations this year on Health Care Reform. A copy of one of those presentations is attached in Appendix D.

Other Management Consulting Services and Special Reviews for OIC

We have done a number of other projects for insurance departments and state agencies. For Michigan OFIR in 2009 to 2010 we have

1. Reviewed health reform proposals by Michigan legislators and provided comments and recommendations to Michigan OFIR. There were two such proposals in 2009.
2. We have conducted a market competitive analysis for Michigan OFIR to assess the impact on market competitiveness of a proposed acquisition of one health plan by another in Michigan (late 2009 – early 2010).
3. As an example of additional studies for Massachusetts, we have provided as follows.
    - Research as to contribution to surplus or profit by insurers doing business in the state.
    - Research on the relative values of benefit plans with variables such as deductible, copays, coinsurance, age, gender, etc. The L&E Health Care Rate Model was a key source for this study.
    - Research on information available on the value of High Deductible Health Plans.

BID AMOUNT

We will comply with State of West Virginia Travel Rules for out of pocket travel expenses.

LEWIS & ELLIS RATE: $275 PER HOUR

This rate is guaranteed for the first two years.

Contact: Tom Handley
913-491-3388
thandley@lewisellis.com

Federal Tax ID # 75-1281520

APPENDIX

There are four attachments – Sample of Rate Review Report and Exhibits, L&E Health Care Rate Model description, Sample Rate Review Worksheets and Sample Presentation on Health reform.

PRELIMINARY REPORT ON THE REVIEW OF THE REQUESTED RATE INCREASE OF SAMPLE COMPANY FOR GROUP CONVERSION LINE OF BUSINESS LEGACY PLANS

PRESENTED TO

THE OFFICE OF FINANCIAL AND INSURANCE REGULATION

DRAFT

Prepared by:

Lewis & Ellis, Inc.
Actuaries & Consultants

Overland Park, Kansas

September 13, 2010

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Sample Company – Group Conversion Legacy

INTRODUCTION

Lewis & Ellis, Inc. was engaged by the Michigan Office of Financial and Insurance Regulation (OFIR) to perform a review to determine if the rates filed by Sample Company (SAMPLE) for its individual lines of business are actuarially sound and are equitable, adequate and not excessive. This included four filings of Nongroup and Group Conversion plus a fifth filing for Medicare Supplement. This report pertains to the Group Conversion filing for the Legacy plans.

This report describes the methodology used in our review and presents our findings and observations. The report is intended for the use of OFIR. Conclusions and recommendations contained in the Report of Examination will be the responsibility of the Department.

Our review was performed in accordance with the provisions of PA 350 or 1980, MCL.550.1101-1704. These statutes are better known as The Nonprofit Health Care Corporation Reform Act. We also relied on the American Academy of Actuaries' Actuarial Standard of Practice No 8, "Regulatory Filings for Rates and Financial Projections for Health Plans".

We sent two requests for clarification and additional information to SAMPLE via OFIR. All correspondence was done using email with OFIR as the contact point. SAMPLE provided satisfactory responses which helped us to better understand their assumptions and methods.

Lewis & Ellis, Inc. is available to answer any questions that may be raised by this report. Please direct any inquiries to Tom Handley in our Overland Park office.

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Sample Company – Group Conversion Legacy

BACKGROUND

SAMPLE is requesting an across the board 12.33% rate increase for their Legacy block of Conversion business. This is a block of business with coverage offered to individuals who lose their group coverage and exercise the right to convert to individual coverage without having to pass any underwriting screens. There are a number of different benefit plans available. Some of the plans are closed to new enrollment but are still being maintained by SAMPLE to benefit the existing enrolled members. Historically, SAMPLE has separated the plans into three categories – High Options, Moderate Options and Value Options. The membership has been gradually shifting from the High Option to the Moderate and now Value Options.

Option	Option Category	Status	Option Name	Description
A	High	Open	Traditional Option A	Full coverage (no cost sharing)
B	High	Closed	Traditional Option B	15% Coins, $0 Deductible, $500 Stop Loss
C	Moderate	Open	Traditional Option C	20% Coins, $0 Deductible, $1000 Stop Loss
D	Moderate	Closed	Traditional Option D	30% Coins, $0 Deductible, $1000 Stop Loss
E	High	Closed	Traditional Option E	$250 Deduct Single / $500 Deduct Family
F	High	Closed	Blue Plus (PPO)	Full coverage (no cost sharing)
G	Moderate	Closed	Basic Blue (PPO)	30% Coins, $0 Deductible, $1000 Stop Loss
M	Value	Closed	Young Adult Blue	30% Coins, $1000 Deduct, $2500 Stop Loss
N	Value	Closed	Value Blue	30% Coins, $1000 Deduct, $2500 Stop Loss
O	Value	Open	Young Adult Blue (PPO)	30% Coins, $1000 Deduct, $2500 Stop Loss
P	Value	Closed	Value Blue (PPO)	30% Coins, $1000 Deduct, $2500 Stop Loss
Q	Value	Closed	Individual Care Blue (PPO)	30% Coins, $0 Deductible, $2500 Stop Loss, 50% Coins Rx
R	Value	Closed	Flexible Blue 1500 (PPO)	100/80% Coins, $1500 Deductible, $2500 Stop Loss OON, Rx paid with Medical
S	Value	Closed	Flexible Blue 2500 (PPO)	80/40% Coins, $2500 Deductible, $2500 Stop Loss OON, 50% Coins Rx

The High and Moderate Options do not provide a prescription drug benefit and differ by level of coinsurance and out-of-pocket maximum. Some options have a deductible and none have an office visit copay benefit. Three of the Value Options (Q, R and S) have a prescription drug benefit and an office visit copay benefit (limited). Generally, the Value Options have a deductible,

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coinsurance and out-of-pocket maximums. Option Q is the only option with no deductible. Maternity is covered in Option Q and is an option for Options R and S.

SAMPLE last received an increase on this block effective October 1, 2009.

REVIEW METHODOLOGY

Our approach was to review the filing package submitted by SAMPLE. We found the filing to be complete and well-organized. It provided good background information about the various products. It gave a clear demonstration of how the amount of the increase was determined and provided significant supporting documentation. We reviewed the filing closely, with emphasis on the sections regarding experience base, development of trend, administrative expenses, claim runouts, risk and profit included, and the mechanics of the development of the requested rate increase.

REVIEW FINDINGS

In the background section, we described the 14 benefit options covered by this filing. Throughout their analysis and documentation, SAMPLE split the options into Blue Cross and Blue Shield components. When the Blue Cross and Blue Shield components are added together, the company refers to it as a "combined" basis.

In the rate request for the previous year, SAMPLE requested rate changes separately for each of the 14 options. The different options were aggregated into the categories of High, Moderate and Value Options as shown in the background section of this report. The category aggregations were considered when trend factors and incurred factors were developed. The aggregations made sense since they represented groupings of plans with similar benefit characteristics. For this rating period, SAMPLE has deviated from the process used in the previous year. This year, rates were developed using a method that aggregated all plans together. The requested rate change is to be applied across the board for all 14 options.

<u>Development of the Requested Rate Increase</u>

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Sample Company – Group Conversion Legacy

The general approach to the development of the required rate is:

1. Determine the claims for the exposure period (calendar year 2009). These are the claims with date of service in calendar year 2009 and paid through March 2010.
2. Adjust this amount to project the remaining runout with the incurred factor.
3. Divide the projected amount by the number of contract months in 2009.
4. Trend the PCPM claims forward from the middle of the exposure period to the middle of the projection period.
5. Add in projected administrative expenses and commissions.
6. Add in the impact of the OTG subsidy contribution.
7. Add a 1% Risk margin.
8. Apply the projected investment income credit.
9. Divide the projected required premium rate by the current rate to develop the required rate increase.

This is a reasonable approach for developing projected premiums and the associated rate increase required to get to those projected premiums. It has a few inherent assumptions which we address.

Experience Base

SAMPLE has used the experience from 2009 as the base. This assumes the mix of business will remain steady and consistent with that in 2009. We reviewed the historical mix of lives covered. There is shifting in benefit options from year to year and there is shifting in distribution by age. The shifting by Option and demographic mix change has not been specifically recognized but it is reflected when analyzing measured trends and will be included in future rate levels if historical measured trend is used in projecting. The methodology used by SAMPLE uses the historical measured trend for projecting so the demographic and benefit plan shifting are properly reflected.

There is the inherent assumption that the data is credible. Throughout their development, SAMPLE has made this assumption. This is a very large block of business and the credibility should be very high.

Cost Transfer

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Sample Company – Group Conversion Legacy

The Group Conversion products do receive a subsidy. This is not specifically recognized in the rating. The needed rate change was calculated using the unsubsidized rates and the first and second year subsidies are applied to the resulting rates only. There is no need to reflect the subsidy in the increase calculation since it is not applied across the board (as for Medicare Supplement). We note the Group Conversion enrollees have a 15% subsidy in the first coverage year and a 7.5% subsidy in the second coverage year.

Note: SAMPLE is proposing changes to the Medicare Supplement subsidy amount, but it does not affect the individual lines of business.

<u>Claim Runout</u>

Development of runout patterns involves vast data and can require extensive actuarial judgment. We found SAMPLE is using very low runout factors. This was partly due to the fact that they are looking at the runout remaining after a three month lag. We compared their calculated factors with the corresponding runout factors from other clients and the SAMPLE factors are consistent with factors from other clients. We are very comfortable with their runout factors. There was a separate factor for Cross, Shield and Drug which made sense due to the nature of the claims and the difference in claim filing patterns between hospitals and physicians. The Cross factor was 1.0144, the Shield factor was 1.0177 and the Drug factor was 1.0005. (Drug claims are typically highly automated so they are paid much more quickly than the hospital or physician claims.)

<u>Trend</u>

The choice of a trend assumption is always difficult and subjective. We spent a considerable effort in this part of the review. Separate trend factors were developed for Cross and Shield (and Drug for Options with that coverage) which made sense to us. They developed trend factors for all options combined.

Described below is the SAMPLE approach to the trend development as well as our comments:

- SAMPLE based their trend assumption solely on their own experience. As we have stated before, this is a large block of business and we are comfortable treating it as 100% credible. Using their own experience also seems appropriate since there has been much shifting

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among the Options and in the age mix with the introduction of age rating. The trend calculations will inherently reflect these shifts.

- SAMPLE used rolling 12 month averages. We believe this approach is reasonable and sound. It eliminates much of the volatility. Also, it eliminates the need to remove the effect of deductibles and seasonality, as every 12 month period includes all 12 calendar months. Adjusting for deductibles and seasonality can be sticky and subjective.
- SAMPLE used exponential regression. We believe this approach is reasonable and sound. This approach finds a best fit based on the assumption that the underlying data is an exponential function, which is consistent with the concept of trend.
- SAMPLE performed 13, 11, and 9-point regressions. The multiple testing provides sensitivity testing. Their analysis also showed correlation coefficients which are a measure of how well the curve fits the data. SAMPLE used the 9-point regression for their final trend determination. The choice is subjective. Ideally you want to use many points to provide stability of the results. But you also want to focus on the most current data. These are conflicting criteria. We noted the results are somewhat sensitive to the number of points used.
- SAMPLE used loss ratio measures. We would have used Allowed incurred claims PMPM. SAMPLE calculates the loss ratio with the numerator using fully incurred claims for the period while the denominator is equal to the actual member months of the period multiplied by the current premium rates. This is a little more complicated than using incurred claims PMPM. However, it does end up properly weighting the individual plans.
- We did extensive checking of the trend calculations. We followed the calculations from the raw data provided in reports, through to the curve fitting and resulting trend measure. We also calculated the trends separate for the High, Moderate and Value options. We did not include the experience for options R or S as they are still too new and too volatile. We also did not include the experience for options M and O (the Young Adult Blue plans) since their claims costs are so low due to the young population. Lower claim costs will result in a lower credibility of data.

