

Primer on Rate Setting and Review

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Presentation Outline

- Primer on Premiums
- ACA Rate Review Provision
- II Grant Application to HHS
- Elements of Model Act
- Key factors for Consumers and Advocates
- Resources

Primer on Premiums

- What do premiums pay for?
- Insurance pools
- Underwriting
- How insurers develop rate increases
- Behind the rate hikes
- Key questions when considering a rate increase

What Do Premiums Pay For?

- Medical Claims
- Activities that Improve Healthcare Quality
- Administrative Expenses
 - Marketing, advertising
 - Salaries, broker commissions
 - Cost containment
 - Claims processing
 - Building expenses, travel, legal, consulting
- Taxes
- Surplus/Profit

Insurance Pools

- Purpose of insurance is to spread risk among large number of people
- Premiums collected from the group are pooled and used to pay medical claims
- Large pools are better for spreading costs among healthy and sick
- Currently, some insurers pool only individuals covered under the same policy or similar policies; risk is not widely spread
- Health reform is designed to create one large pool containing each insurer's individual enrollees and a pool with small group enrollees

Underwriting

- Underwriting requires each individual and family to apply for coverage.
- Applicants are classified according to “rating factors”
 - Rating factors = age, gender, geographic location, health status, tobacco use, family size, occupation, etc.
- Rates are higher or lower depending on an individual’s classifications. Those with medical history are denied coverage or covered at higher rates.
- Health Reform 2014: Modified community rating = Insurers can no longer classify by health status or any other factor except age, family size, tobacco use, and geographic location. Limits on how much higher individuals can be charged based on these factors.
- Key Question: What rating factors do IL insurers use?

Basic Rate Setting

(varies by insurer)

Jane

42 years old

Health status tier 2 (mild condition)

Lives in Chicago

PPO with \$2,000 deductible



- Base rate = \$200/mo
 - X age factor (1.3)
 - X gender factor (1.05)
 - X tier 2 factor (1.1)
 - X geographic factor (1.2)
 - X benefit factor (.9)
 - = Jane's rate: \$324/mo

How Insurers Develop Rate Increases

- Insurer projects premium revenue for the *rating period* at current rates from enrollees in a policy or *block of business*
 - Rating period = time period during which new rates will be in effect (usually 12 months).
- Insurer projects medical claims for the rating period for enrollees in a policy or block of business
 - *Medical trend* = rate at which insurer predicts medical claims will increase (e.g., 10%)
 - Developed by looking at past medical claims for enrollees in the policy or *block of business*
 - Medical trend = price (unit) increases + utilization
 - Other actuarial assumptions
 - Insurer applies other assumptions to predict medical claims
 - “Underwriting wear-off” (duration), deductible leveraging, lapse rates, demographic changes, “anti-selection”

Rate Setting Continued...

- Medical trend and other assumptions are applied to *experience period* claims
 - Experience period = claims during a recent time period (usually 12 months)
 - Experience period claims multiplied by trend factor and possibly other factors
- Projected medical claims are added to projected administrative expenses and target profit margins (using insurer's desired *retention* within MLR requirements)
 - Retention = Portion of premium that insurer will retain for administration, taxes, and surplus/profits
 - Medical loss ratio minimums traditionally low in most states
- Insurers increase rates to cover any shortfall between projected revenue at current rates and amount needed to cover projected medical claims, expenses, taxes and/or fees, and desired profit

Behind the Rate Increases

- Rising Medical Costs
 - Lack of transparency around provider rates
 - Payment reform needed
- Insurers Pricing to Lower Medical Loss Ratios to State-Required Minimums
- