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An Advocate's Guide to
HEALTH INSURANCE RATE HIKES
What You Can Do To Protect Individual Market Consumers

INTRODUCTION

Health insurance premium increases have caused many individuals and families to move to plans with higher cost-sharing or drop coverage all together. The high cost of coverage has gained nationwide attention as insurers continue to impose double-digit rate hikes, particularly on those who purchase coverage in the individual market, without the help of an employer.

Why do insurers raise rates? Are they required to justify rate hikes, and if so, how? How can advocates protect consumers from unreasonable or unjustified increases?

This Guide aims to answer these questions. You'll find information to help you understand how insurers develop premiums, and help you evaluate insurers' rate filings – those highly technical documents that insurers submit to regulators in most states to show how they came up with a rate increase. You can read Consumers Union recommendations for improving state rate review so you can push for changes in your state. And you'll find suggestions to help you effectively participate in a rate review process.

Now is the time to advocate for closer scrutiny of rate hikes and more open, participatory rate review processes. Rate review authority remains primarily in the states, and the federal Patient Protection and Affordable Care Act (PPACA) provides grants to states to improve their health insurance rate review. Forty-five states and the District of Columbia have accepted grant funds so far with the intent to improve their rate review through measures such as collecting more data from insurers, hiring more agency staff to conduct reviews, releasing more information about rate increases on state agency websites, and in some cases, enacting new legislation with stronger rate review authority. More than 14 million consumers buy coverage in the individual market and many more are expected to access this market after health reforms take full effect in 2014. They need strong advocates to ensure that rate review rules and processes protect them from unjustified rate hikes.

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Section 1

FEDERAL HEALTH REFORM IS PROMPTING CHANGES TO STATE RATE REVIEW

The Patient Protection and Affordable Care Act (PPACA) includes provisions to strengthen oversight of premium rates. In a nutshell, these provisions give the Secretary of Health and Human Services (HHS) authority to review premium increases that are potentially "unreasonable" and to monitor trends in premium increases across the country. The Act does not give federal regulators the power to deny insurers' proposed rate increases – that power remains with the states if they choose to exercise it. Here are the key PPACA changes related to premium increases:

REVIEW AND JUSTIFICATION OF "UNREASONABLE INCREASES"

Section 1003\2794 of the PPACA requires the Secretary of HHS, in conjunction with the states, to establish a process for annual review of "unreasonable" premium increases. The process must require insurers to submit a "justification" for an unreasonable increase to HHS and the relevant state prior to implementing the increase. The Secretary must ensure that unreasonable increases and justifications for them are publicly disclosed.

WHAT'S AN UNREASONABLE RATE INCREASE?

HHS has issued a proposed federal rule to establish the PPACA process for reviewing unreasonable premium increases. The rule would require insurers to justify individual and small group increases that meet a certain threshold (on non-grandfathered[1] plans only). In 2011, any rate increase of 10% or more would require a justification. Beginning in 2012, HHS may establish a state-specific threshold based on each state's costs of healthcare and coverage. For rate increases meeting the threshold, insurers would submit to the state and HHS a "preliminary" justification that will be posted on HHS's website. State regulators would determine whether proposed rates for their states are unreasonable (i.e. unjustified) under state law standards if HHS has determined that the state has an "effective rate review program" in place. States that have given their regulators the authority to reject a proposed rate increase could do so if the rates are found to be unjustified under state law. For those states that do not meet HHS's criteria for effective rate review, HHS would review proposed rates and decide whether they are "unreasonable," meaning the rates are "excessive, unjustified, or unfairly discriminatory." However, HHS will have no authority to deny a rate increase even if it finds the increase unreasonable. HHS

[1] "Grandfathered" plans are those that existed when the health care reform law was signed on March 23, 2010, and that have not made significant changes in benefits causing them to lose this status. "Non-grandfathered" plans are newer plans or those that have made changes resulting in loss of grandfathered status, and therefore must comply with certain additional PPACA requirements.

would post its determination of unreasonableness on its website and require insurers to post the determination on their websites.

FEDERAL FUNDS FOR STATE RATE REVIEW AVAILABLE FROM 2010 THROUGH 2014

Section 1003\2794 allocates $250 million in grants to states for five years beginning with fiscal year 2010 for states to implement a rate review process. HHS awarded the first round of rate review grants on August 16, 2010. Forty-five states and the District of Columbia received up to $1 million each to work toward rate review improvements. Each state receiving a grant has submitted a plan describing how it intends to improve rate review.

FEDERAL AND STATE MONITORING OF PREMIUM INCREASES

Effective beginning in the 2014 plan year, the law requires the Secretary of HHS, along with the States, to monitor premium increases for insurance plans offered in or outside of an exchange (new state-based insurance marketplaces). As a condition of receiving a rate review grant, states insurance officials must provide the Secretary of HHS with information about trends in premium increases in various areas throughout their states, and make recommendations to state exchanges about whether certain insurers should be excluded from exchanges based on a pattern or practice of excessive or unjustified rate increases.

MEDICAL LOSS RATIOS

Effective on January 1, 2011, section 1001\2718 of the PPACA set new medical loss ratio (MLR) standards for insurers, meaning that it requires insurers to spend at least 80% of individual and small group premiums (85% for large groups) on medical care and activities that improve healthcare quality. In June 2012, and each year after, insurers will submit a report to HHS on MLR results from the prior calendar year, and rebates to policyholders will follow if results fall short of the new standards. The law includes new MLR reporting and disclosure requirements as well.

MORE COMING IN 2014

The PPACA includes other reforms that will affect how insurers set rates and may impact state oversight of rates. For example, new risk pooling requirements and the mandate that all individuals have insurance coverage, with some exceptions, are designed to make premiums more affordable by spreading costs over a larger number of people. The creation of state exchanges will change the way that individual market consumers and small groups buy insurance and should result in a more competitive marketplace.

Also, in 2014, insurers seeking to offer plans through an exchange must submit a justification for any premium increase to the exchanges and prominently post it

on their websites prior to implementing the increase. The exchanges will consider such premium increases, as well as recommendations from state regulators about insurers having a pattern or practice of unreasonable rates, when deciding whether to make an insurer's plan available in an exchange.

Section 2

PRIMER: HOW INSURERS SET PREMIUMS IN THE INDIVIDUAL MARKET

"It is the nature of health insurance that those who remain in relatively good health throughout the policy period will pay more in premiums than they will receive in claims payments. They are paying for protection against the risk that their health will change and that they will have substantial health care costs as a result."

-Mila Kofman
Superintendent of Insurance, Maine, Decision on Anthem rates, Sept. 2010

A key principle underlying the concept of insurance is pooling together the premium revenue from many policyholders so that—collectively—these monies can be used to pay for the medical claims incurred by members of the group along with other costs. Within the pool, some members will use fewer than average healthcare services, while others will use more. A benefit of insurance is that the consumer, in exchange for a fixed premium, receives coverage for unanticipated and potentially high medical costs. One purpose of the "individual mandate" under health reform is to achieve large pools of insured people so that costs are spread among a wide range of individuals with varying health characteristics.

People who buy insurance for themselves or their families in the non-group market are pooled with other individuals and costs are spread among the pool members.[2] Unless otherwise specified by state laws, insurers[3] typically pool together individuals who are covered under the same policy or similar policies, commonly referred to as a *block of business*. Pool size will vary depending on how many individuals have purchased a particular policy or similar policies.

OVERALL FRAMEWORK FOR DEVELOPING INSURANCE RATES: REVENUES = COSTS

The process by which insurers calculate the premium to charge policyholders consists of two main steps.[4]

One step is to determine the overall premium that the insurance company wants to collect across an entire set of policyholders. This represents the overall rate change the insurance company wants to implement. For example, when a rate filing indicates that the rate change is an increase of +15%, that means the insurance company wants to increase the overall collective premium for the

[2] The premium paid by members within a pool can vary based upon certain characteristics of the members. See page 14 for further discussion.

[3] Throughout this guide, the term "insurers" refers to all companies offering health insurance, including commercial life and health insurers and managed care organizations.

[4] This is a general discussion of ratemaking. It does not represent the procedures used by any particular insurance company, or the ratemaking procedures used in a given state. The process may vary according to the particular circumstances associated with a rate filing or based on differences in state laws.

block of business covered by the rate filing by 15%. The rate change for particular policyholders, however, can be more or less than 15%.

The other step is to determine how much the insurance company wants to collect from each category of policyholders. This is the process of risk classification and ratemaking. As stated, with an overall rate change of +15%, policyholders in a certain risk classification may get a smaller rate change (e.g. +10%), while policyholders in other risk classifications may get a larger rate change (e.g. +20%).

The overall conceptual framework for both steps is that the expected revenue for the block of business should equal the expected costs.[5] When reviewing a rate filing, it is useful to remember that the various analyses and calculations used to determine the rate change are a way of implementing this simple equation: EXPECTED REVENUE = EXPECTED COSTS.

STEP 1: DETERMINING THE TOTAL AMOUNT OF PREMIUM TO BE COLLECTED FROM POLICYHOLDERS

In the first step of implementing the basic ratemaking equation, the various types of insurance company revenues and costs are evaluated. In broad categories, the revenues and costs for an insurance company can generally be split into the following components.

REVENUES	COSTS
Premium	Medical claims
Investment Gain	Expenses (including taxes and fees)
Other Revenue	Profit

On the revenue side of the equation, the largest component by far is the premium charged to policyholders. However, investment gain is a material factor and is a significant contributor to the profit of the insurance company. Other revenue, if applicable, should also be considered.

On the cost side of the equation, the largest component by far is medical claims incurred under the terms of an insurance policy. However, expenses and profit are also important, as demonstrated by the consideration given to these factors in the health reform law, which, as discussed in Section 1, limits spending on these items to 20% of premium for individual market and small group customers, and 15% for large groups.[6]

[5] The process of implementing this framework is typically different for the overall rate change compared to classification rate changes. In a given state, statutes or regulations may require deviation from this procedure.

[6] The meanings of the terms "premium," "expenses," and "profit" as used in PPACA Section 2718, the medical loss ratio standard, do not match exactly to how those terms have been used in ratemaking to

Two common methods for implementing the ratemaking equation are the "pure premium method" and "loss ratio method." These methods employ actuarial formulas to achieve the desired balance in revenues and costs. A detailed description of these formulas is beyond the scope of this paper. However, a rate filing should identify the method used and contain the calculations and documentation used to determine the numerical values that go into the pure premium or loss ratio formulas.

Keep in mind that ratemaking is prospective. The goal for insurers is to test the adequacy of the *projected* revenue for a future time period against the *projected* costs for the same future time period.

Revenue Projections

Premium Revenue

The largest component of an insurer's revenue projection is the premium projection, that is, the amount the insurer expects to earn from premium dollars at current rates. Insurers calculate the projected premium by adjusting the actual reported premium from the *experience period* (a recent historical period of time) to reflect anticipated changes in premium revenue during the *rating period* (a future period of time).

Two important terms to know when evaluating a rate increase:

EXPERIENCE PERIOD - To develop projected revenues and costs, insurers adjust the actual revenues and costs from a recent historical time frame, called the *experience period*, based on anticipated changes in the amounts of money coming in and going out.

RATING PERIOD – The future period of time for which revenues and costs are being projected, and during which the new rates will be in effect.

There are two main items that cause the future projected premium to differ from the historical reported premium. Those are rate changes and premium trend.

When insurers predict premium revenues, they must account for expected changes in revenue that are due to rate changes (increases or decreases) that are not fully reflected in the data from the historical experience period, but will impact the premium in the prospective rating period. As an example, if rates are being evaluated for the 2012 rating period based upon the 2010 experience period, then any rate changes implemented during 2011 need to be accounted for, as those rate changes will impact the premium revenue for 2012 but are not reflected in the actual premiums charged during 2010.

