Office of the Health Insurance Commissioner
Health Insurer Rate Factor Review
Public Comment Solicitation: May 16, 2011

Summary:

The Office of the Health Insurance Commissioner (OHIC) is soliciting public comment on the proposed rate factors to be used by United HealthCare of New England (UHCNE) and Blue Cross and Blue Shield of Rhode Island (BCBSRI) in calculating insurance premiums in 2010 for their large employer (>50 employees) and small employer products (50 or fewer).

This document describes the rate review process, the decision criteria and information available for public comment. Oral and written public comment is being collected through June 10, 2011.

Public input in this process is important.

I. Process and Standards

What are the goals of this Rate Factor Review Process?

1. To keep health insurance pricing fair
    - Purchasers of health insurance should pay the estimated costs of their products and not bear the burden or benefit of the financial performance other lines of business.

2. More Public Accountability of Health Plans
    - A publicly accessible rate review process helps hold insurers accountable for sometimes-conflicting goals of financial solvency, consumer protection, fair treatment of providers and system affordability.

3. Public Education
    - Stakeholders in the system do not always understand what drives the affordability of health insurance. Increased transparency can help people make informed choices.

What Health Insurance Markets are Covered by this Process?

- This process addresses rate oversight for businesses who buy health insurance, including:
    i. "Small Groups" (50 or fewer employees) - there are about 90,000 enrollees in this market.
    ii. "Large Groups" (51 or more employees) – about 230,000 enrollees.
- Self Insured Groups (240,000 enrollees) are exempt from state-based regulation.

Does this process set the specific rates that businesses pay?

- No. The process allows OHIC to approve, reject or modify the "inflation factors" that insurers use to calculate the rates that are paid. Once these rate components are determined, insurers use rating formulas to set an employer-specific year long, fixed rate based on that employer's benefit plan, demographic mix and (for larger business) past claims experience.
- OHIC separately reviews the plans' rating formulas to ensure they are fair, and are consistently applied.

What will OHIC do during the public comment period?

- Publish the proposed rate factors and collect public comment.
- Conduct actuarial analysis and other review as needed.
- Review the factors with its Health Insurance Advisory Council
- At its discretion, hold public meetings and/or formal hearings.

What does OHIC consider when reviewing rate factors?

- By statute, OHIC has to balance competing needs between consumers who want affordable health insurance and financially sound insurers, providers who want good payments, and insurers who need surpluses and profits to stay in business. Meeting all these needs completely is not possible.
- In striking this balance OHIC considers projected rates of increase in an insurer's medical expenses, administrative costs and profits. It is important to note that medical expenses make up 80 to 85% of the insurance premium and typically are increasing at 5-10 times general inflation. Efforts to control these increases – by public or private efforts – often are not well received. These challenges exist across the country and by the public as well as private sector. There is no single solution.
- Attachment two of the document lists the specific standards OHIC uses when considering rate increases.

Once acted upon, when would revised rating factors go into effect and for how long?

The health plans have asked for the new rate factors to be effective for Small and Large Groups for all contracts starting or renewing between January 1, 2012 and December 31, 2012.

II. Summary of Rate Factors Submitted by Health Plans

OHIC attempts to analyze and make public information about health insurance cost drivers to promote better policy making and increased transparency, insurer competition, provider accountability and public awareness. These are available at (LINK ADDRESS) Readers are encouraged to study these documents carefully.

III. Additional information

Available at www.ohic.ri.gov are the guidance given to the health plans for this rate filing, non-proprietary information submitted as part of the filing and additional analysis by OHIC.

IV. Public Input in this Process is Important

- Rising health insurance costs are a state and national concern. The reasons are complex but this rate review is an important opportunity to balance competing concerns. Your input is important.
- OHIC is soliciting public comment from interested parties to help inform its rulings on these factors. This solicitation will be distributed via email, posted on the www.ohic.ri.gov and advertised publicly.
- While any comments are welcome, OHIC is particularly interested in recommendations regarding:
    i. Particular rate factors based on the standards identified in this document.
    ii. Assessment of health plan performance in areas of "General Conduct" and "Efforts to Improve Affordability " as defined in Attachment 1.

iii. Any possible conditions or comments to be attached to a decision. In particular, OHIC's Health Insurance Advisory Council has issued "Affordability Priorities and Standards for Commercial Health Insurers"[1] which sets forth four priority areas of work for health plans to improve health insurance affordability:

1. Health plans will increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.
2. As part of the increased primary care spend, health plans will promote the expansion of the CSI-Rhode Island project or an alternative all payer medical home model with a chronic care focus by at least *25* physicians in the coming year
3. Health plans will promote Electronic Medical Records incentive programs that meet or exceed a minimum value.
4. Health plans commit to participation in a broader payment reform initiative as convened by public officials in the future.

