

Risk Selection Among Plans From the Regulator's View

European Health Care Systems:
Need for Substantial Change

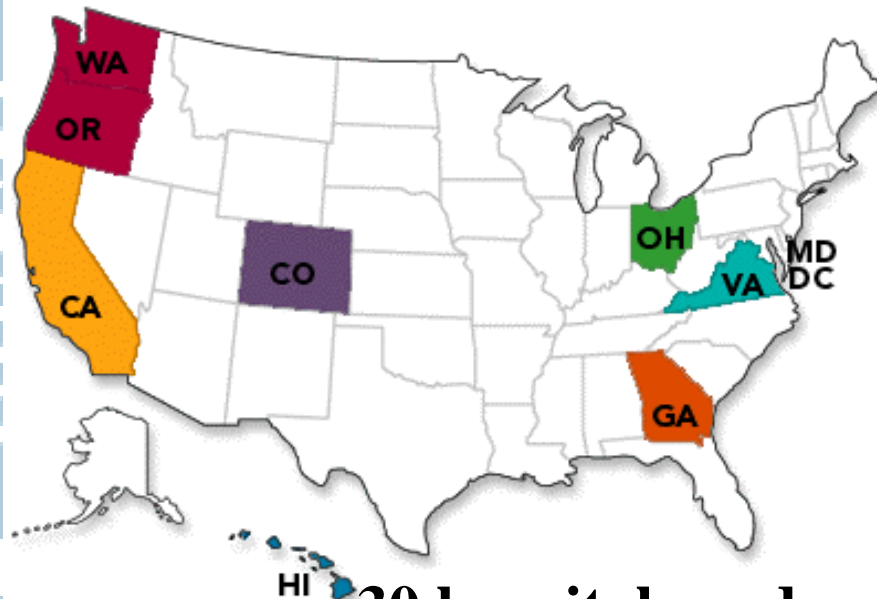
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Kaiser Permanente

- Community-based Medical Care Program; providing comprehensive medical, surgical, hospital and ambulatory care, and pharmaceutical services to its members.
- Integrated financing and delivery scheme
- Three separate organizations (Health Plan, Hospitals, Medical Group), bound together in both partnership and mutually exclusive contractual relationships

America's Largest Non-profit Health Care Program



Integrated health care delivery system

8.4 million members

11,900+ physicians

134,000 employees

8 regions serving 9 states and D.C.

30 hospitals and medical centers

431 medical offices

450,000 surgeries

85,000 deliveries

\$28 billion annual revenue

Insurance Regulation Relating to Risk Selection In The US

- Regulated by each of the 50 states.
- No uniform standard.

Insurance Regulation Relating to Risk Selection In The US

Goal of Regulators is to prevent unfair discrimination against vulnerable, high risk people.

Insurance Regulation Relating to Risk Selection In The US

- Regulations to protect against unfair discrimination primarily address:
 - Rating.
 - Medical Screening or Underwriting.
 - Benefit Design.
 - Provider Contracting.

US Healthcare is Generally Purchased by Employers

Employers purchase coverage 3 ways:

- Self insure.
- Indemnity Insurers.
- Health Maintenance Organizations.

US Healthcare is Generally Purchased by Employers

Self Insurance

- Employers set aside a sum of money to cover health care costs.
- Hire a third-party administrator (generally an indemnity insurer) to administer the benefit.
- Employer defines benefit and cost-sharing by employees.
- No state regulation and minimal federal regulation.

US Healthcare is Generally Purchased by Employers

Indemnity Insurance

- Pay providers on a fee-for-service basis.
- Preferred Provider Organizations are a form of indemnity insurance.
 - PPOs arrange for providers to accept a discounted rate for enrollees.

US Healthcare is Generally Purchased by Employers

- Self insurance
- Employers set aside a sum of money to cover health care costs and hiring a third-party administrator (generally an indemnity insurer) to administer the benefit.
- Indemnity Insurers who pay providers on a fee-for-service basis.
 - Preferred Provider Organizations are a form of indemnity insurance
- Health Maintenance Organizations that:
 - Organize provider networks.
 - Assume responsibility for providing health care to members in a geographic area.
 - Collect a fixed annual fee from the employer or the individual purchaser without regard to the actual amount of services provided to an individual enrollee.

US Healthcare is Generally Purchased by Employers

Health Maintenance Organizations

- Organize provider networks.
- Assume responsibility for providing health care to members in a geographic area.
- Collect a fixed annual fee from the employer or the individual purchaser without regard to the actual amount of services provided to an individual enrollee.

Risk Among Purchasers

- Large Employers Most Desirable to Carriers. Larger Pool of Employees Means Risk is Spread.
- Smaller Employers Present More Risk. Fewer People Covered; Fewer People to Spread Risk.
- Individual Purchasers Present the Greatest Risk.

Rate Regulation

- Most States Review Rates Prior to Allowing Carrier to Offer Plan.
 - File and Use: Carrier files plan with rates and can offer it until the Regulator disapproves it.
 - File and Approve: Carrier files plan with rates. Plan can only be offered after Regulator approves.

Rate Regulation

- Regulator reviews rates and rating methodology for fairness and actuarial validity.
- Prohibit including some factors, such as race.

Rate Regulation

- Rating Methodologies:
 - Experience Rating – Most specific to risk of individual and employer group.
 - Community Rating – Population based. Not specific to either individual or employer group.
 - Adjusted Community Rating – Combination of both methodologies.