Premium trend is the result of the insurance rates varying based upon the particular characteristics of a policyholder. Policyholders and their dependents are commonly classified according to rate factors, such as benefit plan, age,

date. A goal of the PPACA standard is to ensure that policyholders receive a certain level of benefits in exchange for their premiums.

gender, geographic location, family composition and health status.[7] If the distribution of business across the various rate classifications is expected to change in a way that the average premium per member per month will change, then this will impact the premium revenue forecast. This can happen, for example, in a "closed block" of business in which policies are no longer being sold. The average age of those insured in these blocks will increase over time (because no new members are coming into the pool). This will result in an increase in the premiums collected by the insurance company even without a rate increase because members will age into a risk category that pays higher premiums. This additional premium revenue needs to be taken into account in predicting how much total revenue would be earned at current rates.

Investment Gain

A second component of revenue is investment gain. Insurance company assets are mostly composed of financial assets. These financial assets generate investment gains,[8] which need to be considered in the evaluation of rates. Insurance company investment gains can be split into two sources – investment gains on reserves and investment gains on surplus.[9] Investment gains on reserves result from the time lag between when the insurance company receives the premiums to the time when claims and expenses are paid. Insurance companies invest the premium income until the claims and expenses are paid. This generates the investment gains on reserves. Investment income on surplus results because insurance companies must have a positive surplus position (i.e. assets in excess of liabilities) in order to operate. These surplus funds are held in various financial assets, which generate investment gains on surplus.

During 2009, the investment gain for health insurance companies was about 7% of surplus.[10] When calculating rate increases, health insurers might omit the potential revenue that may be generated by investments attributable to a block of business. But insurers should disclose this type of revenue because it will add to the underwriting profits that are already included elsewhere in the rate calculation. (See below, Underwriting Profits).

Other Revenue

The annual financial statements for health insurance companies list several sources of revenue other than premiums. The largest such item in 2009 for

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[7] Some states restrict the rating factors that insurers may use. See a further discussion of state laws and risk categories on page 17.

[8] The investment gain shown in an insurance company Annual Statement consists of investment income plus realized capital gains (or losses).

[9] Reserves represent values for liabilities of the insurance company for both known and estimated amounts. Surplus – the difference between a company's assets and liabilities – represents the net worth of the company. Surplus provides solvency protection, for example, in the event that actual liabilities exceed the reserve values established. Insurers sometimes use the term "reserves" to refer to surplus.

[10] A. M. Best Aggregate and Averages, 2010.

health insurers overall was labeled "Aggregate write-ins for other health care related revenues."[11] This item was about 1.4% of the total amount of premium revenue. A determination should be made if there is any other revenue collected by the insurance company that should be taken into account in the rate calculation.

Cost Projections

Medical Claims Costs

The largest cost for an insurer is medical claims, which insurers refer to as "losses." As with premium revenue projections, claims projections are developed by adjusting actual claims incurred during the historical experience period for the block of business to account for anticipated changes in costs during the rating period.[12]

Anticipated changes to claims costs may be predicted by looking at historical changes in the amount of claims paid for a time period. For health insurance, this is often measured by how much claims costs have changed per member per month (PMPM) over the time period. From this data, an actuary can see patterns of change and predict the *medical trend* for a block of business.

The medical trend is sometimes identified in rate filings as the "claims trend," "trend factor," "trend assumption" or "loss trend." It is the rate at which claims are expected to increase for the future rating period. For example, if an insurer applies a trend assumption of 12%, it is predicting that the amount it will pay in claims during the rating period will be 12% higher than the amount actually paid during the experience period.[13]

Because the amount of a rate increase depends to a very large extent on the medical trend used by the insurance company, this factor should receive close scrutiny in a filing.

Elements Comprising the Medical Trend

Insurers point to rising medical costs as the chief reason for rate increases. But the medical trend assumptions they use, i.e. the rates at which they predict medical claims will increase, tend to far exceed medical price inflation, the rate

[11] A. M. Best Aggregate and Averages, 2010.

[12] Claims for the historical experience period fall into two categories: those that the insurer has paid for and those for which the insurer is liable (whether known or not) but have not yet been paid. Insurance companies establish reserves for the claim liabilities that have not been paid (see the box about reserves on page 13). While the amount paid is known with certainty, the amount of the claim reserve is an estimated value calculated using various procedures. Claims tend to be reported and paid relatively quickly for health insurance, so that reserves are typically not as large an issue as they are for other types of insurance, such as automobile liability and medical malpractice.

[13] The total trend is usually calculated based upon an annual trend along with the number of years of trend. For example, if the annual trend is 5.83% and the trend period is two years, then the total trend factor is 12% (1.0583 x 1.0583 = 1.12).

at which prices for medical goods and services are rising, which has been between 3.2% and 3.7% from 2008 to 2010.[14] One reason for this difference is that an insurer's medical trend encompasses more than just inflation. The elements comprising the medical trend represent an insurer's primary justifications for a rate increase.

The two most important elements that make up the medical trend are:

- *Unit Cost Trend (Price Inflation)* – A measure of changes in the prices paid to healthcare providers. As the name implies, the unit cost trend should be reflective of medical inflation. However, there are various factors that can cause unit costs (or prices) for a particular insurer to change at a rate different than inflation.

- *Utilization & Mix of Services* – A measure of changes in the number of services, the intensity of services, and the number of treatable conditions.

For a further discussion of unit cost trend and utilization, see Section 3 and Appendix B.

In addition to unit costs and utilization/mix of services, insurers may include other components, or assumptions, in their medical trend, purportedly to account for other expected changes in claims costs. In other words, in a rate calculation, an insurer may use a "base trend" to reflect expected increases in claims costs due to changes in unit costs and utilization/mix, and then may add other components to the base trend to get a result equaling the total medical trend. [15] Here's how insurers may identify these additional components in rate filings:

- *Leveraging or Deductible Leveraging* – The effect on claims costs of the interaction between price inflation and cost sharing arrangements with the policyholder. As a simple example, assume a procedure costs $1,000 and the policyholder has a deductible/co-pay of $100. The insurance company will pay $900 and the policyholder will pay $100. If the cost of that procedure increases by 9% to $1,090 and the deductible remains static, then the cost sharing will be $990 for the insurer and $100 for the policyholder. That is, the increase in the cost paid by the insurer is 10%, 1% higher than the inflation trend, while the cost trend for the policyholder is 0%. The impact

14 Bureau of Labor Statistics, Consumer Price Index – All Urban Consumers, Medical Care, U.S. City Average. The federal Bureau of Labor Statistics tracks the price of a "market basket" of medical goods and services. For other cost measures and further discussion, see Appendix B.

15 While insurers sometimes identify these additional components as being part of the medical trend, at least one state, Colorado, has separated these from unit cost and utilization and requires insurers to identify them as "insurance trend" adjustments. See "Actuarial Memorandum" standardized form for rate filings, Colorado Department of Regulatory Agencies, Division of Insurance.

of leveraging depends on the cost of the procedure, the deductible/co-pay and the rate of inflation.[16]

- *Duration or Underwriting Wear-off* – The effect on claims costs of once-healthy people (who the insurer agreed to cover in the underwriting process because they were healthy) developing more medical needs after they are insured under the policy for a while.

- *Selection or Deterioration* – The effect on claims costs of healthy people dropping coverage or switching to other policies, leaving mostly those with higher medical costs in the block of business.

- *Provision for Adverse Deviation (PFAD)* – An insurer may increase the claims projection to account for "uncertainty." This item may actually be a disguised extra profit margin. (See discussion of profits on page 12).

- *Benefit Mandates and Other Items* – This could include the impact of government-mandated benefits (most recently of health reform requirements), legislative changes, or an insurer's changes to benefits.[17]

MEDICAL TREND CALCULATION, BLUE SHIELD OF CA

Claims Trend	16.2%
Benefit Change	0.3%
Duration Trend	2.7%
Selection Trend	2.9%
Demographic Trend	(0.8%)
Health Reform Impact	2.9%
Plan & Region Mix	(4.3%)
HIPPA Mix	6.8%
PFAD	2.3%
Other	0.1%
Net Trend	**29.1%**

These additional components can add significantly to the overall medical trend used. For example, for new rates effective March 1, 2011 for individual market policies, Blue Shield of California applied a 16.2% "Claims Trend" based on unit cost, utilization, and leveraging, then added duration, selection, PFAD, and other adjustments for a total "net trend" of 29.1%. In other words, the company predicted that its claims costs would increase 29.1%, from $130.30 per member per month during the experience period to $168.17 per member per month for the future rating period. The company did not include data in the publicly-disclosed rate filing to support all of the components included in the claims trend.[18]

An analysis of historical claims data may be used to evaluate the reasonableness of the medical trend used by an insurer. For example, a 2010 rate filing for individual market products for Blue Cross Blue Shield of New Mexico (a division of Health Care Service Corp.) included four different trend components. In addition to an "Annual Base Trend" of 10% a year, the rate calculation included an "Annual Deductible Leverage" of 1.1% a year, a "Duration Adjustment" of more than 5% and a "Deterioration Adjustment" of more than 3%.[19] But an analysis of historical data showed that actual increases in annual claims for the

16 The higher the cost of the procedure, the lesser the impact of leveraging on the insurer's trend. However, the higher the deductible/co-pay, the greater the impact of the leveraging, resulting in a higher trend for the insurer.

17 These "one time" changes are sometimes handled as part of trend, and sometimes as a separate issue.

18 Blue Shield of California Life and Health Insurance Company, Rates for Individual and Family Plans Effective March 1, 2011, Exhibits III and IV, available at http://www.insurance.ca.gov/0250-insurers/IndHlthRateFilings/.

19 BlueCross BlueShield of New Mexico, Individual Rate Filing, Actuarial Memorandum, Nov. 5, 2009.

policies over the past three to seven years ranged from about 4% to 8%, and therefore did not support the 10% base trend or the additional components used by the company.[20]

Further, when historical claims experience is used to analyze and predict future claims, adding in a separate trend component for items such as duration and selection can result in double counting the same impact, producing an overstated medical trend. That's because the historical claims data may already reflect the impact of these elements. For example, while it is accurate that leveraging will result in the trend impact on the insurance company being higher than the unit cost trend, a separate component for leveraging does not necessarily need to be added to the trend. The historical claims experience analyzed may already reflect the impact of leveraging.

The Connecticut Insurance Department has recognized the double counting that can result from adding these separate trend components, stating:

> Anthem applies an adjustment for the wearing off of underwriting. No explicit evidence was provided to support this adjustment, and **any increase in claims on this basis should be captured in the actual claims experience. The Department finds no actuarial merit to this adjustment.** [21]

Regulators in some other states, likewise, do not permit insurers to add some or all of these additional elements to their medical trend assumptions.[22] For further information, see Section 3, "Evaluating the Medical Trend Used in a Rate Filing."

After determining the medical trend, projected claims for the rating period are calculated by increasing the actual claims for the experience period by the trend. For example, if claims per member per month during the experience period were $130, and the predicted medical trend (including unit cost, utilization, and other components, if used) is 13%, then projected claims for the rating period would be $146.90 per member per month.

Expenses

Health insurance company expenses fall into four main categories. Those are: (i) cost containment expenses, (ii) other claim adjustment expenses, (iii) general

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20 See Prefiled Direct Testimony of Allan I. Schwartz on Behalf of the New Mexico Attorney General, In the Matter of BCBSNM's Requested Rate Increase for Individual Health Insurance Plans on behalf of Health Care Service Corp., Case No. 10-00054-IN, Before the NM Superintendent of Insurance, March 2, 2010, at p. 7.

21 Order and Decision In the Matter of The Proposed Rate Increase Application Of Anthem Blue Cross And Blue Shield; page 16 (emphasis added), available at http://www.ct.gov/cid/lib/cid/Order_and_Decision_Docket_No._LH10-159_-_Anthem_Blue_Cross_and_Blue_Shield.pdf.