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Sample Company – Group Conversion Legacy

SAMPLE used quarterly calculations. L&E performed independent calculations of trend using methods we typically use. One method is a variation of the rolling 12 which relies on exponential regression. The second method calculates cost changes from year to year (2007 to 2008 to 2009) and an annualized two year change. We compared our independent calculations to those generated by SAMPLE in the table below.

OPTION CATEGORY	SAMPLE	L&E
High Options		5.30%
Moderate Options		5.90%
Value Options		8.70%
ALL OPTIONS	10.27%	6.80%
*High & Moderate Combined		5.50%

The SAMPLE trend calculation includes the entire block, including Options M, O, R and S which we did not use as explained in the above Trend section of this report. For the L&E calculations, the High and Moderate trends were determined using 36-month exponential regression trends on the incurred claims PMPM. L&E calculations for the Value plans used exponential regression trend over the last 12-18 months for plans N, P and Q. We used the more recent period for the Value options because the enrollment for these plans has stabilized. All L&E trend calculations were calculated separately for each option then weighted by the 2009 incurred claims for an average trend by Option category.

We reviewed the SAMPLE values and the L&E values and have the following recommendations for the trend factor to use in the rate calculations. Our recommended values are within the ranges from both sets of trend calculations.

High and Moderate Options: use 1.055 versus the SAMPLE value of 1.1027

**For greater credibility, we have combined the trends for high and moderate options.*

Value Options – use 1.087 versus the SAMPLE value of 1.1027

Administrative Expenses

SAMPLE has projected administrative expenses to increase 3% per year. As the historic revenue for these plans has shifted toward the Value options, the overall revenue per contact has decreased (prior to rate increases). The administrative expenses per contract as a percent of revenue have

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increased. Historical administrative expenses have been increasing at a rate of more than 3% per year so use of a 3% trend seems reasonable.

SAMPLE used a methodology to allocate expenses by line of business. For the Legacy filing, all expenses for the Conversion plans were combined and calculated on a PCPM basis. This methodology is reasonable, sound and consistent with industry practice.

We note SAMPLE does pay commissions for the Value Options. In the SAMPLE projection, commissions were added across the board impacting all options. The expense assumptions used are at reasonable and acceptable levels. However, we would project the needed rate change allocating commissions only to the options that have a commission expense.

Risk Charges and Profit

SAMPLE included a 1% risk margin in the determination of the required premium. In the 2009 rate filing, SAMPLE did not include a risk margin in the projected rate calculation. Including a margin is reasonable within actuarial practices.

SUMMARY OF FINDINGS

We find the 12.33% overall proposed rate increase to be excessive. We recommend a few changes to the projected increases by option plan as well as a few adjustments to the trend used for the projection. We believe the needed rate change for this block to be adequate is 7.7%. Below is a brief outline of our major findings:

- Plan experience was used as the baseline for the projections. Experience was treated as 100% credible. Paid claims were based on incurred dates of January 1 to December 31, 2009 and paid dates through March 31, 2010. The calculation of the fully incurred amounts used a very small completion factor.
- Trend was calculated using an appropriate and well-recognized methodology. However, trend was determined for the entire block versus a pooling of like benefit options. We revised the trend assumptions based on a pooling of like benefit options. We believe that

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our blocks are more appropriate for determining trend, rather than using the entire block. Additionally, we did not use the data for options M, O, R or S when we calculated our trend for the Value Plans. Our independent analysis has lowered the trend rates below the values calculated by SAMPLE.

- Administrative expenses plus commissions (8.9% in aggregate) continue to be below the rate of industry norm levels of 12% to 15%.
- There is a 1% margin in the determination of the required premium. While the 1% margin is an acceptable level within normal actuarial parameters, SAMPLE did not include this margin in the prior year rate filing so it could be removed for consistency.

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RECOMMENDATION

We recommend the rate increase be modified as in the table below.

Conversion Options	SAMPLE Increase %	L&E Recommended Increase %
High Options: A, B, E and F	12.33%	1.3%
Moderate Options: C D, and G	12.33%	1.3%
COMBINED HIGH AND MODERATE	12.33%	1.3%
All Value Options: O, N, P, Q, R, S	12.33%	12.3%
ALL OPTIONS COMBINED	**12.33%**	**7.7%**

The proposed changes are primarily due to changes in the trend assumptions identified in the trend discussion. Additionally, projections are based on a pooling of options by High, Moderate and Value.

RELIANCE AND QUALIFICATION

The purpose of this letter is to communicate our review of this filing. The use of this report by parties outside of the Office of Financial and Insurance Regulations is unauthorized. Outside parties rely on this report at their own risk.

Sample Company – Group Conversion Legacy

Our conclusions are based on information supplied by Sample Company in their original filing and in response to our inquiries for additional information. The information was not verified, but we did review it for consistency and reasonableness. If any information was inaccurate, it may require us to revise our conclusions and opinions.

Respectfully Submitted,

Thomas L. Handley, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.
September 13, 2010

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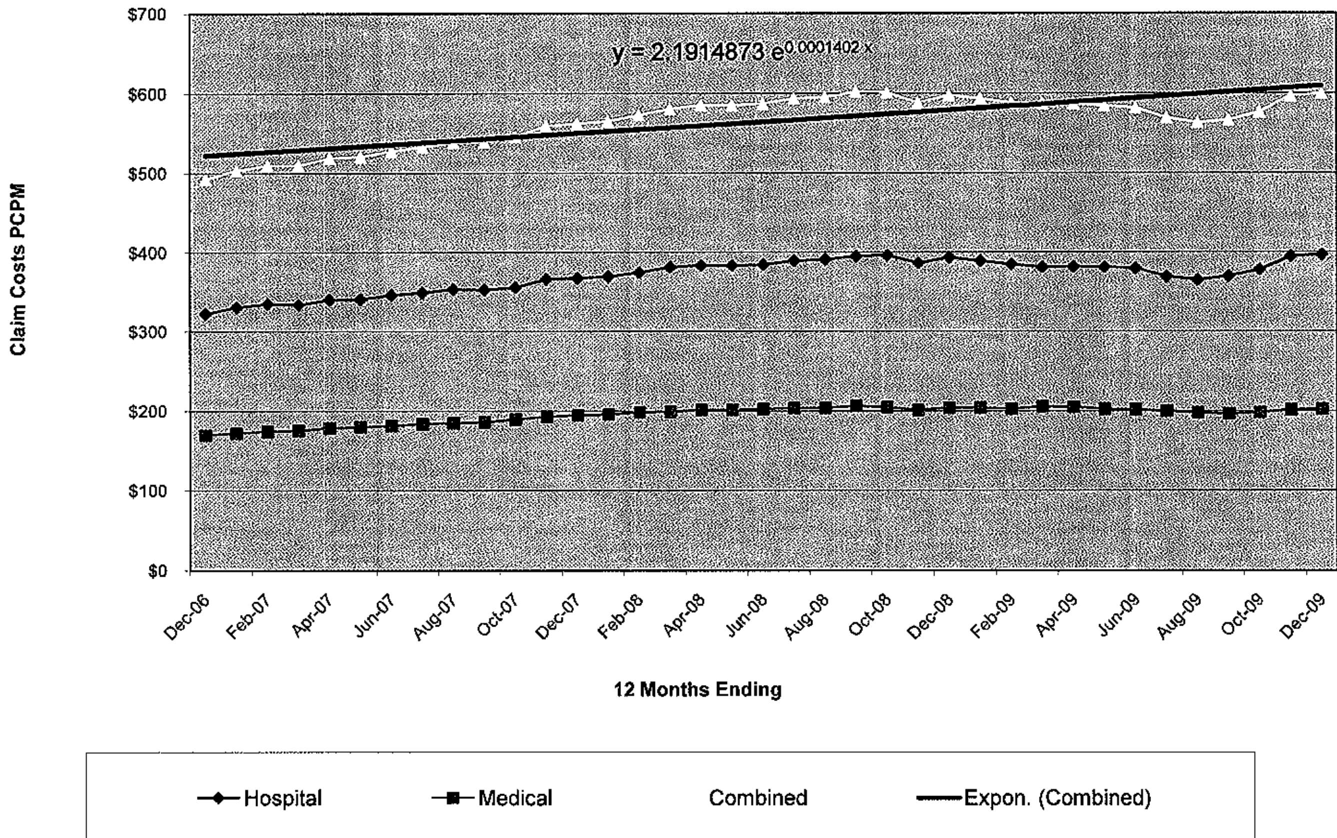
Plans A,B,E,F

Rolling 12 Mo-Claim Cost PCPM

Hospital	Medical	Combined
322.91	169.65	492.55
331.10	172.31	503.41
335.48	174.36	509.84
334.26	175.38	509.63
340.34	178.60	518.94
340.93	179.91	520.84
346.10	181.44	527.54
349.30	183.63	532.93
353.65	185.04	538.69
352.86	186.00	538.86
355.95	189.53	545.48
366.04	193.01	559.05
367.26	194.78	562.04
369.50	195.77	565.27
374.36	198.59	572.95
381.29	199.18	580.46
383.51	201.61	585.12
383.33	201.60	584.93
384.36	202.66	587.02
389.37	204.08	593.45
390.93	204.06	594.99
395.12	206.83	601.95
396.31	204.75	601.06
386.50	201.39	587.89
393.58	203.98	597.56
389.20	204.22	593.42
384.96	202.82	587.78
381.40	205.84	587.24
381.97	205.15	587.12
381.34	202.67	584.01
379.63	201.93	581.56
369.35	199.96	569.32
365.16	197.97	563.13
369.86	196.53	566.39
377.98	198.18	576.16
395.00	201.47	596.46
397.00	202.50	599.50

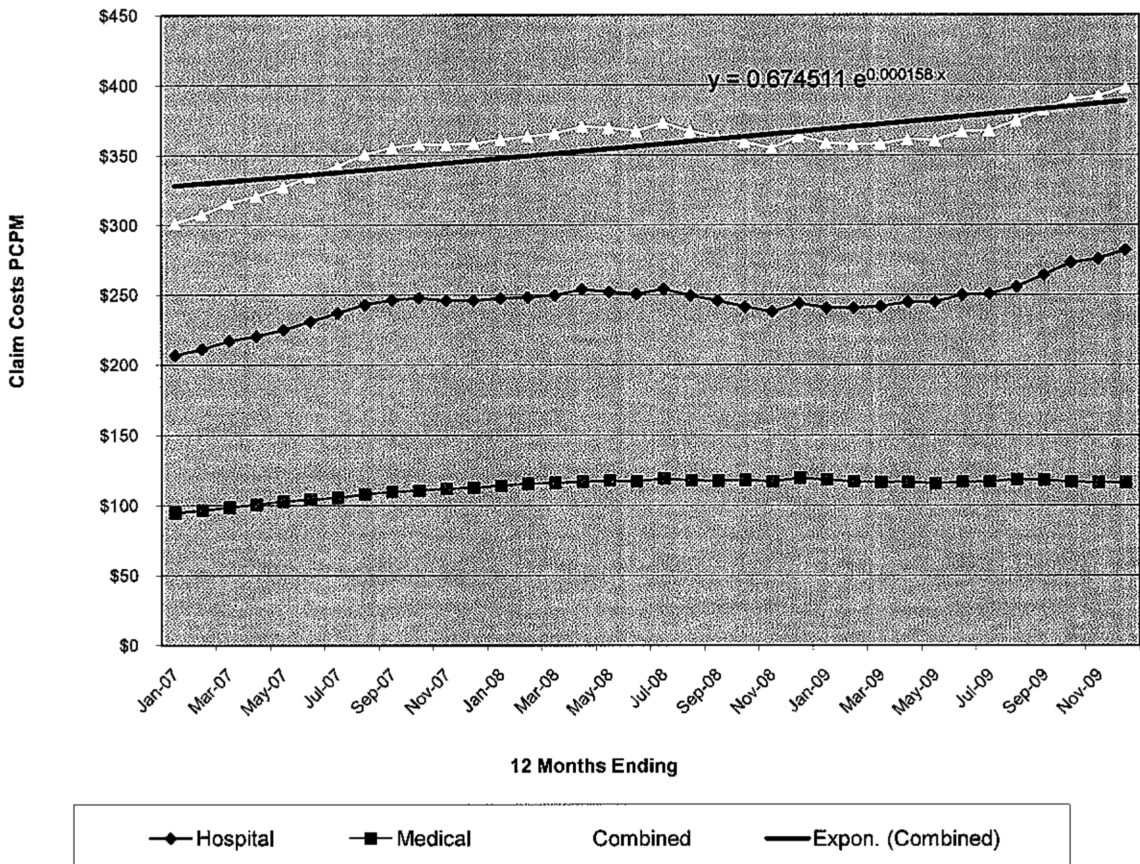


Using the exponential regression formula, combined trend was determined to be 5.3%.