The public is invited to comment on the performance of insurers in these areas and to suggest future direction by the Office.

- Oral public comment will be taken at a June 8, 2011 meeting of OHIC and its Health Insurance Advisory Council at 4:30 pm at the Department of Labor and Training in Cranston, RI and possibly in other subsequent settings.
- Written public comments should be submitted by June 10, 2011 via either:
  i. email to healthinsinquiry@ohic.ri.gov (preferred) or
  ii. OHIC
  1511 Pontiac Ave. Building 69-1
  Cranston, RI 02920
- All communications regarding public comments will be considered public documents.

Attachments:

Regulatory Standards for Health Plan Conduct
Standards for Health Plan Rate Factor Review

[1] See http://www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_Affordability%20Report.php

Attachment 1: Regulatory Standards for Plan Conduct.
(Summary of OHIC Regulation 2)[2]

I. General Conduct by insurers to be taken into consideration in reviewing the projected trend factors includes but are not limited to:

1. Efforts by health insurers to develop benefit design and payment policies that:
    a. Enhance the *affordability* of products (defined below)
    b. Encourage more efficient use of existing resources.
    c. Promote appropriate and cost effective acquisition of health care technology and expansion of existing infrastructure.
    d. Advance development and use of high quality health care centers.
    e. Prioritize use of limited resources.
2. Efforts by health insurers to promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions.
3. Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities.
4. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency.
5. Participating in the development and implementation of public policy issues related to health.
6. The interests of the state's health insurance consumers, including:
    a. efforts by the health insurer to ensure that consumers are able to read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and make fully informed choices about the health insurance coverage provided by the health insurer;
    b. the effectiveness of the health insurer's consumer appeal and complaint procedures;
    c. the efforts by the health insurer to ensure that consumers have ready access to claims information;
    d. efforts by the health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;
    e. ensuring that that the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws; ensuring that the benefits delivered by a health insurer are consistent with those guaranteed by the health insurance coverage documents issued or provided by the health insurer; and
    f. that the insurer takes steps to enhance the affordability of its products.
7. The interests of the state's health care providers, including:
    a. that the policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes are understandable and transparent; and
    b. that the efforts undertaken to enhance communications with providers.

[2] Full regulation at: http://www.ohic.ri.gov/Regulation2OHICPurposes.php

OHIC
Regulatory Standards for Plan Conduct. (Summary of OHIC Regulation 2) Cont'd

II. Evaluation of Insurer's Efforts to Improve Affordability of Health Insurance

1. Whether the health insurer offers a spectrum of product choices to meet consumer needs;
2. Whether the health insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself. Such incentives will drive efficiency in the following areas:
    a. Creating a focus on primary care, prevention and wellness;
    b. Establishing active management procedures for the chronically ill population;
    c. Encouraging use of the least cost, most appropriate settings; and
    d. Promoting use of evidence based, quality care;
3. Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;
4. Whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers;
5. Whether the insurer addresses consumer need for cost information through
    a. Increasing the availability of provider cost information; and
    b. Promoting public conversation on trade-offs and cost effects of medical choices; and
6. Whether the insurer allows for an appropriate contribution to surplus.

Attachment 2

Rate factors health plans submit for approval and standards to consider

As set out in statute, OHIC must determine whether the proposed rates or rating formulas are "consistent with the proper conduct of [the insurer's] business and with the interest of the public". OHIC has defined this standard further, based on statute (RI General Laws: 42-14.5-2) in its Regulation 2.[3] (http://www.ohic.ri.gov/Regulation2OHICPurposes.php)

Rating Factor	Standards for OHIC to Consider [4]
Contributions to Reserves (%)	• Existing reserves relative to OHIC determined reserve levels (see http://www.ohic.ri.gov/2006ReservesStudy.php and http://www.dbr.state.ri.us/divisions/insurance/financial.php) • Industry averages (see http://www.ohic.ri.gov/070717healthriinsurersreport.php) • Historical performance of plan relative to budget • Return to shareholders (if appropriate) • General conduct of health plans (defined in Reg 2)
Admin Costs *(as % of total revenue)*	• Other health plans for comparable products. (see http://www.ohic.ri.gov/070717healthriinsurersreport.php) • Other commercial products from same insurer • Compliance with NAIC categorization of costs • Affordability efforts (defined in Reg 2) • General conduct (defined in Reg 2)
Trend factors *(% annual projected change in utilization and costs for five medical service categories)*	• Actuarial soundness • Other health plans in market, based on public submission • Commercial industry standards • Governmental Health Care Programs (i.e. Medicare and RIte Care) • Affordability Efforts (as defined in Reg 2) • Alignment of the affordability report with "Affordability Priorities and Standards" document from OHIC's Health Insurance Advisory Council.

[3] Summarized as Attachment 1
[4] Citations given are illustrative but not exhaustive.