22 Some of these components may not be explicitly identified in a rate filing, but may be incorporated into an adjustment to the claims trend resulting in a "normalized trend."

administrative expenses and (iv) investment expenses. Information on historical expenses can be obtained from insurance company Annual Statements and financial reports. The overall expenses are further split into about twenty-five items in the Annual Statement. The largest expense items generally are salaries, broker commissions and outsourced services (including electronic data or claims processing and other services).

The amount of projected premium that is targeted for expenses and profit can have a major impact on the indicated rate. In the past, a state with a low medical loss ratio standard or no standard at all can experience higher rate increases. For example, compare below the rate increases that result from different allowable medical loss ratios.

Projected Loss Ratio at Current Rates	Allowable Percent for Benefits	Allowable Percent for Expenses and Profit	Indicated Rate Change
78%	75%	25%	4%
78%	65%	35%	20%

Increase in rate change caused by the 10% difference in expenses is 16% (20% - 4%).

As can be seen, a very large difference in the indicated rate change can arise from using an inflated value for expenses (or profit). Rate filings show, and some regulators report, that some past increases were due in large part to insurers seeking to retain more premium for expenses and profit, i.e. reduce the medical loss ratios on a block of business down toward state-allowed minimums, which have been as low as 50% in some states for certain individual market policies.[23] A 2010 rate filing from HealthNet in Arizona, for example, shows that a 10.5% increase was primarily due to the insurer desiring to lower the medical loss ratio on the block of business. The anticipated loss ratio at current rates, with no rate change, would have been 72.9%; the rate increase was needed to achieve a desired anticipated ratio of 66%.[24] The new federal medical loss ratio requirements should help to limit these types of premium fluctuations.

As part of examining the portion of premiums that will go to expenses and profit, it is important to consider whether excessive amounts are being included in expenses. Every extra dollar of expense included in a rate filing means one less dollar that goes towards the payment of health care benefits.

[23] The National Association of Insurance Commissioners' model regulation on individual market rate filings provided that "benefits shall be deemed reasonable in relation to premiums" if the anticipated loss ratio is between 50% and 60%, depending on the renewability aspects of the policy. Guidelines for Filing of Rates for Individual Health Insurance Forms, Model Regulation 134.

[24] Health Net Life Insurance Company, Actuarial Memorandum for Individual PPO Products, effective July 1, 2010, obtained from the Arizona Department of Insurance. The Arizona standard for these products required an anticipated loss ratio of at least 55%.

Another question is whether or not it is appropriate for an insurer to include all the expenses in the rate calculation. This has been examined more closely in other lines of insurance, such as liability and homeowners insurance. The California Department of Insurance excludes certain expenses from the rate calculation for lines of insurance subject to Proposition 103.[25] The excluded expenses are: (a) political contributions and lobbying, (b) executive compensation that exceeds the reasonable amount for such compensation, (c) bad faith judgments and associated defense and cost containment expenses, (d) all costs attendant to the unsuccessful defense of discrimination claims, (e) fines and penalties, (f) institutional advertising expenses and (g) all payments to affiliates, to the extent that such payments exceed the fair market rate or value of the goods or services in the open market.[26] The Maine Bureau of Insurance has concluded that certain litigation expenses should not be passed on in the rates charged to policyholders.[27]

Underwriting Profits

The final component on the cost side of the equation is profits. Health insurance rate filings typically will contain a provision for underwriting profit. Underwriting profit is calculated as premiums less losses (i.e. medical claims) less expenses. This can be calculated based upon the actual values for a historical period, or based upon projected values for a future period. In making rates, the underwriting profit provision included in the calculation is based upon the projected revenues and costs for the rating period. As previously discussed, in addition to underwriting profit, insurance companies also have investment gains.

RED FLAGS: Charges for a "Contingency Provision," "Risk Load," "Provision for Adverse Deviation" (PFAD), or "Margin for Uncertainty" are actually extra profit margins. Other extra profits may be built into the rate, but may not be apparent without analysis of underlying data.

Insurance companies usually are permitted to have one underwriting profit provision in the rates, although a few regulators, such as in Maine and Rhode Island, have denied profit margins (at least temporarily) on some individual market products. In a rate filing, the portion of the premium targeted for profit may be identified as "Profit" or for nonprofit insurers as a "Contribution to Surplus."

Insurance companies sometimes attempt to include implicit extra profit provisions in the rate under different names. For example, insurance companies may use conservative (from the insurers' viewpoint) projections regarding medical trends. By doing so, they may be effectively exaggerating the cost projections, the end result of which is extra expected profits. Sometimes these targeted extra profits are not readily apparent in a rate filing and can only be discovered through an analysis of underlying data. But other times, certain

25 Health insurance in California is not subject to the provisions of Proposition 103.

26 10 Code of California Regulations 2644.10

27 Decision and Order in Re: Anthem Blue Cross And Blue Shield 2010 Individual Rate Filing For Healthchoice, Healthchoice Standard And Basic, And Lumenos Consumer Directed Health Plan Products; Docket No. INS-10-1000; Section 4H – Litigation Costs; http://www.maine.gov/pfr/insurance/orders/10-1000.html.

components in a rate filing raise red flags that an insurer may be building in extra profits. These would include a "Contingency Provision", "Risk Load", "Provision for Adverse Deviation", or "Margin for Uncertainty." These are simply extra profit provisions disguised by using a different label.

Calculating The Total Increase In Premium

After an insurer predicts its future costs, it will know how much it expects to need in future revenue. The amount of revenue needed to cover costs (including expenses and profit) will be compared to the predicted revenue at current rates. The difference between these two revenue figures will indicate the rate change that will be needed to satisfy the Revenues = Costs equation. Insurers often show the indicated rate increase on an average, per member per month basis. For example, if the average desired premium is $250 per member per month, and the premium revenue projection is that the insurer will receive, on average, $225 per member per month at current rates, then the insurer would want to increase rates by an average of $25 per member per month, or by 11%.

THE IMPORTANCE OF RESERVES

Insurance companies hold various types of reserves that may be relevant to a rate increase. These reserves can build up over time, resulting in a significant amount of money for an insurance company. One type of reserve is held for claims that the insurer expects to incur but that have not yet been reported to or paid by the insurer. Another type of reserve is commonly referred to as a contract reserve. Contract reserves theoretically are portions of the premium set aside in the early years of a policy to pay future claims and stabilize rates as customers' medical costs rise during the life of the policy. Here are examples of the impact that reserves can have:

- UnitedHealth Group brought hundreds of millions of dollars into earnings in 2009 and 2010 from the release of previously excessive loss reserves. United Health Group stated, "In the third quarter *the Company realized $230 million in favorable prior period reserve development, including $80 million from prior years, as compared to $190 million in the third quarter of 2009, $100 million of which related to prior years.*" (HUnitedHealth Group News ReleaseH, "UnitedHealth Group Reports Third Quarter Results," Oct. 19, 2010, pg. 3).
- Blue Cross Blue Shield of North Carolina is returning over $150 million to policyholders as a result of excess contract (active life) reserves resulting from changes under the health reform law. (HNCDOI NewsH, "More than 215,000 BCBSNC Individual Policyholders Begin Receiving Refunds," Dec. 1, 2010).

Insurers often do not disclose information about their reserves in rate filings, although financial statements do show reserves. The extent to which insurers hold reserves and actually use them for their intended purpose (e.g., to pay claims or stabilize rates) needs to be evaluated when insurers seek rate increases. Advocates should seek disclosure of reserve amounts, and question whether the values used for these estimated costs are reasonable. As the UnitedHealth announcement shows, portions of a premium designated for reserves can end up being extra profits in an insurer's coffers.

STEP 2: DETERMINING HOW MUCH DIFFERENT GROUPS OF POLICYHOLDERS SHOULD PAY

After the insurance company determines the overall amount of premium it wants to collect, the next step is to apply the overall rate increase to different groups of policyholders and adjust the rate upwards or downwards based on the risk classifications of the various groups. This relates to the process of risk classification in ratemaking.

There are two main steps relative to this part of the ratemaking process. First, policyholders are combined into groups based upon characteristics that result in different expected costs between groups, but the same expected cost within a given group. Second, the impact of these characteristics on expected costs is evaluated to determine how the premium charge would vary between groups.

Generally, insurers classify individuals and families into groups based on rating factors that may include their age, gender, family composition, geographic location, health condition or medical history, occupation, tobacco use, and level of benefits or "plan factor."

An insurance company ordinarily would apply the overall ratemaking formula to each policyholder, such that the expected revenue from a group containing policyholders with similar risk characteristics would equal the expected cost from this group.[28] In about 18 states, however, insurance companies are not permitted to set premiums in this way. Six states use adjusted community rating, one state (New York) uses pure community rating, and 11 states use rate bands to restrict the number and type of risk categories insurers may use to classify individuals and/or limit how much more they can charge policyholders based on risk characteristics.[29]

The following example, from a rate filing for Blue Cross Blue Shield of New Mexico, illustrates how rating factors are applied to result in the rate charged to an individual based on risk classifications.[30] The rate classifications used by Blue Cross Blue Shield of New Mexico (at that time) for its BlueDirect B plan were: benefit plan, age, gender, existence of a dependent child, geographic location and health status "tier." The company applied these rating factors subject to rate bands required under New Mexico law.[31]

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[28] Insurance actuaries refer to this concept as "actuarial equity."

[29] Kaiser Family Foundation, Individual Market Rate Restrictions, statehealthfacts.org. The idea behind these state rules is to try to make rates more affordable for those with risk factors, including health conditions.

[30] Blue Cross Blue Shield of New Mexico, Individual Rate Filing, Nov. 5, 2009.

[31] New Mexico Insurance Code, 59A-23B-6 requires that the premium charge for any person cannot exceed by more than 250% the premium charged to any other person (with an exception allowing lower rates for certain age children).

For a policy or block of business, an insurer will have established a "base rate" that typically reflects the costs of a person in good health (a "preferred risk") at a certain benefit level, age, geographic area, etc. Blue Cross Blue Shield of New Mexico's base rate for this plan reflected the costs of a 40-44 year-old male, with a $250 deductible, in Albuquerque, with preferred health status (healthiest tier).

Blue Cross Blue Shield of New Mexico, Application of Rating Factors

	Male, 33, $500 Deductible, Santa Fe, Health Tier Preferred	Female, 44, $1,000 Deductible, Albuquerque, Health Tier I	Male, 57, $2,000 Deductible, Taos, Health Tier IV
Average Base Rate PMPM (includes a 29.5% desired average increase)	$285.61 x (multiplied by)	$285.61 x	$285.61 x
Age Factor	.7037 x	1.1999 x	1.4999 x
Plan Factor	.8327 x	.7235 x	.5806 x
Area Factor	1.1000 x	1.0000 x	1.1000 x
Tier Factor	1.0000 =	1.0500 =	1.2000 =
Monthly Premium	$184.10	$260.34	$328.31

One of the goals of health reform was to end the current widespread practice of insurers refusing to cover – or charging exorbitant premiums to cover – people who have pre-existing medical conditions. The new rules that go into effect in 2014 will impact how insurers set individual market premiums in most states by allowing rating differences based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group markets. States may maintain or enact stronger restrictions if desired.

Section 3

EVALUATING THE MEDICAL TREND USED IN A RATE FILING

Because rate increases depend to a large extent on the medical trend used by the insurer to predict claims, this factor deserves close evaluation and should be supported by historical claims data. If an insurer's medical trend is inflated, the resulting indicated rate increase likely will be excessive.

INSURER'S HISTORICAL DATA

A useful method for evaluating an insurer's medical trend is to examine the historical claims experience. This shows how claims costs have changed in the past. It is common to review several years of historical experience when evaluating trends. Historical experience will reflect the combination of all the components of the medical trend. That is, if "deterioration" or "duration" is causing medical trends to increase, the historical data would reflect the impact of those items on claims costs. As discussed, if historical data is used to predict future claims costs, and then separate components are added for "leveraging," "deterioration" or "duration," that could result in the double counting of the impact of those items and an overstated cost projection.