Trend Analysis - Group Conversion 2010-TLH.xlsx

Plans C,D,G

12 Months Ending	Rolling 12 Mo-Claim Cost PCPM Hospital	Medical	Combined
12/1/2006	202.80	93.69	296.50
1/1/2007	206.70	94.82	301.53
2/1/2007	211.22	96.46	307.68
3/1/2007	217.12	98.63	315.75
4/1/2007	220.33	100.57	320.90
5/1/2007	224.86	102.75	327.61
6/1/2007	230.84	104.19	335.03
7/1/2007	236.98	105.44	342.42
8/1/2007	242.89	107.84	350.73
9/1/2007	246.28	109.65	355.93
10/1/2007	247.79	110.38	358.17
11/1/2007	245.96	111.80	357.76
12/1/2007	245.96	112.53	358.49
1/1/2008	247.44	113.95	361.39
2/1/2008	248.19	115.34	363.54
3/1/2008	249.56	115.96	365.52
4/1/2008	253.82	116.85	370.66
5/1/2008	252.19	117.56	369.75
6/1/2008	250.45	117.09	367.55
7/1/2008	254.14	119.04	373.18
8/1/2008	249.55	117.70	367.24
9/1/2008	245.90	117.55	363.46
10/1/2008	241.23	118.18	359.41
11/1/2008	238.07	117.01	355.08
12/1/2008	243.92	119.60	363.52
1/1/2009	240.67	118.33	359.00
2/1/2009	240.62	117.17	357.79
3/1/2009	241.67	116.68	358.36
4/1/2009	244.81	116.74	361.55
5/1/2009	244.98	115.68	360.66
6/1/2009	250.04	116.95	366.99
7/1/2009	250.68	117.13	367.81
8/1/2009	255.92	118.56	374.49
9/1/2009	264.36	118.19	382.55
10/1/2009	273.26	116.72	389.98
11/1/2009	275.83	116.39	392.22
12/1/2009	282.07	116.15	398.23

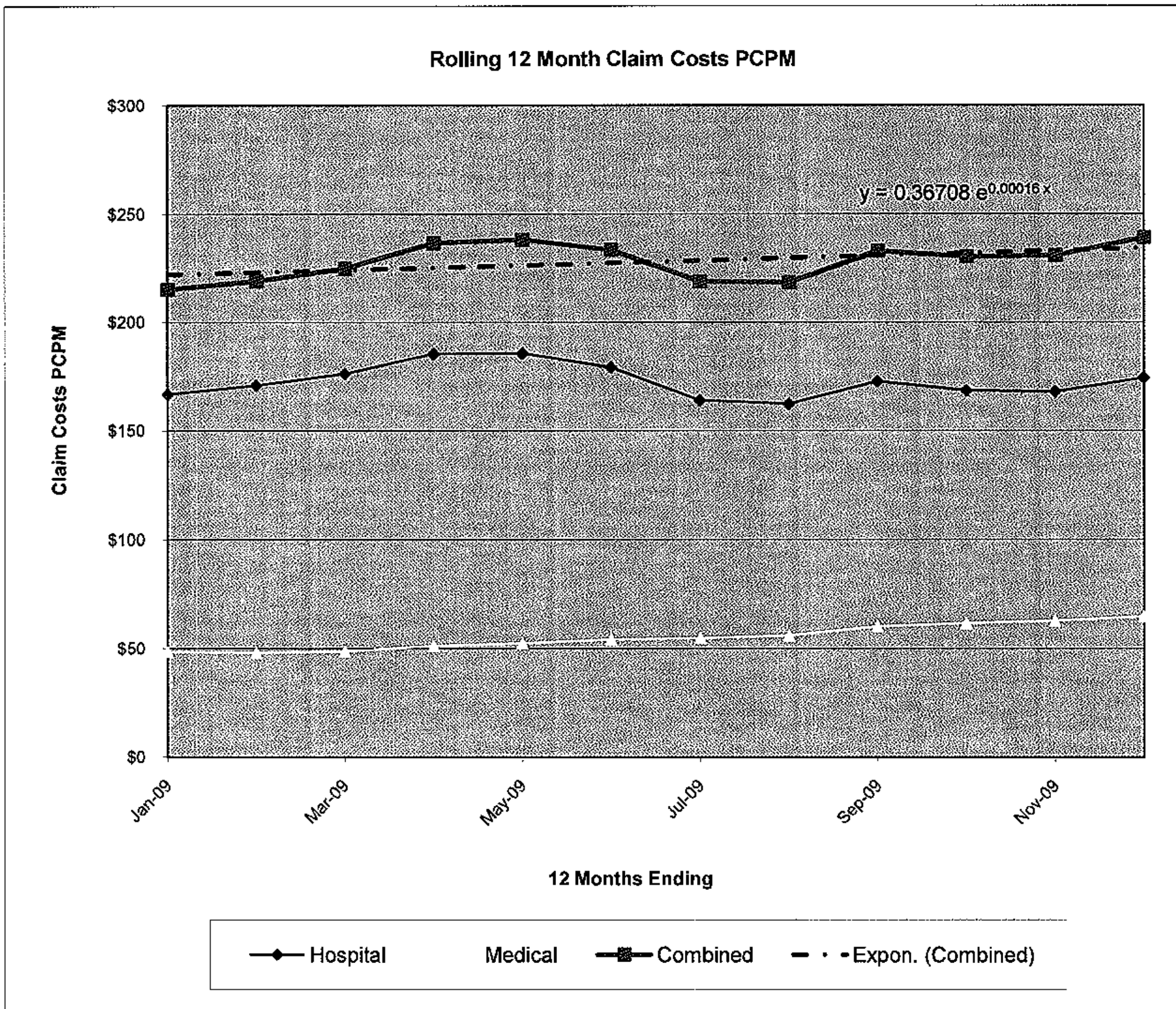


Using the exponential regression formula, combined trend was determined to be 5.9%.

Trend Analysis - Group Conversion 2010-TLH.xlsx

Plan N

12 Months Ending	Rolling 12 Mo-Claim Cost PCPM Hospital	Medical	Combined
12/1/2006	114.42	33.02	147.44
1/1/2007	105.96	32.97	138.93
2/1/2007	103.31	33.94	137.25
3/1/2007	101.37	32.87	134.25
4/1/2007	103.93	33.89	137.82
5/1/2007	106.32	34.59	140.91
6/1/2007	100.38	34.16	134.53
7/1/2007	98.93	34.94	133.86
8/1/2007	90.28	34.44	124.73
9/1/2007	93.47	35.60	129.07
10/1/2007	100.79	36.11	136.89
11/1/2007	107.95	36.28	144.23
12/1/2007	112.44	37.34	149.78
1/1/2008	106.05	35.09	141.15
2/1/2008	107.80	36.30	144.10
3/1/2008	103.98	38.30	142.28
4/1/2008	101.04	38.12	139.16
5/1/2008	98.08	37.96	136.04
6/1/2008	106.40	38.96	145.35
7/1/2008	121.67	40.89	162.56
8/1/2008	133.43	43.46	176.90
9/1/2008	132.89	43.44	176.33
10/1/2008	140.02	44.97	184.99
11/1/2008	137.50	46.06	183.56
12/1/2008	142.29	47.54	189.83
1/1/2009	166.58	48.48	215.07
2/1/2009	170.82	48.21	219.02
3/1/2009	176.17	48.70	224.87
4/1/2009	185.37	51.27	236.64
5/1/2009	185.64	52.55	238.19
6/1/2009	179.25	54.25	233.50
7/1/2009	163.98	54.91	218.88
8/1/2009	162.36	56.05	218.40
9/1/2009	172.78	60.17	232.95
10/1/2009	168.60	61.70	230.31
11/1/2009	168.01	62.85	230.86
12/1/2009	174.35	64.81	239.16

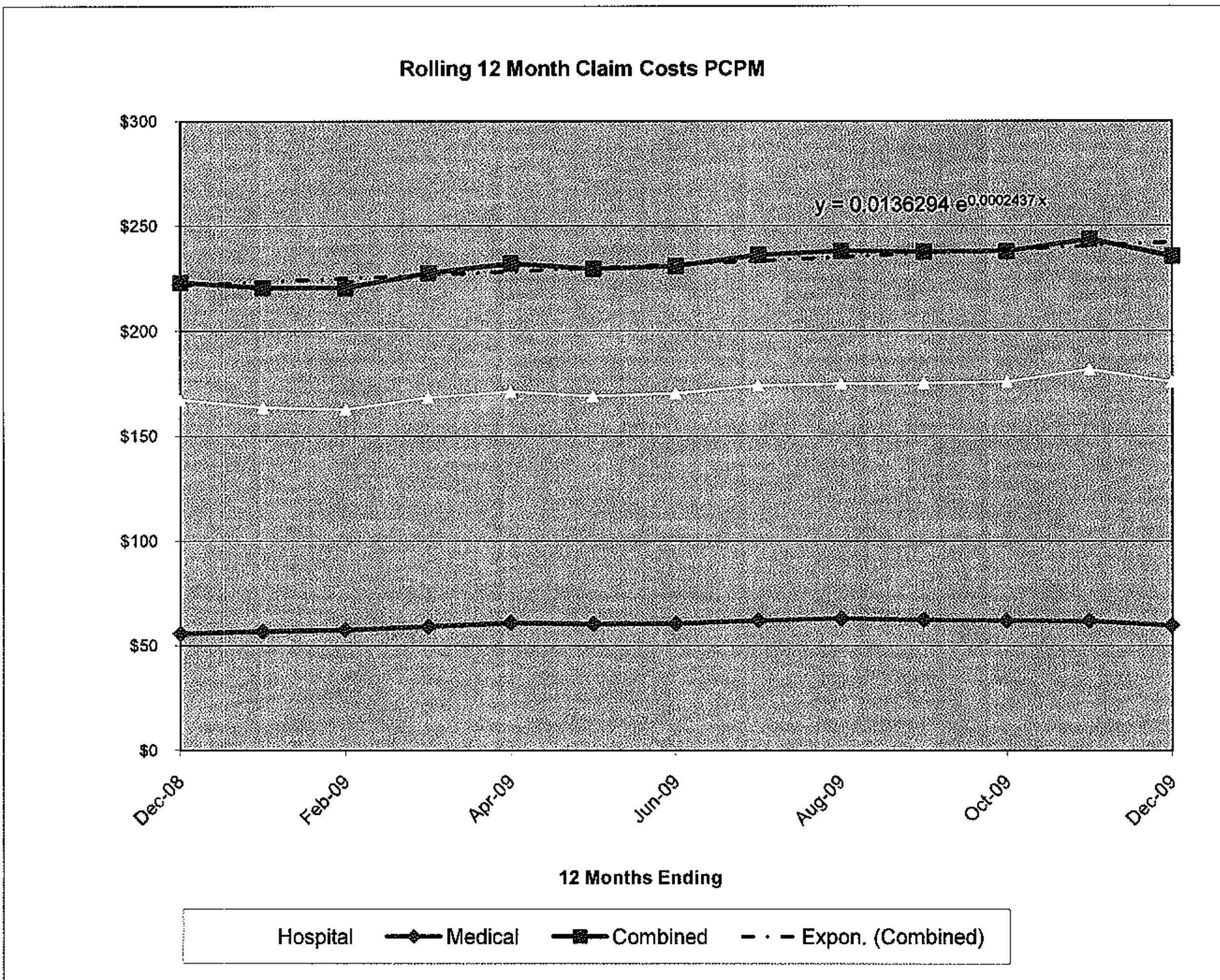


Using the exponential regression formula, combined trend was determined to be 6.0%.

