# Health Care Reform Review Committee
**September 6, 2012**

Chairman Keiser and Committee members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of ND (BCBSND). At your last meeting I was asked to provide an update on the actual cost increases experienced for the near term provisions of PPACA and also the estimated cost for future provisions. I am not sure if other insurers will be providing data for their plans, but please keep in mind the data we are supplying reflect our actual claims and projected claims based on current enrollment demography.

## Cost Impact of PPACA

**Near Term Provisions:** BCBSND claims and enrollment data were used to calculate the cost impact for some of the near term provisions including preventive services, dependents up to age 26 and elimination of lifetime limits. Women's preventive, including contraceptives, was added August 1, 2012 and the estimated cost is not based on actual data. Below are estimates of the near term provisions:

| Near Term Provision | Cost Impact |
|---|---|
| Preventive services with no cost sharing | 5% for Individual and 3.5% for Employer Group |
| Women's preventive | 1.0% |
| Dependent up to age 26 on parent's plan | 1.0% |
| Elimination of lifetime limits | 0.2% (8 current members have exceeded pre-PPACA lifetime limits over 2 yrs) |
| Rescission Limits | No Impact |
| Children's pre-existing exclusion | No Impact |

In the provision for dependent coverage up to age 26, BCBSND had 600 individuals within the Individual Market (Non-group) that were added to their parent's plan and 3,932 individuals that were added in the Group Market.

**Future provisions:** Below are estimates of the cost of future provisions. The cost impact of guaranteed issue is a rough estimate due to not having all the Exchange rules. Even if all the rules were available, the new 2014 insurance environment has so many changes that it would still be difficult to accurately estimate the cost of guaranteed issue. The impact of the age rating restriction is premium neutral overall and intended to show the potential impact to older and younger ages. The age impact is based on preliminary pricing work for Exchange products and is not based on current pricing. The insurer tax estimate is based on detailed studies of projected future premium and should be fairly accurate. The following is an estimate of the cost impact of 2014 provisions.

| Future 2014 Provision | Cost Impact |
|---|---|
| Guaranteed issue | 10% - 25% rough estimate |
| Age restriction change from 5:1 to 3:1 | Ages of 60 plus = 2% decrease<br>Ages less than 30 = 8% increase |
| Insurer Tax | 1.5% in 2014 and increases to about 2.5% over five years |

The cost impact in the rating bands (5:1 to 3:1) is based on BCBSND's actual age distribution within our current market and our actual rating bands. Our actual rating bands are closer to 3.2 to 1. Based on an equal distribution of members and converting from 5:1 to 3:1, the actual results would be a 10% decrease for Ages of 60 plus and a 50% increase in the Ages less than 30-group.

As I have previously testified, our actuaries have estimated that as an average they expect that the Insurer Tax will result in an approximate $65/yr increase for single plans and an estimated $200/yr increase in family plans.

**Historical Rate Table Increases**

Below are the historical rate increases that were also requested. I must caution the committee members that the approved rates do not necessarily reflect the current rate of health care claim trends. Several factors affect the final approved insurance rates. The rate review process can take several months to finalize from rate preparation, rate review process by the insurance department, and the final approval/disapproval decision. It is not much different than predicting the number of winter days where you will experience daily low temperatures below 32 degrees as much as 15 months ahead of time. You can use the past history and the most current weather trend, but no matter what you guess in terms of the number of freezing days, you will most likely be wrong. The same goes with rate submissions. Our actuaries maintain numerous records regarding current health care claims trends, pharmaceutical claims data, group and individual enrollment data, and many other records affecting insurance rates. This data is analyzed and appropriate premium rates calculated according to generally accepted actuarial practices and professional standards. But one thing must be kept in perspective. If one year's estimate is long and there is an underwriting gain, then those "excesses" go into the reserves to protect our members when just the opposite occurs. Further, BCBSND's rating methodologies and formulas are self-correcting with respect to any error in the previous year—premiums that are set too high (or low) in one year result in a lower (or higher) calculation in the following year. This prevents errors for compounding or accumulating over time. With that background, I wanted the committee to fully understand that one cannot simply look at approved rates to tell the entire story. The following two tables reflect the past 10 years of insurance premium rate increases for the Individual (Non-Group) Market and for the Group Market.

**Individual (Non-Group) Rate Increases**

| Year | Approved |
|---|---|
| August 2003 | 6.3% |

| | |
|---|---|
| August 2004 | 4.2% |
| August 2005 | 6.7% |
| August 2006 | 2.9% |
| August 2007 | 9.3% |
| August 2008 | Disapproved |
| April 2008 | Withdrawn |
| August 2009 | Withdrawn |
| May 2010 | 12.2% |
| October 2010 NGF Only | 20.2% |
| May 2011 | 13.9% |
| May 2012 | 7.5% |

**Group Rate Table Increases**

| Year | Approved |
|---|---|
| 2003 | 11.9% |
| 2004 | 8.2% |
| 2005 | 8.5% |
| 2006 | 6.0% |
| 2007 | 7.0% |
| 2008 | 9.9% |
| 2009 | 7.9% |
| 2010 | 11.3% |
| 2011 | 3.5% |
| 2012 | 1.1% |

Mr. Chairman, I hope this answers the previously asked questions of your committee. I would be willing to attempt to answer any questions the committee may have.