An example of the type of historical trend experience that can be informative for regulators and advocates was disclosed in a rate hearing proceeding in Connecticut and is attached in Appendix C. Anthem Blue Cross and Blue Shield was required to show its claims history data for a "rolling twelve month basis" to show how much claims had increased from December 2007 to December 2008, January 2008 to January 2009, February 2008 to February 2009, and so on until June 2009 to June 2010. The data revealed that Anthem's claims trend had declined steadily since the twelve-month period ending on November 2009, and that claims had increased just 4.19% between June 2009 and June 2010. Based on this data, the Connecticut Insurance Department found that the 12.5% medical tend that Anthem used for pricing was "excessive" and "deem[ed] 5% to be a reasonable trend factor to project claims for the rating period."[32] In addition, as noted, the Department rejected a duration adjustment to the trend. Use of the 5% trend and rejecting the duration adjustment yielded a 0% increase for policyholders, instead of the 19.9% increase requested by Anthem.

When selecting a medical trend factor to apply, consideration should be given to how the future may be different from the past. In other words, the trend should reflect the various components previously discussed, and also whether or not the historical trends for those components is likely to be repeated in the future. Various cost containment activities, as well as overall economic and medical care practice conditions, could have an impact on medical trends, making the future different from the past. For example, UnitedHealth Group showed higher profits in 2010 because of what it characterized as, "... moderation in overall health system utilization, successful clinical engagement and management ..."[33] If there is an expectation that future trends will differ from historically observed values as a result of these, or other influences, then that should be taken into account in the rate calculation.

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[32] Order and Decision In the Matter of the Proposed Rate Increase Application Of Anthem Blue Cross And Blue Shield; pg. 18-19, available at http://www.ct.gov/cid/lib/cid/Order_and_Decision_Docket_No._LH10-159_-_Anthem_Blue_Cross_and_Blue_Shield.pdf.

[33] UnitedHealth Group News Release, "UnitedHealth Group Reports Third Quarter Results," Oct. 19, 2010, p. 3.

The aggregate impact of provider contracts as reflected in unit cost claims trends and utilization/mix of services also should be examined for reasonableness. In rate filings, insurers should break down the medical trend into separate trends for unit cost and utilization to show how much each of these factors contributes to costs. Also, consideration should be given to whether future unit cost trends will be equal to historical trends. There is increasing emphasis being placed on controlling the various factors that drive up the cost of health care, including increases in unit costs. If future price increases are expected to vary from the historical experience, this needs to be reflected in the claims trend used to calculate a rate increase. Likewise, in the past, utilization/mix of services generally has put upward pressure on health care costs and insurance premiums. However, today more emphasis is being placed on reducing unnecessary services, improving medical outcomes and bending the cost curve.[34]

OUTSIDE INFORMATION TO CONSIDER

In evaluating medical trends, sources of information other than the rate filing could be useful. Relevant data may be found in the insurance company financial statements and public documents. For example, WellPoint stated the following regarding trends:

> **Premium and Cost Trends:** *Trends represent Local Group fully insured business*. For the full year of 2010, the Company continues to project that underlying medical cost trend will be in the range of 8.0 percent, plus or minus 50 basis points, and believes that full year cost trend will be closer to the lower end of the range. Unit cost increases continue to be the primary driver of overall medical cost trend. The Company continues to price its business so that expected premium yield exceeds total cost trend, where total cost trend includes medical costs and selling, general and administrative ("SG&A") expense.[35]

In reviewing a rate filing, a comparison can be made between what the insurance company is telling regulatory agencies and what the insurance company is telling others, such as investors.

Comparisons can also be made between the insurer's medical trend and objective trend data. For example, an insurer's unit cost trend can be compared to the medical consumer price index for the nation or a specific geographic location, keeping in mind that an insurer's unit costs are heavily dependent on their

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34 In many states, one of the first challenges in evaluating the reasonableness of an insurer's medical trend will be getting access to sufficient historical data and other relevant information. In some states, insurers are not required to submit detailed data to back-up their projections, and in others all or portions of an insurer's rate filing is kept confidential. See Section 4 discussion on transparency.

35 WellPoint Press Release; Second Quarter 2010 Results; page 2; (emphasis in original) http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-newsArticle_financial_invest&t=Regular&id=1452767&.

particular contractual reimbursement rates with providers (see Appendix B). Several organizations publish studies of medical trends. A study from Standard and Poor's, for example, showed that average claims nationwide for hospital and physician services increased by 7.8% between November 2009 and November 2010 for commercial insurers.[36] Another study estimates that nationwide average medical trends will be 9% in 2011, a decrease from 9.5% in 2010.[37]

The claims trend an insurance company chooses to include in a rate filing can be conservative (from the point of view of the insurance company) by being higher than the expected value. A presentation at a Society of Actuaries meeting gave the following definition of pricing trend, "Carrier's estimate of *future* claim cost changes over *future* experience periods with **some level of margin for uncertainty**."[38] But, as discussed, a "margin for uncertainty" is a way of adding in an extra provision for profit, disguised by calling it another name.

The evaluation of medical trends is a technical issue which depends upon the circumstances of a particular situation.[39] However, even if you don't have an actuary on hand to help you evaluate rate filings, there are key pieces of information you can examine – and key questions you can ask – to get a sense of the reasonableness of the insurer's medical trend and rate increase overall. See Appendix A, Checklist for Evaluating a Rate Increase, for more information.

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[36] Standard and Poor's Healthcare Economic Commercial Index, Published Jan. 20, 2010.

[37] PriceWaterhouse Coopers, Behind the Numbers, Medical Trends 2011.

38 SOA '10 Health Meeting; June 28- 30, 2010; Session # 34 PD: Health Pricing; page 7 – slide 13 (Bold added); http://www.soa.org/files/pdf/2010-spring-health-weilant-34.pdf.

39 Certain technical issues which may need to be taken into account, depending upon the data used, include seasonality reflecting that the expected claims costs for insurance varies depending on the section of the calendar year, work/calendar day adjustments which reflects changes due to more or fewer work/calendar days in a given period of time, and the treatment of large or unusual claims.

ARE ADJUSTMENTS FOR "DURATION" OR "SELECTION" NECESSARY?

It may not be unusual that over time a disproportionate percent of members in a block of business have significant healthcare needs. This can be the result of what insurers call **UNDERWRITING WEAR-OFF**, or **DURATION**, the impact of once-healthy members (who passed underwriting because they were healthy) developing more medical needs after they are insured for a while. It can also be the result of **ADVERSE SELECTION**, in which healthier members drop out of the policy as costs rise, leaving remaining members who are, on average, unhealthier and have higher medical costs.

A serious consequence of a shift from healthy to less healthy members in a block can be a significant increase in the indicated premiums. As the health insurance rates continue to rise dramatically, consumers will find it increasingly difficult to afford the premiums. The expected result is that a higher proportion of the less healthy policyholders will stay in the program if they can afford it, leading to higher costs per insured in the future, which will then fuel further drops in enrollment and a repeating pattern of higher costs and increased rates. This is the so-called "**DEATH SPIRAL**" that can lead to a point where only people with costly medical conditions will continue to purchase the insurance at the very high rates that will result. As this process continues, the pooling aspect of insurance will be lost as essentially only people with significant medical issues will remain in the program.

Insurance companies may adjust the medical claims trend used to calculate rates to account for this shift in a block of business from healthier to less healthy members, using various terms, such as "**DURATION**" or "**UNDERWRITING WEAR-OFF**," or "**SELECTION**" or "**DETERIORATION**." However, a separate component to account for this shift does not necessarily need to be added to the medical trend. The historical experience analyzed may reflect the impact of changes in the health of a block's members. In that case, adding these separate trend components can result in double counting the same item, producing an inflated overall trend used in the premium calculation. Further, a process that based insurance rates on a larger grouping of people with a bigger spread of risk, or where the rate increases for a closed block of business (policies no longer being sold) were related to that for an open block of business (policies still enrolling new members), as some states require, could lead to more affordable insurance premiums for people with health conditions. (See Section 4, Risk Spreading Among Individual Market Members).

Section 4

IS YOUR STATE'S RATE REVIEW EFFECTIVE?

Currently, states take various approaches to review individual market rates. About 34 states have "prior approval" laws for at least some individual market products.[40] About 15 states have "file and use" laws, and the remaining states do not have rate review at all, although they may require insurers to file rate increases "for information only."[41]

Within these statutory frameworks, specific requirements and procedures vary by state. And in some states, requirements vary depending on the type of product, such as HMO or PPO, or by type of insurer, such as nonprofit or commercial life and health insurer. Moreover, statutory authority does not always reflect what happens in practice a given state. A study of state rate review laws and practices found that "having approval authority over rates does not necessarily protect consumers from large rate increases, and that the rigor and thoroughness that states bring to rate review can vary widely, depending on motivation, resources, and staff capacity."[42]

PRIOR APPROVAL

Under prior approval laws, insurers must file rate increase requests with state regulators and rates must be approved before they go into effect. In most prior approval states, the requested rates are "deemed" approved if the Insurance Commissioner or other agency official does not affirmatively approve or deny them within a certain time frame, usually 30 or 60 days.

FILE AND USE

File and use laws permit an insurer to file rate increases before or on the effective date, and implement them without having received state approval first. But state regulators may conduct retrospective review and take corrective action if rates are found to be excessive or not in compliance with state laws and regulations.

Under the PPACA framework, states and HHS will review potentially "unreasonable" premium increases to determine whether they are justified. As discussed in Section 1, HHS has proposed a new rule to implement the "unreasonable" provisions of the PPACA. The proposed rule envisions a system in which rates of 10% or higher for individual consumers or small groups are reviewed to determine whether they are unreasonable. States remain primarily responsible for reviewing rate increases that meet the threshold. HHS will conduct such a review only on behalf of states that have been found to lack "an effective rate review program."

Under the proposed rule, HHS would conclude that a state has an "effective" program if the state meets four criteria:

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40 Kaiser Family Foundation, State Statutory Authority to Review Health Insurance Rates, Individual Plans, 2010, statehealthfacts.org.

41 According to HHS, Alabama, Arizona, Georgia, Illinois, Louisiana, Missouri, Montana, and Texas currently do not conduct any rate review in the individual or small group markets.

42 "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," Kaiser Family Foundation and Georgetown University Health Policy Institute, Dec. 2010, available at www.kff.org.

(1) the state requires insurers to provide data and documentation sufficient to conduct the review described in (3);

(2) the state conducts an effective and timely review of that data and documentation;

(3) the state examines the reasonableness of the assumptions used by an insurer in developing a rate request and the validity of the historical data underlying the assumptions, and the reliability of past projections in light of actual experience, including analysis of:

(a) medical trend changes by major service categories
(b) utilization changes by major service categories
(c) cost-sharing changes by major service categories
(d) benefit changes
(e) changes in enrollee risk profile
(f) any overestimate or underestimate of medical trend for prior year periods
(g) changes in reserve needs
(h) changes in administrative costs related to programs that improve health care quality
(i) changes in other administrative costs
(j) changes in applicable taxes, licensing or regulatory fees
(k) medical loss ratios
(l) the insurer's risk-based capital status (surplus) relative to national standards; and

(4) the state makes a determination of whether a rate increase is unreasonable under a standard that is set forth in a state statute or regulation.[43]

HHS expects that a "vast majority of states will be able to conduct effective rate reviews in the future" for the individual or small group markets or both.[44] However, existing laws, regulations and practices in many states will need to be improved if rate review is to play an effective role in making premiums affordable.

To truly protect consumers from unjustified rate hikes, states must increase scrutiny of insurers' justifications for rate increases, broaden the scope of review and regulatory authority over rates, and open the process to consumers and consumer advocates. Described below are some issues you should consider when evaluating the strength of your state's rate review.

[43] Rate Increase Disclosure and Review; 75 Fed. Reg. 246 (proposed Dec. 23, 2010) (to be codified at 45 C.F.R. 154.301).