Trend Analysis - Group Conversion 2010-TLH.xlsx

Plan P

12 Months Ending	Hospital	Medical	Combined
	Rolling 12 Mo-Claim Cost PCPM		
12/1/2006	91.91	43.87	135.78
1/1/2007	93.93	41.52	135.45
2/1/2007	95.62	40.78	136.40
3/1/2007	97.28	40.32	137.60
4/1/2007	102.87	41.22	144.09
5/1/2007	108.84	41.47	150.31
6/1/2007	107.57	38.88	146.45
7/1/2007	107.26	38.13	145.39
8/1/2007	107.67	38.02	145.70
9/1/2007	111.01	37.89	148.90
10/1/2007	115.70	38.68	154.38
11/1/2007	117.50	39.29	156.79
12/1/2007	123.05	39.08	162.14
1/1/2008	130.17	39.72	169.88
2/1/2008	133.65	39.65	173.30
3/1/2008	139.05	40.44	179.48
4/1/2008	138.33	40.53	178.86
5/1/2008	140.23	41.15	181.38
6/1/2008	139.90	42.32	182.23
7/1/2008	140.47	42.81	183.28
8/1/2008	147.98	44.02	192.00
9/1/2008	150.94	47.34	198.28
10/1/2008	158.60	50.15	208.74
11/1/2008	157.33	51.36	208.69
12/1/2008	167.08	55.81	222.89
1/1/2009	163.55	56.86	220.40
2/1/2009	162.78	57.52	220.31
3/1/2009	168.31	59.13	227.43
4/1/2009	171.13	60.92	232.05
5/1/2009	168.98	60.46	229.44
6/1/2009	170.24	60.69	230.93
7/1/2009	174.00	62.14	236.14
8/1/2009	174.89	63.17	238.06
9/1/2009	175.16	62.50	237.66
10/1/2009	175.73	62.11	237.84
11/1/2009	181.58	62.08	243.66
12/1/2009	175.60	59.94	235.54



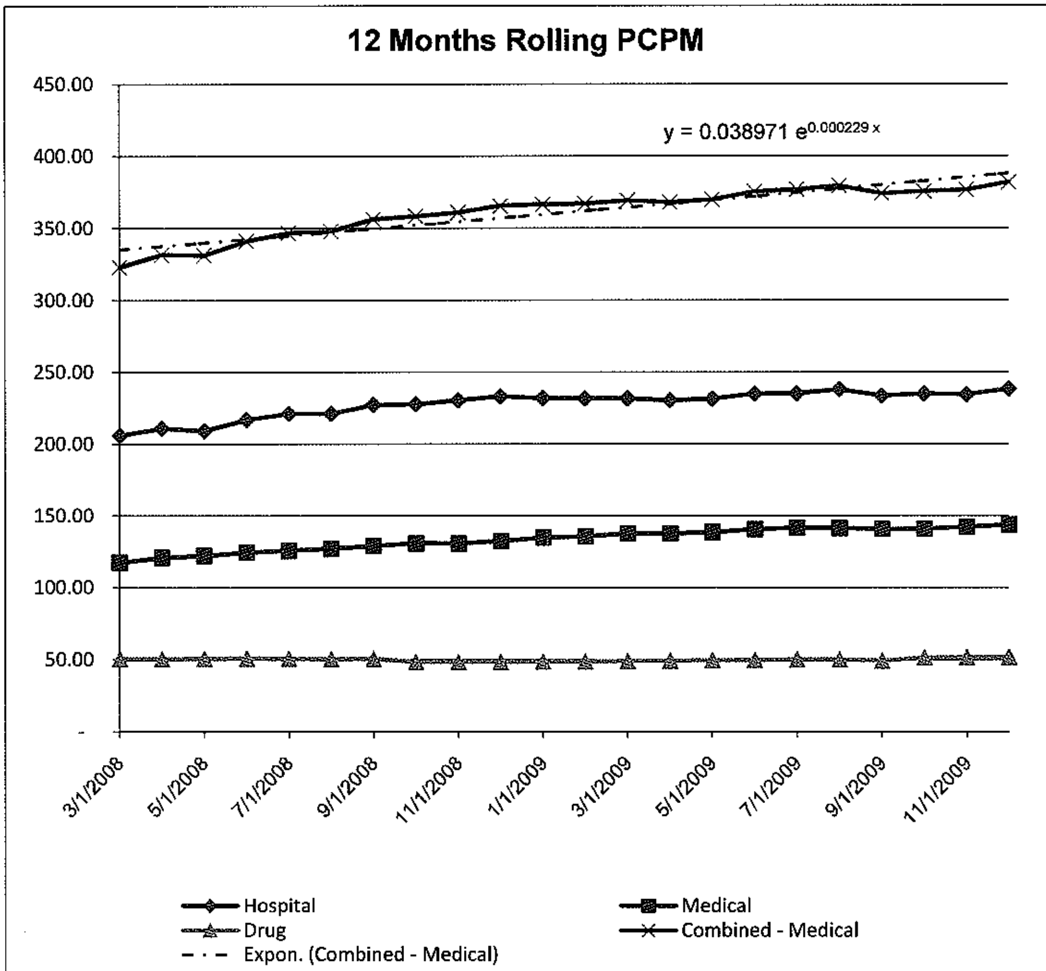
Using the exponential regression formula, combined trend was determined to be 9.3%.

Trend Analysis - Group Conversion 2010-TLH.xlsx

Plan Q

Rolling 12 Mo-Claim Cost PCPM

12 Months Ending	Hospital	Medical	Drug	Combined - Medical
12/1/2006	166.64	83.08	51.05	249.72
1/1/2007	166.11	84.52	51.63	250.63
2/1/2007	168.93	86.00	51.85	254.93
3/1/2007	168.39	87.18	51.96	255.57
4/1/2007	171.33	89.95	52.07	261.28
5/1/2007	174.82	92.68	51.63	267.50
6/1/2007	173.14	93.98	51.34	267.13
7/1/2007	177.98	97.09	51.23	275.07
8/1/2007	179.69	100.78	50.90	280.48
9/1/2007	182.22	103.35	50.35	285.57
10/1/2007	190.02	106.31	50.26	296.33
11/1/2007	189.92	109.38	49.85	299.30
12/1/2007	190.91	109.85	49.62	300.77
1/1/2008	197.29	112.98	49.85	310.27
2/1/2008	200.39	115.56	50.20	315.95
3/1/2008	205.80	117.33	50.41	323.13
4/1/2008	210.73	120.85	50.42	331.58
5/1/2008	209.14	122.12	50.67	331.26
6/1/2008	216.82	124.27	50.75	341.10
7/1/2008	221.05	125.72	50.63	346.77
8/1/2008	220.99	126.93	50.44	347.92
9/1/2008	227.37	128.83	50.57	356.20
10/1/2008	227.80	130.71	48.47	358.51
11/1/2008	230.47	130.57	48.34	361.04
12/1/2008	233.29	132.34	48.42	365.62
1/1/2009	232.08	134.60	48.71	366.69
2/1/2009	231.74	135.51	48.70	367.24
3/1/2009	231.74	137.67	49.07	369.41
4/1/2009	230.51	137.68	49.27	368.19
5/1/2009	231.54	138.52	49.46	370.06
6/1/2009	235.04	140.59	49.81	375.63
7/1/2009	235.32	141.69	50.08	377.01
8/1/2009	238.07	141.46	50.06	379.53
9/1/2009	233.60	140.73	49.26	374.33
10/1/2009	235.01	140.76	51.31	375.76
11/1/2009	234.49	142.20	51.55	376.69
12/1/2009	238.31	143.63	51.60	381.94



Using the exponential regression formula, combined trend was determined to be 8.7%.

Trend Analysis - Group Conversion 2010-TLH.xlsx

Summary

BCBS Opt Cat		# of Policies	2009 Inc Clms	Trend Hospital	Trend Medical	Trend Rx	PMPM Claim Costs Hospital	PMPM Claim Costs Medical	PMPM Claim Costs Rx	Weighted using PMPM
High	A,B,E,F	5,835	53,249,000	1.052	1.054		397.00	202.50	-	1.053
Mod	C,D,G	5,822	31,267,970	1.059	1.059		282.07	116.15	-	1.059
High & Mod		11,657	84,516,970	*Combined trend is weighted by 2009 Inc claims*						**1.055**
Value	**N**	**1,156**	**3,667,792**							**1.060**
	P	**4,124**	**12,849,479**							**1.093**
	Q	**7,157**	**39,300,308**							**1.087**
	N, P, Q	12,437	**55,817,579**							**1.087**
All Options		24,094	140,334,549							**1.068**

Q is included with N and P since all 3 classified as Value plans by BCBSM

All of above trend values were developed using exponential regression analysis and projection of PCPM values.

