STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

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In re:	2011 Small and Large Group Rate Factor Review	)	**OHIC - 2011 - 04**
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COMMISSIONER'S 2011 RATE FACTOR REVIEW

Now comes the Commissioner of the Office of the Health Insurance Commissioner, and hereby offers his explanation of the manner in which he has considered the 2011 Rate Factor Review filings of the carriers in the small and large group markets.

The Commissioner has considered the following information and analysis in connection with his review of the 2011 Rate Factors filings of the carriers.

1. The Rate Factor Filings made by each carrier.
2. "Standards for Rate Factor Review: Health Plan Evaluation". Office of the Health Insurance Commissioner. June, 2011.
3. "New England Group Health Plan Benchmarking", Wakely Consulting Group. May 30, 2011.
4. "Quarterly Statement of UnitedHealthcare of New England for the quarter ending March 31, 2011."
5. "Annual Statement for the year 2010 of the UnitedHealthcare Insurance Company."
6. July 2010 Rate Factor Decision – Additional Conditions. Office of the Health Insurance Commissioner.
7. "System Affordability Priorities and Standards for Health Insurers in Rhode Island." Health Insurance Advisory Council. April 17, 2009.
8. "Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: United HealthCare of New England." August 11, 2006
9. "Considerations for Appropriate Surplus Accumulation in the Rhode Island Health Insurance Market As It Relates to: Clue Cross and Blue Shield of Rhode Island." August 11, 2006

Upon a review of the above-referenced information and analysis, the Commissioner focused on three areas of rate factors for each submission: (1) Requested Profit and Contributions to Reserves; (2) Budgeted Administrative Costs; and (3) Requested Medical Trend Factors.

With regard to Tufts Health Plan ("Tufts"), the Commissioner accepts the rates and the Consent to Conditions as filed.

With regard to Blue Cross and Blue Shield of Rhode Island ("BCBSRI"), the Commissioner finds that the budgeted administrative costs are higher than acceptable based on regional benchmarks and historical trends, and inconsistent with the legal and regulatory standards for approval of health insurance rate increases. The Commissioner's suggested modifications, which BCBSRI has accepted by filing amended rates and by filing a signed Consent to Conditions form, are reflected in a reduction of revised submissions for administrative costs from 12.7% of premium to 11.8% of premium for large group, and from 14.6% of premium to 12.1% of premium for small group. The Commissioner notes BCBSRI's weakening reserve situation relative to other insurers in the region, as well as reserve targets set by OHIC in 2006, and accepts BCBSRI's requested contribution to reserves. The resulting estimated average premium increases for renewal business in 2012, before any changes in product benefits or group demographics, is estimated to be 9.6% for large group (a decrease from the 10.5% increase originally submitted) and 8.0% for small group (a decrease from the 10.5% increase originally submitted).

With regard to United Healthcare Insurance Company of New England and United Health Insurance Company ("UHC"), the Commissioner finds that its budgeted large group administrative costs are higher than acceptable based on regional benchmarks and historical trends, and inconsistent with the legal and regulatory standards for approval of health insurance rate increases. Therefore, the Commissioner did not accept UHC's original filing for administrative costs, and suggested reductions of revised submissions for administrative costs from 12.8% of premium to 12.6% for large groups, and from 13.4% to 13.1% for small groups. United's reserves are more than adequate for its needs using the standards set by OHIC in 2006, and therefore in consideration of the public's interest in affordable health insurance UHC's requested contributions for profit and reserves are reduced from 2.5% of premium to 1% for both large group and small group. Finally, the Commissioner is not persuaded by UHC's claims of

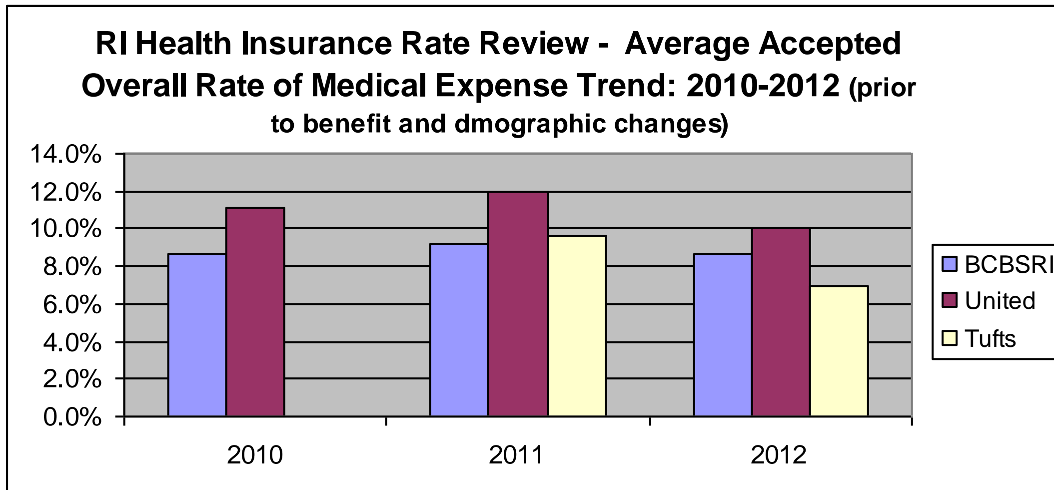
historical premium insufficiency, and has suggested reductions to UHC's estimated trend factors for hospital inpatient and outpatient for both large group and small group, for medical/surgical for small group, and for pharmacy for large group. In each case the resulting medical trend factors more closely match those trends estimated and filed by BCBSRI and Tufts. The Commissioner has not been presented with any information explaining why UHC is in such a different situation than BCBSRI and Tufts such that their medical trend factors should be so much higher than the other health insurance carriers given the recent favorable financial performance by UHCNE and UHIC. The Commissioner's suggest modifications, which UHC has accepted by filing amended rates and by filing a signed Consent to Conditions form, results in estimated average premium increases for renewal business in 2012, before any changes in product benefits or group demographics, of 10% for large group (a decrease from the 20.15% increase originally submitted) and 10.6% for small group (a decrease from the 18.0% increase originally submitted).