[44] Id. at 81012.

DOES YOUR STATE COLLECT SUFFICIENT DATA AND THOROUGHLY EXAMINE INSURERS' ACTUARIAL CALCULATIONS?

In practice, state rate review typically involves an insurer submitting a rate filing to the state's Department of Insurance or other insurance oversight agency. Most states with rate review require that the rate filing include an actuarial memorandum providing "actuarial justification" for rate increases, meaning that the insurer's actuary must demonstrate or certify that the rates comply with state laws and were developed in accordance with professional standards of actuarial practice.

CALIFORNIA's Insurance Commissioner had already greenlighted Anthem Blue Cross's request to raise rates as high as 39% on some policyholders in 2010, but public outcry prompted the state to hire an outside actuary to audit the insurer's calculations. The actuarial firm, Axene Health Partners, found that Anthem made "material" mistakes in its actuarial assumptions resulting in an inflated medical trend, the expected rate of increase in medical costs. The biggest mistake was that Anthem "double-counted" the effects of members aging in its calculation of medical trend. The error led Anthem to predict a rate of cost increases of 19.8%, but Axne found that only 14% was justified. Rate increases and underlying medical trends that seem inordinately high, like Anthem's, should raise red flags with regulators, indicating that a deeper actuarial review is necessary.

Most states with rate review rely heavily on "actuarial justification" as a standard for deciding whether to approve a rate increase. The Actuarial Standards Board, a body that promulgates professional standards of practice, recommends that actuaries consider "which assumptions are necessary" for the rate filing, including "health cost trends" among several items. The standards, however, recognize that actuaries have broad leeway in predicting costs, noting that:

"In many cases, [a state] law may be silent as to the assumptions and methodology to be used, thus giving the actuary significant discretion to exercise professional judgment in preparing and reviewing the filings."[45]

In some cases, rate filings show, an insurer's actuarial assumptions result in projected medical claims that exceed the rate at which medical claims have increased in the past. For example, the Maine Superintendent of Insurance rejected a 2010 request from Anthem Blue Cross and Blue Shield to raise rates an average of 23%, finding that Anthem overstated its claims projections. The company assumed that claims would rise by 11.7%, but after examining claims data the Superintendent found Anthem's trend assumption to be "far in excess of historic levels." The Superintendent determined, with the help of consultants, that a trend assumption of 7.3% was justified.[46]

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[45] *Actuarial Standards Board, Actuarial Standard of Practice No. 8, Regulatory Filings for Health Plan Entities. See also* NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act, May 12, 2010: "Most states with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with state law...This allows the states to rely on the Code of Professional Conduct and the Standards of Practice that actuaries must follow."

[46] Decision and Order in Re: Anthem Blue Cross And Blue Shield 2010 Individual Rate Filing For Healthchoice, Healthchoice Standard And Basic, And Lumenos Consumer Directed Health Plan Products, Docket No. INS-10-1000, at p. 10; http://www.maine.gov/pfr/insurance/orders/10-1000.html.

The Maine case and other examples discussed in Sections 2 and 3 demonstrate that it is important for regulators to determine how an insurer has arrived at a rate increase and whether the factors and assumptions used in the calculation are accurate, necessary, and in line with patterns of actual past increases in medical claims. The infamous Anthem Blue Cross case in California is another example of why close checks on insurers' "math" are needed (see box). State reviewers also should consider the accuracy of an insurer's past revenue and cost projections when evaluating a rate increase.

The discretion permitted by actuarial justification can harm consumers if states accept at face value an insurer's projections, without examining underlying data to sufficiently justify the calculations. To that end, regulators must collect sufficient data to support all actuarial assumptions. States currently vary in the amount and type of data that an insurer needs to include to demonstrate compliance with the state's standards.

To evaluate the effectiveness of your state's rate review, an important step will be to determine what authority your state has to collect data, what data is collected, whether your state has actuaries and other staff on hand to analyze it, and what level of review is conducted. For example, does your state merely review filings for completeness? How thorough is the actuarial review? Does your state have resources to review every filing?

DOES YOUR STATE HAVE A BROAD STANDARD OF REVIEW ALLOWING REGULATORS TO CONSIDER A HOST OF RELEVANT FACTORS?

For most states with either prior approval or file and use rate review, statutes provide that rates must result in "benefits that are reasonable in relation to the premium charged" and/or that the rates may not be "excessive, inadequate, or unfairly discriminatory" (or some variation of these two standards). These standards are not defined in every state, but are meant to serve as a basis for a regulator's approval or disapproval of a requested rate increase.

The requirement that benefits be reasonable in relation to premiums usually refers to a medical loss ratio standard.[47] Thus, in states with this standard alone, rates tend to be approved if the insurer shows that they meet the loss ratio standard. The "excessive, inadequate, or unfairly discriminatory" standard generally provides more authority for state regulators to reject rates than the "reasonable in relation to premium" standard. But in many states using this broader standard, what is "excessive" is not defined.

47 See e.g. the National Association of Insurance Commissioners, Guidelines for Filing of Rates for Individual Health Insurance Forms, Model Regulation 134 ("...benefits shall be deemed reasonable in relation to premiums" if the anticipated loss ratio is between 50% and 60%, depending on the renewability aspects of the policy).

Both of these standards may limit a regulator's ability to consider factors other than actuarial justification, such as the company's profitability and financial strength, risk spreading in the individual market, efforts to control costs, and the hardship on consumers.

Overall Financial Condition of the Insurance Company

In current state rate reviews, regulators often look only at the financial performance of each individual market policy or block of business when determining whether to approve or disapprove rate increases. Insurers tend to argue that each separate block must be independently profitable in order to maintain company solvency or to give insurers the incentive to continue offering products in the individual market.

However, while an insurer may be losing money or breaking even on one block, it may be making strong profits on another or in other areas of the company. Some very profitable health insurers have claimed that they are forced to raise rates due to losses on individual market products.[48] State regulators may be reluctant to push back against a rate increase, no matter the hardship on consumers, when an insurer reports that it will lose money on an individual market block. Some regulators have said that they do not believe that the current, commonly used standards give them authority to consider the financial condition of the entire company when deciding whether to approve or disapprove rates.[49]

"The most vulnerable members of the Blue Cross community of insureds should not be asked to add to Blue Cross' surplus this year, especially on the heels of a 20-30% increase."

-Rhode Island Hearing Officer, rejecting BCBS of Rhode Island's request in 2007 to contribute 2.5% of a 7.8% increase to surplus profit.

A few states have passed laws that explicitly allow regulators to examine an insurer's financial position, including profits, surplus, reserves, dividends, investment income, and other measures of financial strength when determining whether a rate increase is excessive or otherwise meets state standards.[50] Further, top insurance officials in Rhode Island and Maine have repeatedly rejected insurers' attempts to add surplus/profit margins into individual market premiums as unnecessary in light of the company's existing surplus and financial condition and the hardship that the increases would impose on consumers. (For more information on health insurer surplus – funds built from premium dollars and held for solvency protection – see our study "How Much is Too Much?").

Another issue that regulators should watch is whether insurers are moving profits to parent companies, sometimes out of state. In Washington, nonprofit Premera Blue Cross was found to have used surplus gained through rate increases on

[48] In a widely-reported example, Wellpoint Inc., parent company of Anthem Blue Cross, claimed that the company lost $10 million in 2009 on individually-insured Californians, yet the company reported $2.7 billion of profit in the fourth quarter 2009, just as it tried to raise rates by up to 39% on some individuals. See Insurer Blames Health Costs for California Rate Hikes, LA Times, Feb. 24, 2010.

[49] See, e.g., Health Insurers Raise Rates, While Increasing Reserves and Salaries, Seattle Post Intelligencer, Oct. 25, 2010 (discussing efforts of the Washington Insurance Commissioner to get explicit authority to include surplus when reviewing rate requests).

[50] See Oregon Revised Statutes § 743.018(5), Colorado Revised Statutes § 10-16-107(1.6).

Washington policyholders to keep afloat a for-profit subsidiary in Arizona.[51] Anthem Blue Cross in California moved $525 million in profits in 2009 to its parent Wellpoint just as it sought rate increases of up to 39% for individuals.[52] And in Colorado, regulators required Kaiser Permanente to return $150 million to policyholders and to create affordable coverage programs after finding that the Colorado subsidiary had transferred millions of dollars to the California-based parent.[53]

Many states need a stronger standard of review that explicitly allows them to consider wider aspects of an insurer's business if rate review is to be effective for individual market consumers.

Risk Spreading Among Individual Market Members

In December 2009, Pennsylvania's former Insurance Commissioner Joel Ario told state lawmakers that some plans in his state sought rate increases of 30% to 40% percent for individual market consumers. He allowed only an average of 10% increases, and explained why in a letter, stating:

> Many of the proposed increases...exceeded 20% and some exceeded 40%, not because medical trend was running that high for all customers but rather because the filings were more aggressive in discriminating between good and bad risks. When the companies pointed to medical inflation as a reason for seeking [the] increase, we pointed out that medical inflation, while still unsustainably high, is running under 10% on average. We also pointed out that the requested rate increases were based more on reducing or eliminating past practices that spread risk broadly across product lines rather than on broad increases in utilization. Finally we found other actuarial problems on a case by case basis.[54]

"Many of the proposed increases...exceeded 20% and 40%, not because medical trend was running that high for all customers, but rather because the filings were more aggressive in discriminating between good and bad risks."

-Joel Ario, Former Pennsylvania Commissioner

Like the plans in Pennsylvania, many insurers try to limit, rather than maximize, risk spreading in the individual market. This can be achieved, for example, by creating separate pools of high cost members and low cost members for the purpose of spreading costs. Or, if currently permitted by state laws, insurers may charge less healthy or older members much higher premiums than younger or healthier members. Insurers may prefer to segregate risk this way because it allows them to offer some policies at lower prices to attract new (and healthy) customers. But these practices undermine the objective of insurance to spread

[51] Premera Surpluses Here Subsidize Arizona Losses, Seattle Post Intelligencer, Feb. 24, 2008.

[52] As Anthem Blue Cross Sends Profits to Wellpoint, It Plans Hefty Rate Hikes for Californians, LA Times, Feb. 23, 2010.

[53] Commissioner and Kaiser Permanente Enter Agreement to Provide $155 Million to Colorado Consumers, Colorado Division of Insurance New Release, June 24, 2008.

[54] Insurance Commissioner Joel Ario letter to Representative Neal P. Goodman, Dec. 2, 2009, attached to Testimony Before the Pennsylvania Senate Appropriations Committee, Feb. 17, 2010.

costs widely among large pools of people with various risk characteristics, and they lead to huge rate increases for some individuals and families.

In particular, closed blocks remain a problem in some states. Closed blocks are blocks of business consisting of a policy or policies that are no longer being sold. Medical claims for individuals covered under these policies tend to be high because no new healthy customers are enrolling in the pool to moderate average claims costs. Further, healthy members who can pass underwriting tend to drop the policy for cheaper coverage, leaving behind higher cost members who can't shop for new policies because they have developed medical conditions. This leads to the "death spiral" of higher costs, higher rate increases, and shrinking enrollment in these closed blocks.

To try to alleviate the death spiral burden on closed block members, about 10 states have laws or regulations requiring broader pooling for these blocks. Kansas and Florida, for example, require insurers to pool the claims of closed blocks with the claims of open blocks when setting premiums.