BASIC INFORMATION MODULE

includes utilization and cost distributed across all classes of service, benefits, and demographic rates

COMMERCIAL HMO [with Gatekeeper]: In-Network

Nation: MSA

AREA SELECTION		PRODUCT SELECTION	ACTION SELECTION
National	BY COUNTY	HMO with Gatekeeper	Apply Inputs & Calculate
Colorado	BY STATE	Use Default Benefits	
Nation	BY MSA		

% ALLOCATION TO THIS TIER OF SERVICES

Class of Services	% Allocation
Inpatient	*100%*
Outpatient	*100%*
Physician (non-Specialty)	*100%*
Physician (Specialty)	*100%*
Prescriptions	*100%*
Other	*100%*

DEGREE OF UTILIZATION MANAGEMENT

Parameters in Use Throughout Model

Aggressive · *Moderate* · *Minimal*

	Current:	Target:	*Aggressive*	*Moderate*	*Minimal*
DISCOUNT PARAMETERS:					
Hospital Inpatient Discount	*50.0%*	*50.0%*	60.0%	50.0%	5.0%
Hospital Outpatient Discount	*40.0%*	*40.0%*	50.0%	40.0%	5.0%
Physician Fee Schedule vs. RBRVS	*115.0%*	*115.0%*	100.0%	115.0%	160.0%
CHARGE PARAMETERS:					
Aggregate Hospital Charge Per Diem		*$2,320*	$2,320	$2,320	$2,320
Aggregate Outpatient Charge Per Service		*$694*	$694	$694	$694
UTILIZATION PARAMETERS:					
Hospital Inpatient Days / 1,000		*208*	163	208	277
Hospital Outpatient Services / 1,000		*660*	561	660	792
Physician Service Units / 1,000		*9,000*	7,956	9,000	10,071
Ambulance Units / 1,000		*16*	16	16	16
Durable Medical Equipment Units / 1,000		*105*	80	105	120
Home Health Visits / 1,000		*40*	35	40	50
Skilled Nursing Days / 1,000		*13*	11	13	16
Drug Prescriptions / 1,000		*7,281*	6,151	7,281	9,415

Degree of Utilization Management Notes: *degree of utilization management (aggressive, moderate, or minimum) reflect the commitment of the insurer to utilization management principles. The SLIDE BAR above puts the correct values into the RED cells (which are then recognized throughout the model). If you do not want to use the slide bar, then you can input the value desired directly into the applicable cell. We do not recommend inputting values below the aggressive or above the minimal. We have not observed nor do we expect utilization to be outside the range defined by the aggressive and minimal values.*
Discount Parameters: *CURRENT discount parameters calculate (and maintain) a constant PMPM; TARGET discount parameters adjust fee amounts calculated from the CURRENT inputs.*
The Reset: *the "reset button" above returns the slide bar to its midpoint value, and returns all "red cells" to their prior formula state - overriding any manual inputs you may have made.*

COMMERCIAL HMO [with Gatekeeper]: In-Network

Nation: MSA

Note: if a co-pay, coinsurance, or OOP applies below, enter the relevant amount. *If no such amount is applicable, "N/A" is the appropriate answer ... NOT $0.* Finally, the deductible and coinsurance *DO NOT APPLY* if a co-pay is applied.

HEALTH BENEFITS

Benefit	*Input*
Global Deductible	N/A
Global Coinsurance	N/A
Coinsurance Out-of-Pocket	N/A
Other Benefits	
Office Visit Co-Pay	$10
Office Diag X-Ray & Lab @100%?	NO
Inpatient Per Admission Deductible:	N/A
ER Co-Pay:	$50

DRUG BENEFITS

In Use?	*Benefit*	*Co-Pay*	*Utilization– Local*	*Utilization– Global*
■	Card:Brand:Ssource	$10	28%	90%
	Brand:Msource	$10	28%	90%
	Generic	$5	45%	90%
■	Mail:Brand:Ssource	$10	28%	10%
	Brand:Msource	$10	28%	10%
	Generic	$5	45%	10%

	□ Combined with Medical	□ Stand-Alone Drug Benefits
Deductible	N/A	$50
Coinsurance	N/A	80%
Coinsurance OOP	N/A	$1,000

ADDITIONAL INDIVIDUAL BENEFITS

01. Family vs. Individual Deductible	2 = 2 times; 2.5 = 2.5 times; 3 = 3 times	2
02. Lifetime Maximum	1 = 1000000; 2 = 2000000, 5 = 5000000, 9 = no limit	1
03. Special Accident	1 = not applicable; 2 = $300 benefit; 3 = $500 benefit	1
04. Covered Child Definition	19; 21; 23; 25	21

RBRVS ADJUSTERS

Work	1.000
Practice Expense	1.000
Malpractice	1.000
Work Adjuster	1.000
Conversion Rate	36.613

ADDITIONAL FINANCIAL ARRANGEMENTS:

1. If you are capitating PCPs, enter the Monthly Cap Rate otherwise, leave this entry set to $0.00. **$0.00**
2. Psychiatric & Substance Abuse [institutional & physician] shown as "Carve-Out" [YES or NO], or enter Capitated Amount [#.##]. **NO**
3. Is Maternity a Covered Benefit [YES or NO]? **YES**

STANDARD BENEFIT PLAN: $10 OV Co-Pay, $5 / $10 DRUG co-pays, and a $50 ER C
Pay. Plans differing from this plan will activate "Adjustment Factors", altering your inpu
utilization numbers.

Allows you to adjust the utilization and discount assumptions
You can also enter the benefit plan desired

BASIC INFORMATION MODULE

includes utilization and cost distributed across all classes of service, benefits, and demographic rates

COMMERCIAL HMO [with Gatekeeper]: In-Network

Nation: MSA

SERVICE CLASSES		Rate Per 1000	Cost Per Unit	PMPM	% of Claims	Co-pay	Value of Co-pay	Value of Plan
HOSPITAL INFORMATION:								
Inpatient Acute	Medical	58	$1,044	$5.05	4.0%	$0	$0.00	($0.00)
	Surgical	71	1,350	7.98	6.4%	0	0.00	0.00
	Medical/Surgica	129	1,212	13.03	10.4%		0.00	0.00
	Rehabilitation	0	0	0.00	0.0%	0	0.00	0.00
	ICU	23	1,694	3.23	2.6%	0	0.00	0.00
	Maternity: Normal Deliveries	27	1,067	2.36	1.9%	0	0.00	0.00
	Maternity: C-Section	9	1,067	0.79	0.6%	0	0.00	0.00
	Maternity: Total Delivery	35	1,067	3.14	2.5%		0.00	0.00
	Psychiatric	16	423	0.55	0.4%	0	0.00	0.00
	Substance Abuse	5	360	0.16	0.1%	0	0.00	0.00
	Psychiatric / Sub Abuse	21	407	0.71	0.6%		0.00	0.00
	Acute Subtotal	208	$1,160	$20.11	16.1%		$0.00	($0.00)
SNF	Skilled Nursing	13	389	0.42	0.3%	0	0.00	0.00
	Inpatient Total			$20.53	16.5%		$0.00	($0.00)
Outpatient	Emergency Room	162	$308	$4.15	3.3%	$50	($0.67)	$0.00
	Outpatient Surgery	73	1,768	10.70	8.6%	0	0.00	0.00
	Lab	178	83	1.24	1.0%	0	0.00	0.00
	X-Ray	119	333	3.30	2.6%	0	0.00	0.00
	Lab & X-Ray	297	183	4.53	3.6%		0.00	0.00
	Therapy	0	0	0.00	0.0%	0	0.00	0.00
	Observation Units	0	0	0.00	0.0%	0	0.00	0.00
	Other	129	327	3.51	2.8%	0	0.00	0.00
	Outpatient Sub-Total	660	$416	$22.89	18.3%		($0.67)	($0.00)
	Home Health Visits	40	198	0.66	0.5%	0	0.00	0.00
	Outpatient Total			$23.55	18.9%		($0.67)	($0.00)

Shows detailed cost and utilization results
Based on assumptions and benefits you entered

COMMERCIAL HMO [with Gatekeeper]: In-Network

Nation: MSA

CLAIM COST SUMMARIZATION BY CLASSIFICATION OF SERVICE

Classification		Gross Information Cost	Gross Information % of Total	Net Information Cost	Net Information % of Total
Hospital:					
	Inpatient	$20.53	16.5%	$20.53	17.7%
	Outpatient	$23.55	18.9%	$22.87	19.7%
Physician:					
	Primary Care	$18.19	14.6%	$15.81	13.6%
	Specialty	$31.42	25.2%	$30.83	26.5%
	X-Ray	$2.92	2.3%	$2.92	2.5%
	Laboratory	$2.15	1.7%	$2.15	1.9%
Miscellaneous:					
	Other	$1.39	1.1%	$1.39	1.2%
	Drugs	$24.63	19.7%	$19.79	17.0%
	Psych / Sub Abuse				
TOTAL		$124.77	100.0%	$116.29	100.0%

CLAIM COST SUMMARIZATION BY AGE AND SEX

Sex	Age Bracket	Hospital Inpat	Hospital Outpat	Physician Primary	Physician Specialty	Other	Drugs	Total	Composite Rates
Male	0	$36.61	$23.34	$30.02	$70.62	$0.95	$13.58	$175.12	Adult
	1-2	18.71	18.46	13.51	20.89	0.81	11.59	83.97	140.16
	3-12	9.12	11.03	7.15	17.70	0.76	10.82	56.58	
	13-17	8.67	11.93	6.36	16.51	0.76	10.82	55.04	Child
	18-29	11.11	14.98	10.51	21.52	0.75	10.75	69.61	65.57
	30-39	12.59	19.42	11.65	25.82	1.00	14.33	84.82	
	40-49	21.96	28.58	15.28	38.74	1.54	21.98	128.07	
	50-59	40.72	30.52	22.92	58.96	2.41	34.40	189.93	
	60-64	62.19	44.39	34.00	86.51	3.45	49.21	279.74	
Female	0	$36.61	$23.34	$30.02	$70.62	$0.95	$13.58	$175.12	
	1-2	18.71	18.46	13.51	20.89	0.81	11.59	83.97	
	3-12	9.12	11.03	7.15	17.70	0.76	10.82	56.58	
	13-17	10.85	10.51	6.36	19.15	0.76	10.82	58.45	
	18-29	29.61	29.69	22.16	51.22	1.71	24.36	158.75	
	30-39	25.91	28.30	21.97	48.20	1.84	26.27	152.50	
	40-49	23.69	33.29	22.16	46.48	1.84	26.27	153.74	
	50-59	28.63	36.07	26.36	51.65	2.34	33.44	178.48	
	60-64	47.38	45.78	33.24	68.86	2.91	41.56	239.73	

MULTI-NETWORK RATING

includes utilization and cost distributed across all classes of service, benefits, and demographic rates, for multiple networks / sets of benefits.

COMMERCIAL HMO [with Gatekeeper]: In-Network

Nation: MSA

AREA SELECTION: National — BY COUNTY; Colorado — BY STATE; Nation — BY MSA

PRODUCT SELECTION: HMO with Gatekeeper; Use Default Benefits

ACTION SELECTION: Apply Inputs & Calculate

% ALLOCATION TO THIS TIER OF SERVICES

Class of Services	% Allocation
Inpatient	70%
Outpatient	70%
Physician (non-Specialty)	70%
Physician (Specialty)	70%
Prescriptions	70%
Other	70%

DEGREE OF UTILIZATION MANAGEMENT

Parameters in Use Throughout Model

Aggressive — *Moderate* — *Minimal*

	Current:	Target:	Aggressive	Moderate	Minimal
DISCOUNT PARAMETERS:					
Hospital Inpatient Discount	50.0%	50.0%	60.0%	50.0%	5.0%
Hospital Outpatient Discount	40.0%	40.0%	50.0%	40.0%	5.0%
Physician Fee Schedule vs. RBRVS	115.0%	115.0%	100.0%	115.0%	160.0%
CHARGE PARAMETERS:					
Aggregate Hospital Charge Per Diem		$2,320	$2,320	$2,320	$2,320
Aggregate Outpatient Charge Per Service		$694	$694	$694	$694
UTILIZATION PARAMETERS:					
Hospital Inpatient Days / 1,000		208	163	208	277
Hospital Outpatient Services / 1,000		660	561	660	792
Physician Service Units / 1,000		9,000	7,956	9,000	10,071
Ambulance Units / 1,000		16	16	16	16
Durable Medical Equipment Units / 1,000		105	80	105	120
Home Health Visits / 1,000		40	35	40	50
Skilled Nursing Days / 1,000		13	11	13	16
Drug Prescriptions / 1,000		7,281	6,151	7,281	9,415

