Setting Health Insurance Rates
Five Facts

Ohio Association of Health Plans

Setting a health insurance premium isn't like deciding how much to charge for any other consumer goods or services. The industry is subject to federal law and state-by-state regulations, including a limit on how much companies can collect beyond what they spend for medical services and quality improvement — in effect, a profit cap.

This requires insurers to project what their costs for clinical care will be and to set rates accordingly.

Here are a few things to keep in mind when thinking about where your health insurance premium comes from:

1

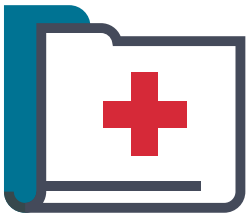
It's all about data.

Health plans use the best data available to project what the coming plan year will bring. If the plan is already established in the market, it has its own historical data to use. If a plan is newly entering the market, it might rely on competitors' rates and publicly available information about industry trends and the market demographics. Specialized datasets are available for purchase.

2

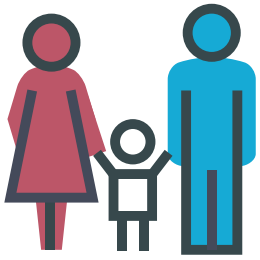
What do we look for in the data?

A number of factors will influence how much a health plan expects to spend for care, and thus how much it needs to charge in premiums. These include:



Utilization trends
Are certain types of care expected to grow or shrink in use? This can be affected by medical advancements making new therapies available or by new knowledge about the efficacy of certain therapies.

New drug therapies
A new and popular drug can have a big impact on healtcare spending, as we're seeing currently with the new class of diabetes/weight-loss drugs.



Population acuity
This refers to the overall level of health of the group of people being covered. In a high-acuity population, members are expected to need more clinical care, which calls for a higher premium.

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3 There are built-in limits, with penalties.

The 2010 Affordable Care Act established minimum levels for what portion of their revenues insurers must spend on clinical care and what's known as quality improvement — programs and processes designed to improve health outcomes for the covered population overall. It's called the medical loss ratio (MLR), and it generally applies to traditional, fully funded employer plans but not self-funded plans.

Generally, large group plans must have an MLR of at least **85%**, while individual and small group plans must spend **80%** on clinical care and quality improvement. Administrative costs must come out of the **15%** or **20%** of remaining revenue. If a health plan fails to meet those targets, it must refund the difference to consumers in the form of rebates, lowered premiums or other spending to benefit plan members.

4 Government plans are more directly regulated.

Plans offering Medicaid or Medicare coverage don't set their own rates. The federal government sets Medicare premiums based on coverage level and income.

For Medicaid, which is run jointly by the federal government and states, the federal government requires state Medicaid departments to set Medicaid managed care rates in accordance with generally accepted actuarial principles and practices, taking into account the population and services to be covered.

"ODM contracts with actuaries who set the capitation rates based on how specific Medicaid populations have used services historically."

The Ohio Department of Medicaid (ODM) contracts with private managed care organizations (MCOs) and pays each a set monthly payment — called a capitation rate — for each Medicaid member enrolled in the MCO. In exchange, the MCOs must cover the health care needs of all its members.

ODM contracts with actuaries who set the capitation rates based on how specific Medicaid populations have used services historically.

The MLR for Ohio's Medicaid MCOs must not fall below **86%**. If it does, the MCO must remit a rebate to ODM.

5 Projecting isn't easy.

This is especially true for plans on the Affordable Care Act Marketplace, where member turnover can be as high as **80%** in a given year. Actuaries are looking at last year's data to set next year's rates, but next year's facts on the ground could change dramatically.

For example, two plan types are currently affected by the ongoing Medicaid "unwinding" process — removing people who no longer are eligible but who had remained on the rolls while pandemic rules were in

effect. Many of those being disenrolled from Medicaid were among the healthier (lower-acuity) patients, leaving a remaining Medicaid population with higher overall acuity. And many of those disenrolled from Medicaid are moving to Marketplace plans.