But in other states, closed blocks continue to cause large increases for some policyholders. Illinois, for example, reported that in 2008 and 2009, rate hikes on closed blocks were almost all in the double-digit range, with a majority of closed block increases at 20% or higher. In contrast, many rate hikes on open blocks were less than 10%, with a majority of increases at 15% or less. In another example, Blue Cross Blue Shield of New Mexico closed three policies to new business in January 2010 just three years after introducing them to the market. Two of the company's oldest closed blocks have less than 400 people remaining in the pools to share costs. These policyholders paid average premiums between $455 to $816 in 2009 and they have endured at least three to four consecutive years of increases at 20 percent and higher.[55]

The PPACA contains several measures designed to fix the lack of risk spreading in the individual market. In addition to the adjusted community rating requirements mentioned in Section 2, beginning in 2014, each "issuer" of health insurance will be required to operate a single risk pool containing all of its non-grandfathered individual market policyholders. Finally, the new federal medical loss ratio requirements, effective January 1, 2011, may result in broader risk spreading if insurers meet the 80% standard by pooling together the claims of higher and lower cost blocks.

Still, until 2014, in deciding whether to approve a requested rate increase, states should closely examine rating factor adjustments, including the maximum and minimum increase that any policyholder will get, to be sure high risk individuals aren't unfairly burdened with unreasonably higher rates than low risk individuals. States should give special consideration to people covered in closed block plans. Regulators should look for ways to mitigate large increases on these

[55] Blue Cross Blue Shield of New Mexico, Individual Rate Filing, Nov. 5, 2009.

individuals by potentially requiring broader cost spreading or subsidization from a company's surplus (see discussion above). And, come 2014, states will need to ensure that companies do not undermine the risk pooling requirements in the PPACA through corporate structures that would segregate "healthy" parts of their individual market business from "sicker" parts.

Encouraging Insurers to Control Costs

States look at whether an insurer's projected revenue will cover projected claims, expenses, and target profits, but that review often does not lead to the next logical step: examining how insurers are attempting to control the cost of medical care to make coverage more affordable. Regulators need broader tools to use rate review as leverage for changing our healthcare delivery into a more cost-effective, higher quality system.

A first step toward getting control of rising healthcare costs is public disclosure of the prices that different providers charge private insurers for a representative sample of goods or services, or at a minimum, disclosure of the rate of medical costs increases identified by type of healthcare costs (e.g., inpatient care, outpatient care, physician services, pharmaceutical drugs, medical devices, radiology, etc.), preferably broken down by provider.

Existing rate review processes usually do not include such disclosures. But Massachusetts and Rhode Island have conducted in-depth studies of provider prices to begin to address the conditions that are driving medical costs up. (See further discussion of Massachusetts' findings in Appendix B.)

States should also zero in an insurer's cost containment efforts when an insurer seeks a rate increase. Insurers should be required to describe their payment models and their efforts to control costs, as well as the projected savings derived from any of these efforts and how they were accounted for in the rate calculation. A few states are requiring insurers, as part of a rate filing, to describe their efforts at bolstering cost control, instead of simply passing on rising costs to consumers through rate increases, but it is too early to tell whether these filing requirements go far enough in encouraging

RHODE ISLAND created an Office of the Health Insurance Commissioner (OHIC) in 2004, separate from the state's other insurance regulation agency. The OHIC was given broad powers to direct insurers to provide policies that promote efficiency, quality, and access. Pursuant to its broad authority, the OHIC requires insurers to enhance **AFFORDABILITY** of their products in all market segments. The affordability standard requires insurers to "address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself." (OHIC Regulation 2). As part of the small group and large group rate approval process, the OHIC required reporting of payment methods and found that insurers were using, in part, long outdated hospital payment methods that had been shown to lead to higher costs. The disclosures also revealed that the insurers had little to no incentives for improving quality of care built into their hospital payment structures. The OHIC directed the insurers to begin working with hospital systems to realign incentives in payments. The OHIC also conducts hearings on individual market rates.

substantive cost containment measures.[56] Rhode Island's earlier experiment in requiring filings describing cost control "affordability" efforts did not prove effective, and the state subsequently implemented stronger directives to insurers to implement cost and quality incentives in payment models.

States may begin to get a handle on rising costs by studying the underlying causes of cost increases in local markets, by requiring more disclosures related to provider prices and rates of cost increases, and by adopting "affordability" as one of the criteria for approving rate increases (see Rhode Island box).

Consumer Hardship

State standards for reviewing rates should include the authority for regulators to consider how the increase will impact consumers, including those who will receive higher than average increases due to rating factors. An insurer can report how many people are expected to drop coverage or buy-down benefits by evaluating past experience. And regulators should look at the history of rate increases across different types of individuals to determine whether an increase is just one in a long line. Consumer perspectives should inform this analysis, as described below.

IS YOUR STATE'S RATE REVIEW TRANSPARENT AND OPEN FOR CONSUMER PERSPECTIVES AND PARTICIPATION?

Most states earn poor marks for transparency in the rate review process, starting with a failure to require full public disclosure of rate filings containing the proposed increases, actuarial justifications, and other information that insurers submit to regulators.[57] Public disclosure of rate filings and company financial information is crucial for holding insurers accountable and informing consumers and consumer advocates about the reasons for rate increases. In addition, in most states, consumers simply don't receive enough plain language information to help them understand why their premiums are going up. Many states have indicated an intent to use federal rate review funds to improve transparency.

Further, in many states, regulators review proposed rate increases outside public view, without consumer input. Negotiations between insurers and state officials occur behind closed doors. Therefore, it is difficult for consumers and advocates to learn when and why a rate increase was approved, or in some cases, lowered

[56] Oregon and California enacted reporting rules in which insurers attest to their efforts at cost control and quality improvements in rate filings. See Oregon Administrative Rule 836-053-0471; CA Health and Safety Code 1385.03(c)(3) and Insurance Code 10181.4(c)(3). California's law was effective Jan. 1, 2011.

[57] Some states post rate filings online, but allow insurers to redact much of the information – even important information showing how rates are justified – because the insurer views it as confidential business information or trade secrets. Other states make all or part of filings available by inspection or mail through public records act requests. Accessing such filings may require a formal request under the state's freedom of information laws and copies may be costly. Other states may not release any part of a rate filing. Maryland, for example, keeps entire rate filings and requested rate increases confidential, and will release the approved rate increase percentages only pursuant to a public records request.

at the behest of state regulators. The actuarial review performed in most states does not require or allow regulators to elicit and assess evidence of the hardship that the rate increase will impose on consumers.

Rate review will be most effective if states provide more information about increases to consumers and consumer advocates, and open up the process to consumer participation. Hearings on rate increases, with the Attorney General or a consumer advocacy group representing policyholders, allow for cross-examination of an insurer's rate calculation and also reveal state officials' level of diligence in evaluating rates. State rate review should provide a clear avenue for a rate hearing by, for example, allowing a policyholder, the Attorney General, and/or a consumer group to request a hearing, and states also should allow a right of intervention for a person with an interest in the outcome, including consumer advocacy groups. Any hearing process must allow the hearing officer to consider the views of consumers as evidence to be weighed in the determination.

Section 5

SUMMARY: ELEMENTS OF STRONG RATE REVIEW FOR INDIVIDUAL MARKET CONSUMERS

Making rate review work better for consumers will require states to exercise greater regulatory power over premiums. The following elements should be considered for any improved rate review process. See our website for a model law designed to enact these elements for individual market consumers.

PRIOR APPROVAL OF RATES HIKES BEFORE THEY GO INTO EFFECT

States should require that their regulators review and make a determination of whether to approve or disapprove all individual market rates before they go into effect.

PUBLIC DISCLOSURE OF RATE FILINGS AND CONSUMER-FRIENDLY RATE SUMMARIES JUSTIFYING RATE HIKES

Insurers' rate increase requests and all material submitted to justify rate hikes should be posted online on a state agency website, with an easy-to-use search tool for retrieving filings, and should be made available for public inspection. Insurers should provide a consumer-friendly summary explaining the reasons for a requested increase.

RATE FILINGS SHOULD BE STANDARDIZED FOR ALL INSURERS AND SHOULD PROVIDE DETAILED JUSTIFICATION FOR ALL RATE INCREASES, INCLUDING DATA SHOWING MEDICAL COST INCREASES OVER TIME

States should develop a standardized form to be used by all insurers to request rate increases. The form and supporting documentation should provide detailed information and data, including historical claims data, and an explanation of all calculations and assumptions used to develop the rate increase.

NOTICE OF A REQUESTED RATE CHANGE AND A PUBLIC COMMENT PERIOD

Insurers must send all policyholders impacted by the proposed rate increases adequate notice of the proposed change, preferably at least 60 days before the proposed effective date. States should provide an opportunity for policyholders to comment on proposed rate changes in public forums, by email, mail, or through a state website.

STATES MUST HAVE A BROAD STANDARD OF REVIEW TO APPROVE OR DISAPPROVE RATES BASED ON A RANGE OF FACTORS

A common standard that some states use today is that rates may not be "excessive, inadequate, or unfairly discriminatory." That standard must be supplemented with criteria that will allow states to look at a range of factors to determine if rates are excessive, including the overall financial condition of the insurer, the history of rate increases, the percent of premium dollars to be spent on medical care, the insurer's efforts to make coverage more affordable, and the reasonableness of cost projections and administrative expenses, and hardship or impact on consumers.

PROTECTIONS FOR CONSUMERS INSURED UNDER POLICIES NO LONGER BEING SOLD

Members who are insured in "closed blocks," which are policies that are no longer being sold, can be hit with especially high rate increases if the insurer is not spreading risk among all of its individual market policyholders. From now until new reforms go into effect in 2014, states should give special consideration to closed blocks, by requiring, for example, that insurers pool people in closed blocks with people in open blocks for the purpose of spreading costs.

NOTICE OF APPROVED RATE CHANGES AT LEAST 60 DAYS BEFORE THE EFFECTIVE DATE

When a rate change is approved, policyholders must receive ample notice, at least 60 days before the effective date of a new rate, so that they may shop for new plans if possible or make changes to benefits if necessary.

HEARINGS ON INDIVIDUAL MARKET RATE CHANGES

Individual market increases should be subject to a public hearing. Public hearings allow for public examination of an insurer's actuaries about their rate increase assumptions and calculations. They also allow for testimony from experts with potentially different views. The Attorney General, policyholders and consumer groups should have the right to participate in rate review hearings as parties. The rules for a hearing must allow the hearing examiner to consider consumer testimony and public comment as evidence to be weighed in the case.

If your state has a large individual market with many carriers, hearings may be impractical or unaffordable for every rate increase. In that case, a rate review statute could establish a threshold for hearings, such as requiring hearings if an annual increase sought is 10% or higher.

CONSUMER AND CONSUMER REPRESENTATIVE PARTICIPATION IN RATE REVIEW

Rate review laws should establish a means to provide consumer representation in the rate review process. States could establish a consumer advocate within a state agency to review rate filings on behalf of policyholders. The consumer advocate must be or have access to an expert with knowledge of rate setting and must have clear authority to apply the state's rate review standards in the best interest of consumers. States should also give consumer advocacy groups a right to intervene in rate hearings and provide funding for those that make substantial contributions to the outcome.

Section 6

SUGGESTIONS FOR PARTICIPATING IN RATE REVIEW IN YOUR STATE

Consumer participation in rate review is important as high rate increases continue. There is a need for advocates in every state to work on behalf of consumers to ensure that insurers are not unnecessarily raising rates and are working toward a more cost-effective delivery system. Here are some suggestions for protecting consumers in your state.

ANALYZE HOW RATE REVIEW WORKS IN YOUR STATE

A logical first step to getting involved is to study the rate review laws and regulations applicable in your state. To get you started, we've collected summaries of rate review laws with statutory citations for some states. We will continue adding to this feature, so check back soon if a summary for your state is not yet available. Be aware that in some states, different statutory sections

apply to different types of health insurers (including managed care organizations), market segments, or insurance products.

While it's important to read statutes and regulations, the laws on the books often do not entirely reflect what's happening on the ground. It may appear that your state lacks authority to reject rates, but regulators may nonetheless be pushing behind the scenes. Or your state may have prior approval authority, but a lack of staff or expertise means that little in-depth review actually takes place. And sometimes the statutes and regulations need clarification to determine how they work in practice.