Degree of Utilization Management Notes: *degree of utilization management (aggressive, moderate, or minimum) reflect the commitment of the insurer to utilization management principles. The SLIDE BAR above puts the correct values into the RED cells (which are then recognized throughout the model). If you do not want to use the slide bar, then you can input the value desired directly into the applicable cell. We do not recommend inputting values below the aggressive or above the minimal. We have not observed nor do we expect utilization to be outside the range defined by the aggressive and minimal values.*

Discount Parameters: *CURRENT discount parameters calculate (and maintain) a constant PMPM; TARGET discount parameters adjust fee amounts calculated from the CURRENT inputs.*

The Reset: *the "reset button" above returns the slide bar to its midpoint value, and returns all "red cells" to their prior formula state - overriding any manual inputs you may have made.*

COMMERCIAL HMO [without Gatekeeper]: Out-of-Network

Nation: MSA

AREA SELECTION: National — BY COUNTY; Colorado — BY STATE; Nation — BY MSA

PRODUCT SELECTION: HMO without Gatekeeper; Use Default Benefits

APPLY

PRINT THIS SHEET

% ALLOCATION TO THIS TIER OF SERVICES

Class of Services	% Allocation
Inpatient	20%
Outpatient	20%
Physician (non-Specialty)	20%
Physician (Specialty)	20%
Prescriptions	20%
Other	20%

DEGREE OF UTILIZATION MANAGEMENT

Parameters in Use Throughout Model

Aggressive — *Moderate* — *Minimal*

	Current:	Target:	Aggressive	Moderate	Minimal
DISCOUNT PARAMETERS:					
Hospital Inpatient Discount	50.0%	50.0%	60.0%	50.0%	5.0%
Hospital Outpatient Discount	40.0%	40.0%	50.0%	40.0%	5.0%
Physician Fee Schedule vs. RBRVS	115.0%	115.0%	100.0%	115.0%	160.0%
CHARGE PARAMETERS:					
Aggregate Hospital Charge Per Diem		$2,320	$2,320	$2,320	$2,320
Aggregate Outpatient Charge Per Service		$694	$694	$694	$694
UTILIZATION PARAMETERS:					
Hospital Inpatient Days / 1,000		208	163	208	277
Hospital Outpatient Services / 1,000		660	561	660	792
Physician Service Units / 1,000		9,000	7,956	9,000	10,071
Ambulance Units / 1,000		16	16	16	16
Durable Medical Equipment Units / 1,000		105	80	105	120
Home Health Visits / 1,000		40	35	40	50
Skilled Nursing Days / 1,000		13	11	13	16
Drug Prescriptions / 1,000		7,281	6,151	7,281	9,415

Degree of Utilization Management Notes: *degree of utilization management (aggressive, moderate, or minimum) reflect the commitment of the insurer to utilization management principles. The SLIDE BAR above puts the correct values into the RED cells (which are then recognized throughout the model). If you do not want to use the slide bar, then you can input the value desired directly into the applicable cell. We do not recommend inputting values below the aggressive or above the minimal. We have not observed nor do we expect utilization to be outside the range defined by the aggressive and minimal values.*

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The Reset: *the "reset button" above returns the slide bar to its midpoint value, and returns all "red cells" to their prior formula state - overriding any manual inputs you may have made.*

MULTI-NETWORK RATING

includes utilization and cost distributed across all classes of service, benefits, and demographic rates, for multiple networks / sets of benefits.

COMMERCIAL PPO: Out-of-Area

Nation: MSA

AREA SELECTION: National — BY COUNTY; Colorado — BY STATE; Nation — BY MSA

PRODUCT SELECTION: PPO; Use Default Benefits

APPLY

PRINT THIS SHEET

% ALLOCATION TO THIS TIER OF SERVICES

Class of Services	% Allocation
Inpatient	10%
Outpatient	10%
Physician (non-Specialty)	10%
Physician (Specialty)	10%
Prescriptions	10%
Other	10%

DEGREE OF UTILIZATION MANAGEMENT

Parameters in Use Throughout Model

Aggressive — *Moderate* — *Minimal*

	Current	Target	Aggressive	Moderate	Minimal
DISCOUNT PARAMETERS:					
Hospital Inpatient Discount	40.0%	22.5%	50.0%	40.0%	5.0%
Hospital Outpatient Discount	35.0%	20.0%	45.0%	35.0%	5.0%
Physician Fee Schedule vs. RBRVS	125.0%	150.0%	110.0%	125.0%	175.0%
CHARGE PARAMETERS:					
Aggregate Hospital Charge Per Diem		$2,320	$2,320	$2,320	$2,320
Aggregate Outpatient Charge Per Service		$694	$694	$694	$694
UTILIZATION PARAMETERS:					
Hospital Inpatient Days / 1,000		279	187	239	319
Hospital Outpatient Services / 1,000		778	645	646	911
Physician Service Units / 1,000		8,897	7,299	8,370	9,425
Ambulance Units / 1,000		16	16	16	16
Durable Medical Equipment Units / 1,000		113	80	105	120
Home Health Visits / 1,000		47	37	42	53
Skilled Nursing Days / 1,000		15	12	14	17
Drug Prescriptions / 1,000		8,157	6,011	7,115	9,200

Degree of Utilization Management Notes: *degree of utilization management (aggressive, moderate, or minimum) reflect the commitment of the insurer to utilization management principles. The SLIDE BAR above puts the correct values into the RED cells (which are then recognized throughout the model). If you do not want to use the slide bar, then you can input the value desired directly into the applicable cell. We do not recommend inputting values below the aggressive or above the minimal. We have not observed nor do we expect utilization to be outside the range defined by the aggressive and minimal values.*

Discount Parameters: *CURRENT discount parameters calculate (and maintain) a constant PMPM; TARGET discount parameters adjust fee amounts calculated from the CURRENT inputs.*

The Reset: *the "reset button" above returns the slide bar to its midpoint value, and returns all "red cells" to their prior formula state - overriding any manual inputs you may have made.*

RATING SUMMARIZATION

Nation: MSA

GENERAL PRODUCT INFORMATION

Class of Services	In-Network	Out-of Network	Out-of Area
Area	Nation: MSA	Nation: MSA	Nation: MSA
Product	COMMERCIAL HMO [with Gatekeeper]	COMMERCIAL HMO [without Gatekeeper]	COMMERCIAL PPO

% ALLOCATION OF SERVICES

Class of Services	Composite	In-Network	Out-of Network	Out-of Area
Inpatient	100.0%	70%	20%	10%
Outpatient	100.0%	70%	20%	10%
Physician (non-Specialty)	100.0%	70%	20%	10%
Physician (Specialty)	100.0%	70%	20%	10%
Prescriptions	100.0%	70%	20%	10%
Other	100.0%	70%	20%	10%

ACCUMULATION OF SERVICES

	Composite	In-Network	Out-of Network	Out-of Area
Hospital Inpatient Days / 1,000	215	208	208	279
Hospital Outpatient Services / 1,000	672	660	660	778
Physician Service Units / 1,000	9,672	9,000	9,000	8,897
Ambulance Units / 1,000	16	16	16	16
Durable Medical Equipment Units / 1,000	106	105	105	113
Home Health Visits / 1,000	41	40	40	47
Skilled Nursing Days / 1,000	13	13	13	15
Drug Prescriptions / 1,000	7,369	7,281	7,281	8,157
CHARGE PARAMETERS:				
Aggregate Hospital Charge Per Diem		$2,320	$2,320	$2,320
Aggregate Outpatient Charge Per Service		$694	$694	$694
DISCOUNT PARAMETERS:				
Hospital Inpatient Discount		50.0%	50.0%	22.5%
Hospital Outpatient Discount		40.0%	40.0%	20.0%
Physician Fee Schedule vs. RBRVS		115.0%	115.0%	150.0%

Shows all of the elements of the multi-network costs

WORKSHEET 1 - BASE PERIOD EXPERIENCE AND PROJECTION ASSUMPTIONS

I. General Information

1. Contract Number:		5. Organization Name		8. Enrollee Type:		11. Region Name:
2. Plan ID:		6. Plan Name:		9. Region of State:		One of regions must be total state
3. Segment ID:		7. Plan Type:		10. Nationwide (Yes or No)		
4. Contract Year:	2010					

II. Base Period Background Information

			Total			
1. Time Period Definition		2. Member Months		5. Plans In Base	Contract-Plan ID	% of MMs
Incurred from:				a.		
Incurred to:		4. Completion Factor		b.		
Paid through:				c.		
				d.		

6. Describe the source of the base period experience data (1000 character limit)

III. Base Period Data / IV. Projection Assumptions

	(c)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)
			Total Benefits			Util. Adjustments to Contract Period				Unit Cost/ Intensity Trend	Additive Adjustments	
	Service Category	Util Type	Annualized Util/1000	Avg Cost	Allowed PMPM	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor		Util/1000	PMPM
a	Inpatient Facility-medical			$0.00								
b	Inpatient Facility-surgery			$0.00								
c	Inpatient Facility-maternity			$0.00								
d	Inpatient Facility-MHSA			$0.00								
e	Skilled Nursing Facility			0.00								
f	Home Health			0.00								
g	Ambulance			0.00								
h	DME/Prosthetics/Supplies			0.00								
i	OP Facility - Emergency			0.00								
j	OP Facility - Surgery			0.00								
k	OP Facility - Other			0.00								
l	Physician-primary care			0.00								
m	Physician-surgery			0.00								
n	Physician-maternity			0.00								
o	Physician-other			0.00								
p	non-Physician lab			0.00								
q	non-Physician radiology			0.00								
r	non-Physician therapy			0.00								
s.	non-Physician other			0.00								
t	Prescription drug			0.00								
u	COB/Subrg. (outside claim system)											
v	**Total Medical Expenses**				**$0.00**							
w	Subtotal Covered Services				$0.00							

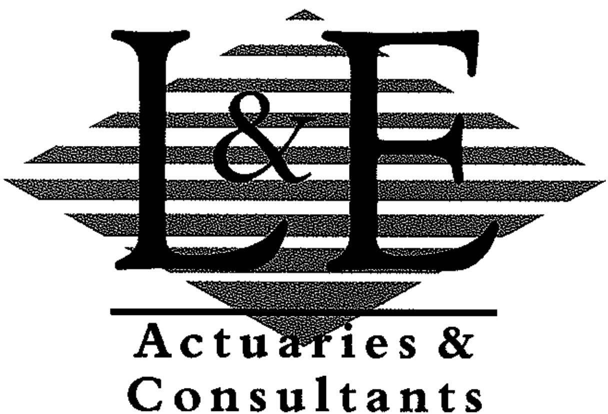
V. Description of Other Utilization Factor and Additive Values (1000 character limit)

Health Care Reform – What Does It Mean?

-To Employers

- To Insurers

Presented by Tom Handley - Lewis & Ellis, Inc.



What are the Key Provisions?

- Coverage and Benefit Reforms
- Individual Mandates
- Employer Mandates and Requirements
- Insurance Reforms
- Benefit Exchanges
- Medicare Changes
- Taxes and Fees
- Grandfathered Health Plans?