With respect to all three carriers, the Commissioner observes that some carriers are seeking guidance as to implementing the Commissioner's approved "estimated average premium increase" in the large group market, due to complexities in the underwriting and marketing process in the large group market. The Commissioner views the term "estimated average premium increase" in connection with the large group market to be the maximum, average premium for renewal business, based on premiums first offered to large groups, and before modifications in premiums resulting from demographic or benefit changes.

Affordability: Notice to Carriers and Health Care Providers – Overall Medical Expense Trend Target

The Commissioner acknowledges that the rates approved for Tufts, BCBSRI, and UHC will result in estimated average rate increases in 2012 ranging from 4.8% to 10.6% before benefits and demographic changes. These rates of premium increase are not unique to Rhode Island, but are a burden for employers and individuals nonetheless. They are partially responsible for a ten percent decline in the number of Rhode Islanders enrolled in commercial health insurance.

While adequate measures are in place with the rate factor review to assess and allow for appropriate health insurers administrative costs and contributions to reserves, the Commissioner remains concerned about the underlying trend of medical costs being health insurers are reporting to OHIC (see graph below)



These "medical expense trends" are rendering health insurance more expensive. Their causes are complex and deeply rooted. To help address these cost drivers, the Commissioner has articulated four "Affordability Standards" which health insurers in Rhode Island have had to meet for the past two years as a condition of rate factor approval. Adherence to these Affordability Standards however, which the insurers in general are demonstrating, will not immediately lower medical expense trends – the Commissioner expects their efficacy to be demonstrated in a five year or longer time frame. Nor does simple adherence to the Affordability Standards by insurers absolve them of their responsibility to find other ways to help change provider and patient behaviors that contribute to these rates of inflation.

In conducting this rate factor review, the Commissioner notes oral and written comment submitted to OHIC, in which purchasers and citizens expressed frustration with the limits of commercial insurance rate regulation to change medical expense trends in the short and intermediate term. Suggested additional actions by the Commissioner included simply limiting any rate increase to create pressure for system change, heightened provider rate regulation and complete deregulation to promote insurer competition. There is recent evidence from Massachusetts to suggest a "just say no" response to rate increases does not sufficiently engage other stakeholders in trend reduction efforts. The Commissioner does not have the authority to set provider rates; and there is no research to suggest that an increased presence of insurers reduces medical expense trends.

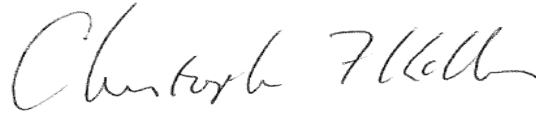
The Commissioner however is charged to "see the system as a whole" and to direct health plans towards system improvement policies. Presumably this includes defining what system

improvement is – including setting performance expectations. With the Affordability Standards setting a clear direction, in carrying out the legislative purposes established in R.I. Gen. Laws 42-14.5-2 the Commissioner expects health plans in Rhode Island to work more aggressively with providers and purchasers to reduce – not merely predict – medical expense trends, to more reasonable levels. Prior to the 2012 Rate Factor Review, and no later than November 1, 2011, the Commissioner will investigate the appropriateness of establishing a common, annual Overall Medical Expense Trend Target for the health insurers in Rhode Island. This will be the maximum Overall Medical Expense figure that health plans would be expected file with the Commissioner in May, 2012. With this Review, health insurers are hereby put on notice in advance of the possible establishment of an Overall Medical Expense Trend Target so that they can begin to take such actions as are necessary to lower their medical claims costs.

As a measure of medical system performance, the accountable entities for Overall Medical Expense Trend are not only the health insurers but also the providers who deliver care and the populations of patients who use the system. Under Rhode Island statute, health insurers are to be more than benefit administrators and medical expense trend forecasters – but they do not have complete control over the cost performance of the system. If effective and credible, the development of the Overall Medical Expense Trend Target should stimulate public attention, provider contracting processes, purchaser actions and benefit design practices.

Setting any target must not be an arbitrary act; it would be a public process recognizing the inherent complexities of such efforts and the medical care financing system itself. It would take into consideration the historical performance of the commercial health insurance market in Rhode Island, and best practices performance of medical expense trends for large stable populations – such as self-insured groups, and Medicare and Medicaid. The target would also be informed by public opinion and data, and set well in advance so health insurers have clear expectations set of them and the ability to adjust management actions accordingly. The consequences of not complying with a target must be explicit but must acknowledge the ability of insurers to influence but not completely control some of the expense drivers. The submission of rate factor requests by health insurers above the Overall Medical Expense Trend Target would also not be grounds for immediate dismissal or reduction of the request by the Commissioner. Circumstances unique to a health insurer might merit such a submission but the standard for review and approval would be higher.

Dated at Cranston, Rhode Island this 1st day of August, 2011.



Christopher F. Koller, Commissioner
Office of the Health Insurance Commissioner

CERTIFICATION

I hereby certify that on this 1st day of August, 2011 a copy of the within Commissioner's 2011 Rate Factor Review was sent by first class mail, postage prepaid and certified mail, return receipt requested to:

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