Insurance department regulators may be a good source of information on how the process works and what they look for in deciding whether to approve rates. Visit your department's website to see what information is available to insurers and consumers regarding rate setting and rate review. Ask your state officials for a call or meeting to discuss rate review procedures.

START WITH TRANSPARENCY

Almost every state needs to improve the amount of information released to the public about rate review and rate increases. Study your state's insurance agency website and make a list of information provided to consumers. An informative, consumer friendly agency website might contain the following:

- **An annual report about the state health insurance market.** This could include financial information and market share for each carrier participating in various market segments, a description of cost drivers, state laws, and other factors affecting rates, and a summary of how people get insurance. Oregon publishes such a report on its website each year.
- **A web page devoted to informing consumers about premiums and rate review**. For example, Colorado, Oregon, and Michigan post FAQs summarizing information such as how insurers set rates, rating factors permitted, what costs and expenses are covered by premiums, and a description of the rate review process and state efforts to ensure compliance with state laws.
- **A web page featuring a list of rate requests and increases.** Rates may be identified by carrier and include the increase requested, and the increase ultimately approved or implemented, the number of people impacted, and the effective date of the increase. Oregon has a search tool that can generate a report with similar information.
- **An historical summary of rate increases.** States should present historical rate increase data by carrier and by policy. Illinois currently does not have rate review, but started publishing such data on its website last year.
- **A search tool that allows consumers to find rate filings applicable to their policies.** The tool should be user-friendly so that consumers can easily determine which filings apply to rates and to their specific policies.

Compare, for example, the easy-to-use search tool in Oregon with the search tool in North Carolina. North Carolina has greater access to numerous types of filings, but the search database may make it difficult for consumers to find the right rate filing for them. Agency websites should feature a prominent link to the search tool on the home page.

- **Consumer-friendly, plain-language summaries of each rate increase with each rate filing.** The summaries should include basic information such as the insurer's primary reason for the increase, the past and anticipated medical loss ratio, the rate increase history, and average and minimum and maximum rate increase that would be effective. Consumers often want to know the minimum and maximum increase – not just the average – so that they can see where they fall on the spectrum of increases. Oregon requires such summaries with individual market filings.

- **Standardized rate filings.** Information presented in a rate filing can vary in substance and form among insurers in the same state. In many states, insurers use an electronic filing system called SERFF to file their rate increases and actuarial justifications. Use of the SERFF system has resulted in standardized cover sheets that provide basic information about a rate increase. However, the format and substance of information in an accompanying actuarial memorandum may vary.[58] Colorado has developed a standardized rate filing form.

BUILD A CONSUMER NETWORK

Insurance regulators may be more likely to challenge a rate increase when they hear from consumers about it. In Colorado, the Division of Insurance launched a probe of Anthem Blue Cross and Blue Shield of Colorado "after a spike in consumer complaints about rate increases."[59] The inquiry led to a settlement between the Division and Anthem resulting in $20 million in premium credits to policyholders or rebates to former policyholders.

Building a network of consumers who are individually insured in your state could be very powerful. Begin to grow your network by reaching out on your organization's website and by meeting policyholders at a rate hearing (if that option is available in your state). Set up an email list to communicate about rate hikes and urge policyholders to send letters, emails and phone calls to regulators. Work with a core group of consumer activists who will attend hearings and/or tell their stories to lawmakers and the media. If regulators don't hear from the people affected by the increase, they are less likely to work on their behalf.

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[58] The NAIC has proposed a disclosure form that carriers would use to justify rate increases meeting the PPACA trigger for state or HHS review. These forms would be posted on HHS's website. However, the proposed rule that would establish the trigger does not appear to adopt the form as a standardized justification.

[59] Anthem Consumers to Receive Share of $20 million Premium Credit, Colorado Division of Insurance News Release, Sept. 16, 2010.

EVALUATE RATE INCREASES AND PRESENT FINDINGS TO LAWMAKERS AND REGULATORS

Check your state agency's website and keep in close contact with your consumer network to find out when insurers file a request to increase rates. Request rate filings from your state agency if they are not available on your agency's website. New federal regulations will ensure that increases meeting a certain trigger (proposed at 10%) will require filings in support of the increase to be posted on the HHS website.

Even if you don't have an actuary to assist with a review of the filings, you can identify key issues, questions, and red flags. See Section 3, Evaluating the Medical Trend, and Appendix A for a checklist for evaluating a rate filing.

Present your findings and questions about the rate filing, along with a description of the consumer hardship that is likely to result from the increase, in a memo or letter to state lawmakers, your insurance commissioner, and the news media. Urge your state regulators to take action to protect consumers from an unjustified rate hike.

REPRESENT CONSUMERS AT RATE HEARINGS

If a hearing will occur, plan to represent consumer interests through public testimony or as an intervening party if state law would allow and if resources are available.

Present your findings and questions about the rate filing and the insurer's actuarial justification. Be sure to publicly disclose details about the company's overall financial picture, any history of raising rates in the individual market, or unreasonable executive compensation. Emphasize the need for both the insurer and the regulator to act in the best interest of consumers. Even if you don't have resources to hire an actuarial expert to examine the insurer's calculations, you can raise questions and points about the rate filing, revenue and cost projections, loss ratios, reasonableness of expenses and profits, efforts to contain costs and other factors.

If your state currently does not conduct rate hearings, check the administrative law statutes. The law may allow for any party "aggrieved by" an agency decision to bring an administrative action to challenge it or may provide a different way of getting a hearing. A policyholder could bring the action with the help of pro bono counsel from an advocacy group or law firm.

USE THE MEDIA

Media outreach is a key tool for advocates working to support stronger state oversight of health insurance rates. As with all advocacy efforts, it's critical to develop a simple, concise message for your campaign that should be emphasized with all communication that you have with the media.

Develop three key messages that capture the essence of the issue in the most accessible way possible. Every time you are interviewed by the media, use that opportunity to deliver your message. For example, your three key messages for rate review issues could be:

Message One: "Many families have been hit by health insurance rate increases year after year, which has made it harder to afford the coverage they need. As a result of repeated rate increases, many consumers can no longer afford coverage or are forced to switch to plans with higher deductibles or fewer benefits."

Use supporting data to show individual market rate increases in your state during the past five years, if such data is available from your state insurance agency, or national information if not.[60]

Message Two: "Our state isn't doing enough to protect consumers from unfair rate hikes."

Use supporting points, depending on your state's rate review process, such as "Our state does not require insurers to get approval for rate increases before they go into effect." Or for those states that do require prior approval: "Regulators in our state rely on insurers' calculations about future medical claims without verifying that these costs are not exaggerated."

Message Three: "Our state needs to strengthen its ability to protect consumers from spiraling health insurance premiums."

Supporting points could include examples of elements of effective rate review that your state lacks.

[60] For example, according to a Kaiser Family Foundation survey, consumers who buy insurance on their own reported that they faced an average rate hike of 20 percent. Average deductibles for individuals were almost $2,500; for families, the average deductible was more than $5,000.

Appendix A

ADOVOCATE'S CHECKLIST FOR EVALUATING A RATE INCREASE

Even if you don't have an actuary on hand to help you examine a rate filing, you can get a sense of the reasonableness of the increase. Here are some key pieces of information you should examine, as well as some questions you should ask when evaluating a rate increase.

The Basic Ratemaking Equation

Section 2 of this Guide describes the basic equation for setting rates: Revenues = Costs. Check the rate filing to determine whether the insurer has presented all of the elements of the basic equation. For example:

- Has the insurer disclosed all projected revenues for the future rating period, including premium revenues, investment income and other revenues?
- Has the insurer disclosed all elements on the cost side of the equation, including projected claims costs, expenses, and profits?

Medical Trend Assumption

As noted in Section 2, the medical trend assumption, or trend factor, reflects how much the insurer predicts it will pay out in medical claims during the period in which the new rates would be in effect. Refer to the discussion in Section 2 for background information on this subject. With respect to medical trend, ask:

- Has the insurer described how it calculated the medical trend assumption?
- Has the insurer presented a history of its claims experience, preferably for several years, showing the rate of change in medical claims per member per month for each month of the period? See Appendix D for the Connecticut example.
- Does the medical trend appear reasonable in light of increases in claims during the past several years?
- Has the insurer broken the trend down to attribute increases to either unit costs or utilization?
- Has the insurer provided a breakdown of costs, in dollar amounts, and by rates of cost increase, by type of medical goods or services for the policy or block of business?
- Is the medical trend in line with those used by other insurers or trend reported on an industry-wide basis? Is the portion of trend attributable to unit cost increases in line with medical inflation?

Other Trend Assumptions

As described in Section 2, insurers may use other factors to predict costs, such as deductible leveraging, duration, and estimates about the impact of adverse selection.

- Has the insurer applied additional assumptions that result in an upward or downward adjustment to the trend used to predict future claims?
- If so, what factors or assumptions were used to do this?
- Did the insurer describe why such adjustments are necessary and substantiate these adjustments with underlying data?
- Has the insurer "double-counted" – in other words, does the historical claims data suggest that these additional assumptions are already accounted for?
- Ask your insurance regulators what adjustments, assumptions or factors to predict costs are permitted in your state.

Administrative Expenses and Profits

An important piece of information is how much the insurer intends to retain in administrative expenses and profits under the proposed premium. Insurers should disclose this information in a rate filing.

- Has the insurer disclosed medical loss ratios, the percent of premium dollars that would be spent on medical care, administrative expenses, taxes and fees, and the percent of premium targeted for profit?
- Has the insurer provided a breakdown of the anticipated MLR showing how the rates will meet the new federal standards requiring 80% of premiums to be spent on medical care and quality activities?
- Has the insurer disclosed the past MLR results for the experience period under state and federal standards?
- Will the new rates result in a lower MLR than the actual MLR during the experience period? If so, why, and is the reduction reasonable or does it result in an unreasonably high increase for policyholders?
- Has the insurer disclosed categories of administrative expenses, as well as how much in premiums went to each category in the prior year and how much is expected to go to such categories under the new rates?
- Do administrative expenses, such as salaries and broker commissions, appear reasonable? Will administrative expenses increase, and if so why?
- Should certain administrative expenses, such as lobbying or certain litigation expenses, be excluded from the rate calculation?
- Is the anticipated profit margin reasonable and fair in light of how individual market consumers are struggling to afford premiums?
- Does the medical trend or other assumptions used in the rate calculation disguise extra profit margins being added to the rate? (See Section 2).

Rating Factors

Rate filings should include a description of the rating factors used to develop the proposed rates.

- In addition to the overall premium increase, has the insurer disclosed the maximum and minimum rate increase that any policyholder or group of policyholders will get?
- Does the maximum rate increase for any group appear reasonable, or would the increase overburden policyholders with certain risk characteristics, such as older individuals and those with health conditions?
- Does the rate filing describe all rating factors used and demonstrate how each rating factor will impact policyholders depending on their classification?
- Does the insurer present rate tables that show base rates, as well as how much in premium a person will pay when rating factors are applied?

Closed or Open Blocks

At least until full reforms are in effect in 2014, closed blocks may be a problem in your state. Individuals and families covered under these policies may need special consideration from state regulators. Check rate filings to determine:

- Has the insurer reported whether the policy or block to which the new rate would be applicable is closed or open (still being sold)?
- How many people are covered under each policy impacted? Do some blocks contain small numbers of members?
- Has the insurer developed the rates by dividing predicted costs only among the members of a closed policy or block, or has the insurer aggregated predicted claims and divided them among members covered under all individual market policies?
- Has the insurer presented an enrollment history, and if so, does it show drops in enrollment that are typical of closed blocks and can lead to higher costs for remaining members (in other words, is the policy in a death spiral)?
- Does the insurer have excess reserves or surplus funds that may be used to support closed blocks?

Rate Hike History

- Has the insurer presented the history of rate hikes for at least the past five years?
- Have the policyholders endured consecutive annual large increases, or is the insurer raising rates more than once a year, resulting in large cumulative increases annually?