Coverage and Benefit Reforms
Plan Years beginning 10-1-2010 and later

- Provide coverage for a dependent child to age 26
- Lifetime limits on essential benefits are prohibited
- Annual limits must be approved by HHS
- Children's pre-existing exclusions prohibited for children under 19
- Rescission of coverage prohibited (except in case of fraud)
- Cost sharing prohibited for preventive services (as defined by US Preventive Services Task Force)

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Coverage and Benefit Reforms
Plan Years beginning 10-1-2010 and later

- Lifetime limits on essential benefits are prohibited
  Increase to unlimited (from $2 million) – 0.1%
  Equivalent to $0.50 single, $1.40 family

- Annual limits allowed by HHS (until 2014)
  $750,000 – savings of 0.56% to 1.36%
  $1,250,000 – savings of 0.11% to 0.43%
  Savings from current expense

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Coverage and Benefit Reforms Plan Years beginning 1-1-2014 and later

- Annual limits prohibited for plan years beginning 1-1-2014
- Waiting periods greater than 90 days prohibited
- No pre-existing conditions exclusions or limitations regardless of age
- Provide coverage for a dependent child to age 26
  - even if eligible under other employer plan
- Limits on annual cost-sharing are same as HSA
  ($5,950 single and $11,900 family for 2010)
- Small employer (100 or less) maximum deductible is $2,000
- Four levels of coverage – Bronze (60%), Silver (70%), Gold (80%) and Platinum (90%)

Individual Mandates

Requires US citizens and legal residents to have coverage or there is a tax penalty

If an Individual has employer-sponsored coverage then mandate is satisfied

Tax Penalty (for Individuals with no coverage)

2010 – 2013 None

2014 Greater of $95 per person in household or 1% of income

2015 Greater of $325 per person in household or 2% of income

2016 Greater of $695 per person in household or 2.5% of income

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Employer Requirements

Required to offer coverage

Employers with more than 200 employees are required to automatically enroll employees into health plan. Employee may opt out.

Employer will be required to include cost of employer-sponsored coverage on W-2. Effective 1-1-2011

Penalty Fees (Effective 1-1-2014)

Penalty Fee – No Offer 50 or fewer employees	None
Penalty Fee – No Offer More than 50 employees	$2,000 per employee per year Excludes first 30 employees
Penalty Fee – With Offer More than 50 employees	Lesser of $3,000 for each employee with premium tax credit or $2,000 per employee

Insurance Reforms
Plan Years beginning 10-1-2010 and later

- Minimum loss ratio required
- Rebate required if loss ratio < minimum requirement
- Minimum LR - Large group (over 100 employees) – 85%
- Minimum LR - Small group and Individual – 80%
- Establish an annual review of <u>unreasonable</u> increases in premiums
- Insurers will be required to submit to HHS and State a justification of increase prior to implementation.

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Insurance Reforms
Plan Years beginning 1-1-2014 and later

- Allowed variables for rating
  - Single versus family
  - Area
  - Age (cannot vary by more than 3 to 1)
  - Tobacco use (cannot vary by more than 1.5 to 1)
- Cannot use gender as a rating variable
- Discrimination based on health status is prohibited
- Each insurer must accept every employer or individual who applies (Can have open enrollment restrictions)
- Each insurer required to renew coverage as long as in market

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Benefit Exchanges

- Each State not later than 1-1-2014 shall establish a Benefit Exchange
- Will facilitate purchase of qualified health plans
- Administered by a governmental agency or non-profit organization
- Individuals and small employers (up to 100) can purchase coverage through Exchange
- Individual employees can choose coverage through Exchange versus company plan
- There can be more than one Exchange in State but must be for different geographic areas
- State-licensed insurers will be required to participate

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Essential Health Benefits

- The essential health benefits that must be included in a qualified health plan (for individual and small employer coverage) are listed below
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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Medicare Changes

- Part D coinsurance will be gradually increased in "gap" from 0% in 2010 to 75% by 2020
- Will require a 50% discount from Drug Manufacturers on brand name drugs filled in gap beginning 2011
- Part D premiums will become income-related
- Medicare Advantage payments will be frozen in 2011
- Reductions in Medicare Advantage payments begin in 2012
- Result – fewer Medicare Advantage plans and more expensive

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Taxes and Fees

- FSA accounts – over-the–counter drugs not prescribed are excluded (applies to HSA as well)
- FSA accounts – effective 1-1-2013, medical expense limited to $2,500
- Medicare Part A tax rate increased from 1.45% to 2.35% on wages > $200,000 (single) effective 1-1-2013
- Cadillac tax effective 1-1-2018. Tax is 40% of value greater than

  Annual single cost of $10,200

  Annual family cost of $27,500
- Annual fee for Drug Manufacturer effective 1-1-2012. We have estimated payments will be equivalent to 0.25%-0.40% of premium.
- Annual fee for health insurers beginning 2014. We have estimated payments will be equivalent to 0.65% - 0.90% of premium.
- There will be a comparative effectiveness research fee of $1 per participant first year and $2 per participant thereafter. Begins with policy year ending after 9-30-2012 through 9-30-2019.

Taxes and Fees

Cadillac tax effective 1-1-2018. Tax is 40% of value greater than

Annual single cost of $10,200

Annual family cost of $27,500

What does that mean for you now?

If annual trend to 2018 is:		8.7%	6.0%	5.0%	10.0%
Maximum Monthly	Single	436.10	533.30	575.31	396.53
Premiums in 2010	Family	1,175.75	1,437.82	1,551.09	1,069.08

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Grandfather Health Plans

- Any group or individual health plan effective on 3-23-2010
- Can be insured or self-insured
- Regulations will clarify impact of changes to plan that might impact status as Grandfathered plan.
- Provisions that do <u>not</u> apply to Grandfather plans
  - Coverage of preventive services at 100%
  - Prohibition of preauthorization for OB/GYN, ER and Pediatrician services
  - Prohibition in favor of highly compensated employees under insured plans
  - Limitations on out-of-pocket maximums and deductibles

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Grandfather Health Plans

Maximum Percent Increase (Applies to Deductibles, OOP amounts, copays)

= Change in overall medical care of CPI-U since March 2010

+ 15%

Year	CPI-U annual %	Maximum Deductible
2010		500
2011	4.0%	592
2013	4.0%	634
2015	4.0%	679

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What Did Not Get Addressed

- Did not make any changes in reimbursement for health care
- Did not address rising costs other than to aggressively oversee Insurer premium increases
- This law will not lower cost of care or insurance premiums
- Cost is important

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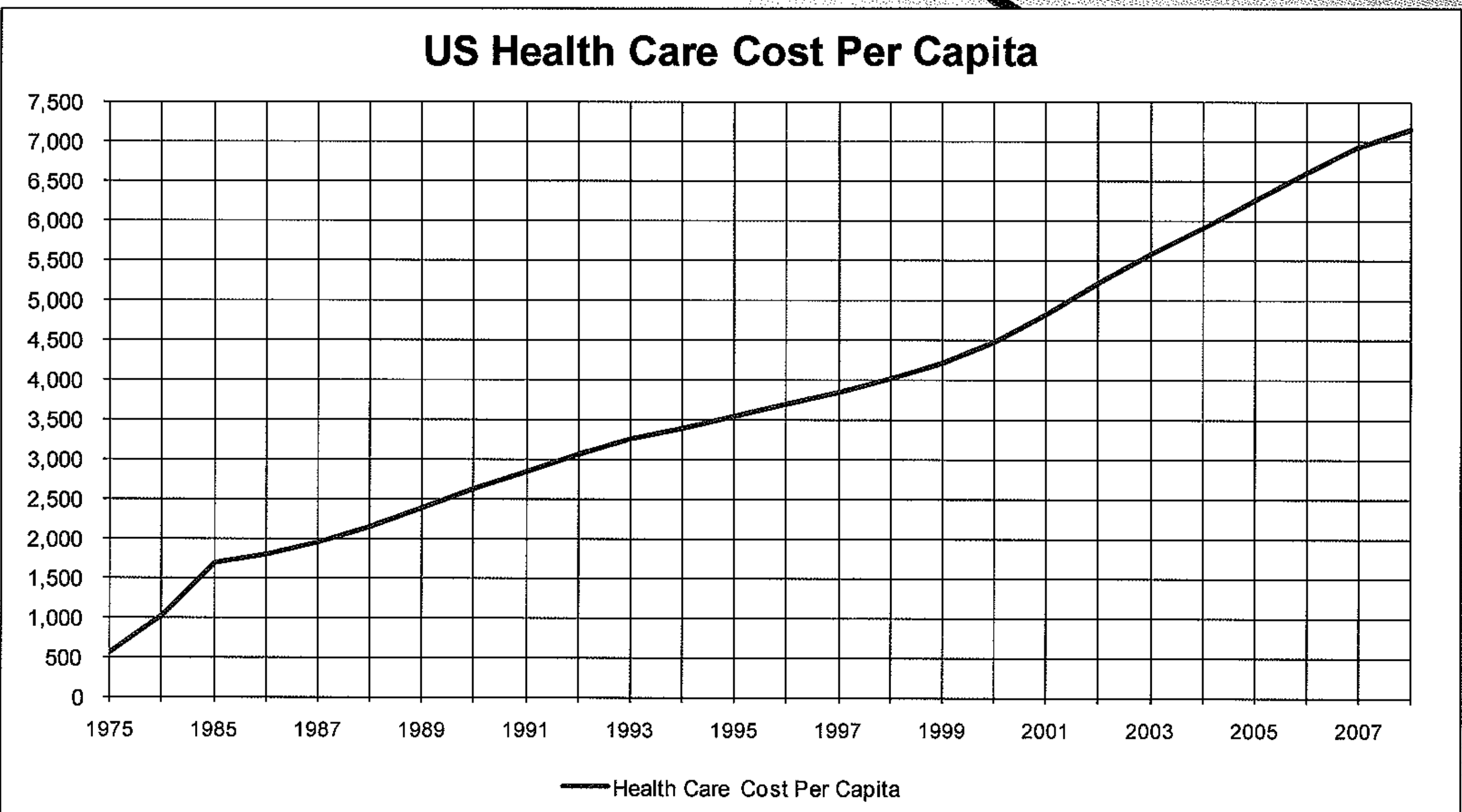
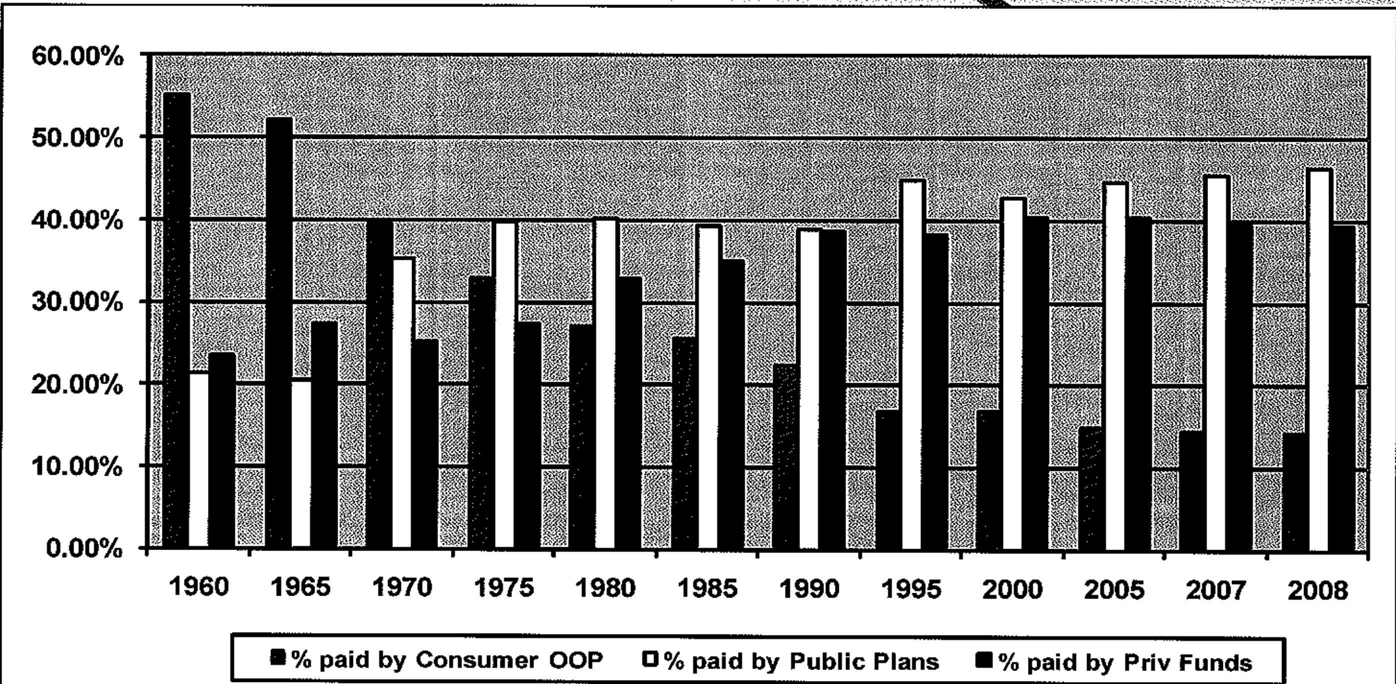
Historical Change in Health Care Cost



Who is Paying for the Care?



