

Rate Review: Factors, Procedures and Administration

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PPACA Rate Review

- HHS and state review of “unreasonable” increases
- Insurers post public “justification” of unreasonable increases
- HHS defining “unreasonable”
- State monitoring and reporting to HHS
- Rate review grants
- **Extent of rate review authority, process, transparency left to states**

Individual Market

“...the Direct-Pay class is particularly vulnerable to the high costs of health care”

- Avg. rate increase imposed – 20%*
- Higher out of pocket costs*
 - Avg. deductible for individual: \$2,959
 - Avg. deductible for family: \$5,149
- Denied coverage for medical conditions**
- Higher premiums based on health status**

*Source: Kaiser Family Foundation, Survey of People Who Purchase Their Own Insurance, June 2010

**In most states, until 2014

New Mexico

Individual: 103,700
5.3% of total pop.

- Adults (19-64):
73,800 – 6.2%
- Children (0-18):
26,700 – 5%

Uninsured: 452,800
23.2% of total pop.

– Source: Kaiser State Health Facts
2007-2008 Data

Individual Market Rules

- Prior Approval
- MLR
- Rate Band
- No Guaranteed Issue
- Health Status
Underwriting Permitted
- Pre-existing Condition
Exclusions Permitted
- High Risk Pool

Behind the Rate Hikes

- Rising Medical Costs
 - Lack of transparency around provider rates
 - Payment reform needed
- Adverse Selection
 - More pronounced in voluntary, GI markets
 - But “death spirals” can occur
- Fragmented Individual Markets
 - Lack of risk pooling, closed blocks
- Lax Oversight of Rate-Setting

Traditional Rate Review

- Prior Approval or File and Use
- Rate Filing
- Desk Review by Agency Staff
- Standards for Approval
 - New rates are *actuarially justified*
 - New rates result in “benefits that are reasonable in relation to premiums,” i.e., rates meet medical loss ratio minimums

Limits of Actuarial Justification

- Discretionary standard: compliance with “actuarial principles”
- Limited or no authority to consider other important factors:
 - Insurer’s Overall Financial Position
 - Affordability / Hardship on Consumers
 - Cost containment and quality efforts are critical
 - Risk Pooling
- Lacks transparency

Limits of Actuarial Justification: Discretionary Standard

- Insurers develop medical trend
 - Growth in costs and utilization over experience period
- Insurers choose assumptions and factors
 - Demographic changes
 - Benefit changes
 - Enrollment projections
 - Duration / Reserving?
 - Deductible leveraging
 - Deterioration? (BCBSNM)
 - Rating factors (health tier, age, geographic location, gender, cost-sharing)
- Administrative costs and target profits presumed reasonable if within MLR standards

“Many laws are silent as to procedures and assumptions to be employed, thus giving the actuary significant discretion to exercise professional judgment in these areas.”

- Actuarial Standards Board
Actuarial Standard of Practice No. 8, Regulatory Filings for Health Plan Entities

Limits of Actuarial Justification: Insurer's Financial Position

- AJ looks at solvency/profitability of each separate pool in individual market
- No or limited authority to consider surplus, overall profitability, historical underwriting margins, reserves, investment income, range of solvency protection mechanisms
- Role of non-profit health insurer

Limits of Actuarial Justification: Affordability

- AJ: no consideration of affordability of coverage, cost containment efforts by insurers, and quality incentives
- AJ: no consideration of consumer hardship
 - How many policyholders will buy-down benefits or drop coverage due to rate hikes?
 - Regulators do not consider consumer comments and rate hike history
 - BCBSNM case: Hearing examiner not permitted to use consumer comment as evidence; policyholder burden of litigating as a party is too high

Limits of Actuarial Justification: Risk Pooling

- Pools segregated by policy, insurers do not pool experience of all products
 - “blocks of business”
- Older, smaller blocks in a death spiral
- Risk is not widely spread among healthy and less healthy members
- Consumers in high risk blocks hit with year-after-year double-digit increases

Risk Pooling Example

BCBS of New Mexico

- Several closed blocks
- Blue Direct ABC plans closed after 3 years
- Three new Blue Direct plans launched in Jan. 2010
- Older closed blocks with less than 300 members; double-digit increases every year since 2004; dwindling membership

Risk Pooling Examples

BCBS Rhode Island

- Four products
- Two risk pools
- GI under state law
- Pool I – GI pool, high risk
- Pool II – lower risk, passed underwriting
- Pool I MLR = 100%
- Pool II MLR = 70%, with subsidy to Pool I

BCBS North Carolina

- Two plans, one introduced in 1996, one in 2003
- Two pools
- MLR = 82%
- Pooling not mandatory, but if pools are joined they must stay joined
- Older pools folded in

Limits of Actuarial Justification: Transparency

- Desk review, negotiations with insurers conducted behind closed doors
- Rate filings not easily accessible
- Rate filings not summarized in consumer-friendly terms and format to facilitate policyholder understanding
- Hearings are rare
- No consumer representation to “cross-examine” insurers’ projections