Rate Regulation Experience Rating

- Experience Rating anticipates claims experience of, or utilization of services by, a group or individual based on age, sex and other attributes expected to affect health care utilization.
- Experience rated premiums are subject to periodic adjustment based on actual claims or utilization experience.
- Most reflective of risk.

Rate Regulation Community Rating

- In simplest form, all groups and individuals charged the same rate for the same benefits, regardless of differences in actual or projected utilization of health care services.
- There may be variations from group to group reflecting differences in benefits, contract renewal rates, lengths of contracts, costs of administration or family structure.
- Risk spread among broad base. Healthy and sick all pay same rate.

Rate Regulation

Adjusted Community Rating

- Prospectively determines rates for groups based on their prior use of health care services.
- Begins with the community rate, then adjusts it using a factor based on expected future use by the specific group relative to the average use for all members.
- Allows some difference in payment between high and low risk persons, but protects high risk persons from very high rates.

Medical Screening

Medical screening, sometimes called “underwriting” is the act of assessing the health risk of the individual requesting to purchase coverage.

Medical screening is used to determine:

- Whether to provide coverage.
- Whether to apply pre-existing condition limitations.
- The rate.

Medical Screening

Pre-existing condition limitations are restrictions on coverage for health conditions, injuries or disease that were existing or occurred prior to enrollment.

Carriers exclude that condition from coverage for a period of time, such as six months, or permanently.

Some states limit the ability of carriers to use pre-existing condition limitations for small groups and for individuals.

Medical Screening

In most markets, carriers can medically screen and deny selling the coverage to:

- Individuals who purchase coverage directly, not through an employer; and
- Entire employer groups of 50 or more employees (but, if coverage is sold to an employer group, not the individual employees within the group)

Medical Screening Small Employer Groups

Federal and many state laws prohibit health plans from denying coverage to employer groups of between 2 and 50.

Health plans must offer benefit plans to small employer groups (“guaranteed issue”). They cannot deny them coverage:

- Federal law requires two most popular plans be offered.
- Some state laws, like California, require all plans offered in the small group market.

Federal law does not include rating rules – most states do.

Many consider these “small group reforms” to have been a failure.

Medical Screening

- In the individual market, the health plan assesses the health status of the individual to predict the potential utilization of health care services by that individual.
- In the employer group market, the health plan looks at the collective health status of all employees and dependents (if dependents are covered) to determine whether to sell coverage to the group.

Medical Screening to Determine Rates

In all markets, carriers can medically screen individuals and groups to determine the rate to charge for coverage.

- Rates for individuals in the individual market are based on the individual health characteristics
- Rates for employer groups of 50 employees or more are based on the collective health characteristics of all employees and dependents (if dependent coverage is offered)

Medical Screening to Determine Rates Small Employer Groups

Rates for employer groups of between 2 and 50 employees are frequently governed by:

- Restrictions on the factors that can be used in setting the rate, and
- Restrictions on the lowest and highest rates that can be charged to any small group.

Small Group Rating Rules

Employer groups of between 2 – 50 (“small groups”) are considered to be “high risk” because one high cost health condition can impact the cost of paying for the health care services in that group.

Employees in small groups are the largest number of people in the US without health benefits coverage.

Small group employers don’t purchase coverage due to:

- Cost.
- Administrative burden.

Benefit Design Mandated Benefits

- States mandate that certain benefits be provided partially to assure that coverage for high risk conditions is available.
- Limits ability of carriers to design benefits to avoid covering certain high-risk populations.

Benefit Design

Mandated Benefits

HMOs are mandated to have a set of “basic benefits” that must be offered to all enrollees.

These generally include:

- Medically necessary hospital services.
- Medically necessary physician services.
- Vaccinations.
- Medically necessary preventive services.
- Emergency services.
- Other services such as limited mental health and substance abuse services, depending on the state.

Benefit Design Mandated Benefits

States also mandate specific benefits be covered by all carriers.

These differ by state but can include:

- Maternity benefits.
- Emergency services.
- Mammograms.
- Special food for infants with nutritional deficiencies.
- Mental health services.

Provider Network and Access Standards

- Mandates that HMOs and PPOs have the provider network under contract so enrollees will be able to access care.
- Some states mandate certain levels of access, including time between request for appointment and date of appointment.

California Provider Network and Access Standards

As an example, California has imposed strict provider network and access standards for HMOs.

- Must demonstrate that HMO has a provider network that can provide a comprehensive range of readily accessible primary, specialty, institutional and ancillary services at reasonable times to all enrollees

California Provider Network and Access Standards

Primary Care Providers

- All enrollees have a residence or workplace within 30 minutes or 15 miles of a primary care physician under contract with the HMO.
- One primary care physician for each 1200 enrollees.

California Provider Network and Access Standards

Hospitals

- No enrollee can live or work more than 30 minutes or 15 miles from a hospital or emergency department under contract with the HMO.
- The contracting hospital must be able to provide regular hospital services.
- The contracting hospital must have a complete network of primary care and specialty physicians to provide the entire range of covered health care services.
- Emergency services must be available 24 hours a day.

California Provider Network and Access Standards

Ancillary Services - Laboratory, pharmacy and similar services and medical equipment are available in a location that is a reasonable distance from the provider prescribing the service or ordering the medical equipment.

Thank You
Questions?