Big surprise - in 1960s most of health care paid by consumer.
Medicare and Medicaid enactment in 1965 has caused significant change.
Publicly financed is almost 50% now.

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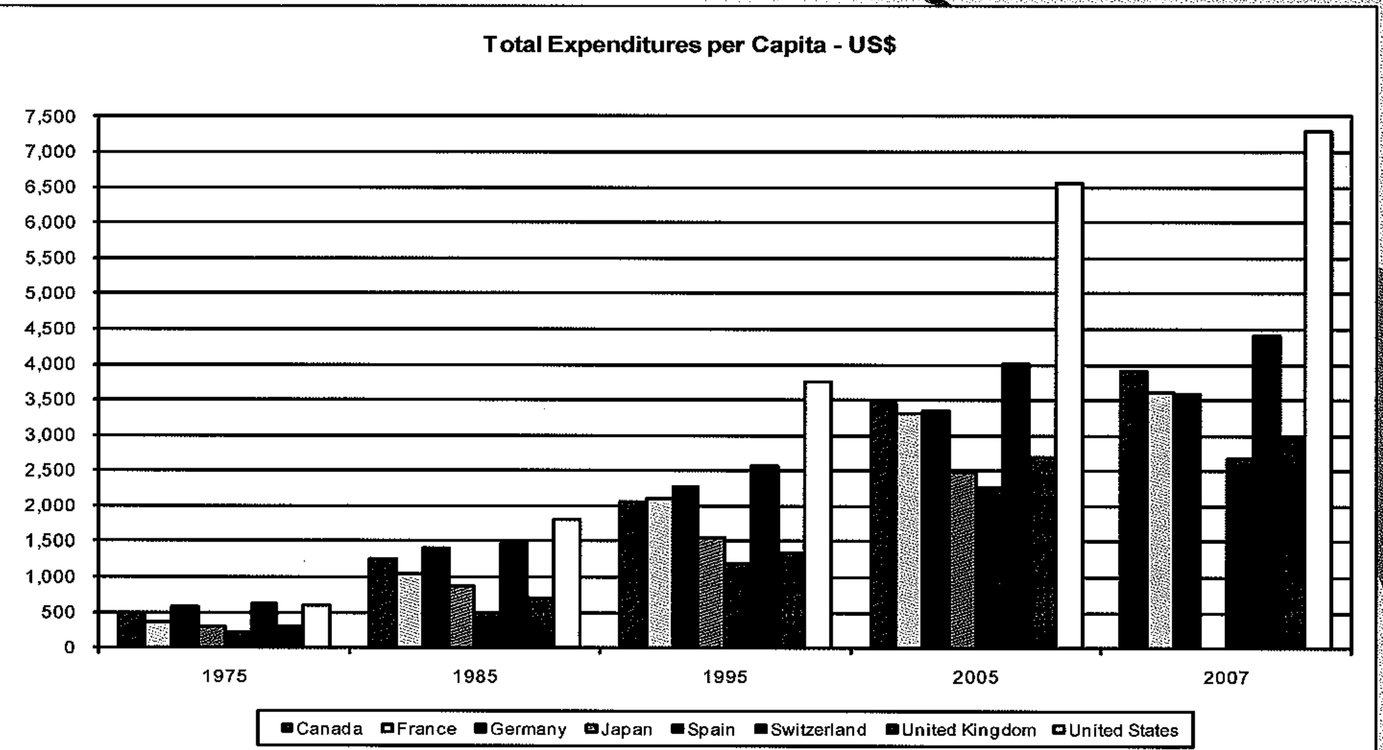
US Costs versus Other Countries



Compares US costs to selected other industrial economies and health systems.
Above costs have been adjusted to US dollars.

Why is the US Higher

Category	US Rates	Rest of World
MRI Use	26 units per million	9 units per million
Cat Scan Use	34 units per million	19 units per million
CABG	85 proc per 100,000	59 proc per 100,000
Angioplasties	435 proc per 100,000	190 proc per 100,000
C-Sections	310 proc per 1000 live births	250 proc per 1000 live births
Over weight	33% of Popl	34.5% of Popl
Obese	34% of Popl	15% of Popl

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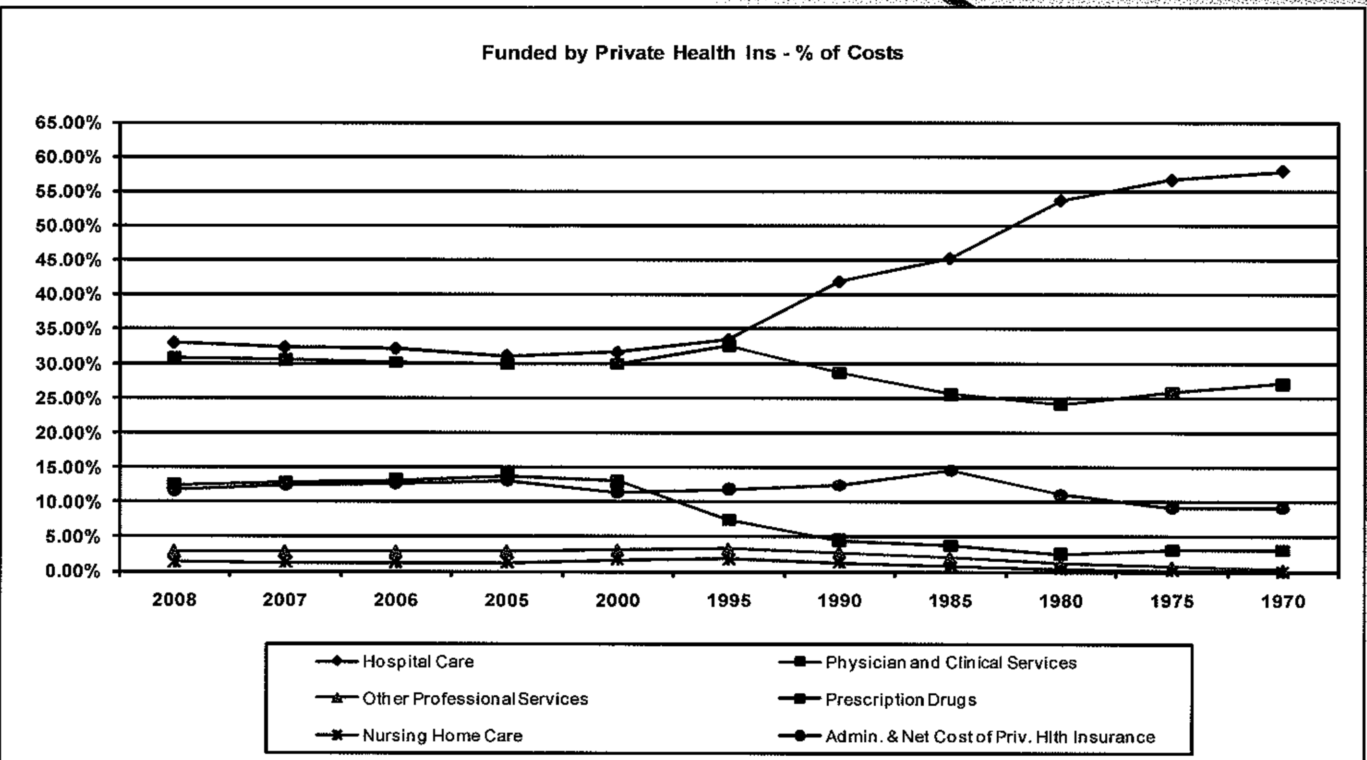
Who Gets the $$ - Private Funding



Hospital costs as a percent have decreased, physician has remained steady percent-wise.
Prescription drugs have increased to between 10% and 15%.

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Some Reasons Costs Increase

	Phys V per 1000-Group	Group Days per 1000
1995	8,739	258
1996	9,121	245
1997	9,768	242
1998	10,346	239
1999	10,932	238
2000	11,107	246
2001	11,759	245
2002	12,234	251
2003	12,057	259
2004	12,038	259
2005	11,819	258
2006	12,430	262
2007	13,059	263
Projected		
2010	14,556	265

Historical data from over 300 health plans

Health Insurance as % of Wages

	Health insurance as % Wage	Soc Sec Medicare as % Wage
1988	7.8%	8.1%
1989	8.2%	8.1%
1990	8.5%	8.2%
1991	8.6%	8.0%
1992	9.2%	7.9%
1993	9.6%	7.9%
1994	9.8%	8.0%
1995	9.2%	8.1%
1996	8.8%	8.0%
1997	8.2%	8.0%
1998	8.0%	8.0%
1999	8.0%	8.0%
2000	8.1%	7.9%
2001	8.4%	8.0%
2002	9.3%	8.0%
2003	10.0%	8.0%
2004	10.2%	8.0%
2005	10.6%	8.0%
2006	10.9%	8.0%
2007	11.2%	8.0%

What can we afford?

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Request for Quotation

RFQ NUMBER	PAGE
INS11006	4

ADDRESS CORRESPONDENCE TO ATTENTION OF:
SHELLY MURRAY
304-558-8801

VENDOR:
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO:
INSURANCE COMMISSION
1124 SMITH STREET
CHARLESTON, WV
25305-0540 304-558-3707

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FREIGHT TERMS
11/14/2010				

BID OPENING DATE: 12/16/2010 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO	ITEM NUMBER	UNIT PRICE	AMOUNT

THE BID SHOULD CONTAIN THIS INFORMATION ON THE FACE OF THE ENVELOPE OR THE BID MAY NOT BE CONSIDERED:

SEALED BID

BUYER: SHELLY MURRAY

RFQ. NO.: INS11006

BID OPENING DATE: 12/16/2010

BID OPENING TIME: 1:30 PM

PLEASE PROVIDE A FAX NUMBER IN CASE IT IS NECESSARY TO CONTACT YOU REGARDING YOUR BID:

913-642-9777

CONTACT PERSON (PLEASE PRINT CLEARLY):

Thomas L. Handley

SEE REVERSE SIDE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO RFQ, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

RFQ No. INS11006

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owed is an amount greater than one thousand dollars in the aggregate.

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, limited liability company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing (***West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: Lewis & Ellis, Inc.

Authorized Signature: Thomas L. Handley Date: December 15, 2010

State of Kansas

County of Johnson, to-wit:

Taken, subscribed, and sworn to before me this 15th day of December, 2010.

My Commission expires February 10, 2014

AFFIX SEAL HERE **NOTARY PUBLIC** Paula J. Miller