“Modern” Rate Review

- Standard for approval:
 - rates must be reasonable and not excessive
- Scrutiny and substantiation of actuarial assumptions and projections
- Host of factors considered
 - MLR
 - Surplus, historical and overall profits, reserves, investment income, solvency protection mechanisms
 - Consumer hardship
 - Affordability, cost containment, quality
 - Risk pooling, closed blocks
- Open process
- Strong regulator charged with studying and improving delivery and holding down rates

Modern Rate Review Standards for Approval

Oregon

Rates must be:

- Actuarially sound
- Reasonable and not excessive, inadequate or unfairly discriminatory; and
- Based upon reasonable administrative expenses

Rhode Island

Commissioner shall:

- Guard solvency of insurers
- Protect consumers
- Encourage fair treatment of providers
- Encourage policies to promote quality, efficiency
- Direct insurers toward policies advancing public welfare through efficiency, quality, access

Modern Rate Review: Scrutiny of Actuarial Projections

- An end to “hocus pocus math”
- Historical and projected cost trends substantiated with data, clearly presented by medical category
- Adjustments and factors scrutinized and substantiated; limited number of factors permitted; ensure no double-counting
- Historical and projected administrative expenses reported by category; reasonableness assessed

Modern Rate Review Example

Actuarial Projections: Colorado

“Complete Explanation as to How the Proposed Rates Were Determined:”

“The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption...”

“Trend:”

Rate filing “must describe trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. The trend assumptions shall be, if practical, separately quantified into two categories, medical and insurance”

- Medical = provider price increases + utilization changes
- Insurance = underwriting wear-off, deductible leveraging, other factors and assumptions

– Regulation 4-2-11

Modern Rate Review: Insurer's Financial Position

- Company's overall solvency remains most important factor
 - Regulator may determine an appropriate surplus range, deny surplus contributions when sufficient
- But regulator considers financial position of entire company, not just block of business
- Commissioner considers “the insurer's financial position, including but not limited to profitability, surplus, reserves and investment savings.”
 - Oregon rate review statute

Modern Rate Review Affordability

- Review considers affordability of product
- Review considers insurer's cost containment efforts
- Review directs insurer toward payment reform using rate approval as leverage
- Review considers consumer hardship, consumer input

Affordability: Rhode Island Model Change Through Insurer Regulation

- Small group and large group rating factors approved, contingent on affordability efforts (individual market benefits)
- Studies of provider rates and payment methods
- Insurers directed to spend larger percentage on primary care
- Insurers directed to change payment methods, include quality incentives in provider contracts
- Surplus reviewed for excessiveness
- Individual market rate increases trimmed as much as possible for affordability

Affordability: Oregon

Commissioner considers in part:

- Any anticipated change in the number of enrollees if the proposed premium rate is approved
- Changes to covered benefits or design
- Changes in insurer's cost containment and quality improvement efforts since last filing
- Any public comments received

Affordability: Maine

- Commissioner denied profit margins on for-profit Anthem BCBS rates in 2009 and 2010; upheld on appeal in 2009
- Among reasons cited: “unique economic situation resulting in extreme financial hardship for subscribers and extreme financial health of the company”

Modern Rate Review: Risk Pooling

- Risk pooling required or at least encouraged as a condition of rate approval
- Smaller, closed blocks of business folded into other blocks
- Regulators seek a balance of affordability for higher risk and lower risk members

Risk Pooling Statute: Kansas

No block of business shall be closed unless:

- (1) carrier notifies policyholders and offers opportunity to purchase from comparable open block with no re-underwriting
- (2) Carrier pools the experience of closed blocks with all appropriate open blocks for determining premium with no penalty
- (3) Blocks presumed closed if 12% enrollment drop over 12 months or less than 500 contracts
- (4) Carrier must notify regulator of decision to close

Risk Pooling Under PPACA

- A “health insurance issuer” shall pool all non-grandfathered individual market plans outside and inside exchanges
- Option to pool small group with individual
- Individual mandate
- State law invalid if includes grandfathered
- State rate review must give authority to ensure pooling not undermined; definition of “issuer” key, e.g., subsidiaries

Modern Rate Review: Transparency

- Timely notification to policyholders
- Public comment period
- Rate filings and summaries posted online
- Rate hearings for all or some individual market products
 - Possible triggers: above %, “unreasonable”
- Consumer representation
 - AG with expert; agency consumer rep; local consumer groups with intervenor/grant funds

Transparency Models

- Oregon
 - Notification to policyholders
 - Public comment period / comments posted
 - Entire rate filings made public, summarized
- Maine
 - Hearings at Commissioner's discretion
 - Rate filings made public
 - AG representation on behalf of consumer
- Rhode Island
 - Hearings for all individual market products
 - AG representation on behalf of consumers

Steps for New Mexico

- Identify current weaknesses
 - AJ and MLR authority
 - Division of Insurance capabilities
 - NAIC accreditation
 - Resources and staff
 - Limited ability to address threat of market withdrawal
- Legislative changes to rate review authority
- Authorize study of provider reimbursements, market conditions
- Define appropriate surplus range for insurers
- Build cost containment into rate review
- Examine insurer charters and missions