Company Finances

Consideration of company finances may require examining financial statements in addition to rate filings. Financial statements may be obtained from state insurance departments or from the NAIC's website for a fee (the first five statements are free; thereafter they are $10 each for annual statements and $3 each for quarterly statements). State agencies also may have a supplemental report of executive compensation. For-profit financial filings are available on the Securities and Exchange Commission website or on company websites. Consolidated statements show the financials for all affiliates in an insurance company. News reports are often helpful in gathering financial information.

- What is the insurer's overall financial condition? How much has it made in underwriting margins, investment income, and net income (profits) for the past five years?
- What is the company's surplus? What is the surplus in relation to how much surplus the insurer must hold at a minimum? Is surplus far beyond minimum levels?
- Does the company have reserves that apply to the policy subject to the increase? Are the reserves being used for their intended purpose?
- Does the company use reinsurance or other mechanisms to protect it from losses?
- Is the company adding profit margins to its individual market products that are too large or unnecessary for solvency?
- What is the insurer's financial picture specific to the state at issue and to the individual market within that state?
- Has the insurer transferred profits to a parent company or affiliate in another state?

Impact on Consumers

As an advocate, you will be best equipped to discern the impact that a rate increase might have on consumers through communicating with policyholders and knowledge of your state's healthcare issues. You might also try to get more information from the insurer, such as:

- How many people does it predict will "buy-down" to fewer benefits or higher deductibles or "lapse" (drop coverage) due to the increase?
- What is the highest increase that will be imposed and what types of policyholders will be subject to that increase?
- What is the rate hike history for consumers in the policy or block?

Appendix B

THE COST CONUNDRUM: ISSUES RELATED TO UNIT COSTS AND UTLIZATION

Insurers are quick to assert that their premiums merely reflect underlying factors that are out of their control, like soaring medical prices, increased use of healthcare services by members, benefit mandates, and changes to health plans' risk pools.

Key factors relevant to rising medical costs are changes to unit costs (prices for medical goods and services) and changes in utilization/mix of services.

UNIT COSTS

Insurers have a legitimate claim when they point to rising medical prices. Due to a host of factors, the price of a hospital stay, a physician visit, or a course of treatment have been rising faster than the general rate of inflation. The federal Bureau of Labor Statistics tracks the price of a "market basket" of medical goods and services. These data indicate that over the past ten years, the average inflation rate for medical care nationally was more than 50% higher than the overall inflation rate.[61]

Having said that, it often is difficult for advocates or regulators to verify insurers' claims regarding increases in the cost of medical goods and services. Insurers negotiate with health care providers in their networks to determine the fees that will be paid for medical goods and services. The fees can depend to a large extent on the relative market position of the health care provider and the insurance company. For example, popular hospitals or physician groups can use the threat of refusing to accept an insurer's patients to force the insurer to pay higher prices. In contrast, smaller providers, such as solo practitioners, may have little negotiating power against insurers, and may be paid according to a fee schedule set by the insurer. To reduce its costs, an insurance company may try to impose lower reimbursement rates on smaller community hospitals and solo physicians, which can cause further imbalances in the payment rates among providers. However, small providers in rural areas may still have market power in negotiations with insurance companies if there are few or no competing providers in the area.

[61] Note: The inflation rate, based on the national CPI, measures general price changes over time (often one year) for a market basket of consumer goods. This information is obtained through surveys conducted in selected urban areas. Price information is also available for subsets of goods and services, such as medical care.

In sum, price negotiations can result in widely varying fees paid to health care providers for similar services, even those in the same geographic markets, and such variations are not necessarily reflective of differences in the quality of service. Contractual reimbursement rates between insurers and providers are kept confidential, and in most states even regulators are not privy to the amounts that insurers pay to specific hospitals and doctors. Insurance companies and providers resist providing that information to regulators. Opening up these contracts, as the Massachusetts Attorney General did (using explicit statutory authority), will be key to understanding and verifying the role of underlying cost increases.

When Massachusetts investigated the contracts that insurers negotiated with their providers, they found significant differences in compensation rates among hospitals and physicians that do not appear to be based on the complexity or quality of the care provided.[62] Instead, they found that price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers. In other words, large or popular hospital or physician groups can use the threat of refusing to accept an insurer's patients to force the insurer to pay higher prices that are unrelated to the underlying costs or the quality of care.

The investigators found that the commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing. Insurance regulators must have access to this type of information if they are to properly evaluate health insurer claims about soaring prices.

Even without this information, the aggregate impact of provider contracts as reflected in unit cost claims trends should be examined for reasonableness. In justifying rate increases, insurers should disclose the portion of their historical and predicted claims trend attributable to unit cost increases. Also, consideration should be given to the whether future unit cost trends will be equal to historical trends. There is increasing emphasis being placed on controlling the various factors that drive up the cost of healthcare, including increases in unit costs. If future price increases are expected to vary from the historical experience, this needs to be reflected in the claims trend used to calculate a rate increase.

UTILIZATION / MIX OF SERVICES

Insurers also attribute rising medical costs to increased utilization – the volume of medical goods and services their members use – as well as changes in the mix of services. For example, an insurer may claim that prescription drug use is increasing among members, and that this needs to be reflected in higher insurance rates. Or an insurer might claim that more expensive procedures are

62 Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b); Report for Annual Public Hearing; March 16, 2010; pages 3 - 4; (Underline in original) http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf.

being used in place of less costly procedures or that new types of claims will be covered.

Historically, utilization/mix of services generally have put upward pressure on health care costs and insurance premiums. However, today more emphasis is being placed on reducing unnecessary services, improving medical outcomes and bending the cost curve. For example, accountable care organizations (ACO), which may share in the risk of the cost of providing medical services, could offset increases in utilization/mix of services.

Further, the Massachusetts investigation found that price increases, not increases in utilization, caused most of the rise in health care costs during the past few years in that state.

As with unit costs, in evaluating a rate filing, it is useful if the insurer shows how much of the historical trend is caused by changes in utilization/mix of services. A comparison of historical and predicted rates of change can help determine whether that portion of the insurer's medical trend assumption is a reasonable projection for the future.

MEDICAL COST MEASURES

- Medical Inflation: 2008 – **3.7%**, 2009 – **3.2%**, 2010 – **3.4%**

  (Source: Bureau of Labor Statistics)

- Growth in National Spending on Healthcare:

  2007 - **6%**, 2008 - **4.7%**, 2009 - **4%**

  (Source: Centers for Medicare and Medicaid Services, National Health Expenditures)

INDIVIDUAL MARKET RATE INCREASES

- Limited data available suggests that rate increases typically exceeded **15%** each year for the past three years, according to HHS.
- Individual market policyholders reported in Spring 2010 that their insurers sought average increases of **20%** in the most recent round of increases, according to Ha Kaiser Family Foundation surveyH.

Appendix C
EXAMPLE OF CLAIMS HISTORY

Anthem Health Plans -Connecticut Grandfathered Direct Pay Plan Options, Effective *1/1/2011*[63]

Claims and member months are on a rolling twelve month basis*

Incurred Date	Claims	Member months**	Per Member Per Month Claims Cost	Trend
Dec-07	$132,434,012	651,642	$203.23	
Jan-08	$131,502,130	652,962	$201.39	
Feb-08	$132,854,502	654,463	$203.00	
Mar-08	$133,496,056	655,643	$203.61	
Apr-08	$135,254,247	656,858	$205.91	
May-08	$135,035,892	657,927	$205.24	
Jun-08	$136,134,416	659,179	$206.52	
Jul-08	$138,521,368	660,468	$209.73	
Aug-08	$140,441,475	661,769	$212.22	
Sep-08	$142,636,811	662,824	$215.20	
Oct-08	$144,884,100	663,868	$218.24	
Nov-08	$146,152,705	664,717	$219.87	
Dec-08	$149,264,950	665,230	$224.38	10.41%
Jan-09	$149,997,183	665,654	$225.34	11.89%
Feb-09	$150,798,239	666,042	$226.41	11.53%
Mar-09	$151,236,870	666,693	$226.85	11.41%
Apr-09	$152,545,106	667,444	$228.55	11.00%
May-09	$153,382,334	668,252	$229.53	11.83%
Jun-09	$155,023,685	668,921	$231.75	12.22%
Jul-09	$156,458,571	669,581	$233.67	11.41%
Aug-09	$156,566,097	670,391	$233.54	10.05%
Sep-09	$158,712,803	671,473	$236.37	9.84%
Oct-09	$159,931,634	672,526	$237.81	8.96%
Nov-09	$163,006,922	673,750	$241.94	10.04%
Dec-09	$164,746,200	674,987	$244.07	8.78%
Jan-10	$164,116,926	675,503	$242.96	7.82%
Feb-10	$163,705,660	675,799	$242.24	6.99%
Mar-10	$163,832,873	675,689	$242.47	6.89%
Apr-10	$163,572,645	675,244	$242.24	5.99%
May-10	$162,935,533	674,660	$241.51	5.22%
Jun-10	$162,680,558	673,737	$241.46	4.19%

*Rolling twelve basis sums the values for the twelve months ending on the incurred date.
**Member months represents the sum of the covered members over a rolling 12 month period as of the incurred date.

63 Excerpt from Order and Decision In the Matter of The Proposed Rate Increase Application Of Anthem Blue Cross And Blue Shield; page 16 (emphasis added), available at http://www.ct.gov/cid/lib/cid/Order_and_Decision_Docket_No._LH10-159_-_Anthem_Blue_Cross_and_Blue_Shield.pdf.

Appendix D

DATA HELPFUL TO YOUR EVALUATION OF RATE INCREASES

- Percentage premium increase for each policy and for the total block of business subject to an increase, and the overall average rate increase for all policyholders affected for each policy and for the block.
- The highest and lowest percentage rate increases for any member or group of members in each policy.
- Description of benefits, co-pays, deductibles, and other cost-sharing for each policy subject to an increase.
- Table of rates for each product subject to an increase showing current and requested future monthly rates for each age category, geographic region, health status tier, and any other rating factor used.
- Number of people in each policy subject to an increase and the overall number of people impacted by the increase, and the number of people expected to drop coverage or raise deductibles or other cost-sharing.
- Identification of policy forms included in each block, and a statement of whether each policy or block subject to an increase is open or closed and date the block was closed if applicable.
- Premium revenue history for at least five years for each policy and the block of business, as well as for the insurer's entire statewide individual market., including actual amounts and on a per member per month basis
- Claims history for at least five years for each policy and the block of business, as well as for the insurer's entire statewide individual market,. including actual amounts and on a per member per month basis
- Administrative expenses history, for at least five years for each policy and the block of business, as well as for the insurer's entire statewide individual market, including actual amounts and on a per member per month basis.
- Profits and profit margins historically earned for at least five years for each policy and the block of business, as well as for the insurer's entire statewide individual market.
- Current and anticipated medical loss ratios for each policy and block of business, plus the aggregate medical loss ratio for the insurer's individual market business in the state under federal standards.
- Break down of the rate increase: what percentage of the increase is targeted for medical claims, administration, taxes, and profits/surplus?
- Break down of administrative expenses: what are projected administrative expenses going to cover, including the percentage of projected administrative costs targeted for broker commissions, compensation, cost/utilization control programs, lobbying and political contributions.
- Experience period used to calculate the rate increase: what specific time period of past claims and expenses was used to project future medical claims and expenses?
- Calculated medical trend, overall, by unit cost/utilization-mix, and by category of medical costs.
- Description of how the medical trend was calculated.
- Disclosure and description of all other assumptions and factors used to project medical costs.
- Five-year history of rate increases implemented, showing average increases and highest/lowest member increases by block.
- Five-year history of average rate increases requested for each block (to compare with rate increases approved or implemented).
- Description of cost containment efforts and strategies, included projected savings from such strategies.
- Insurer's financial information, including profits, surplus, investment income, and reserves on a company wide basis and for each policy/block of business subject to the rate change.
- General description of the types of information that has been kept confidential (if any).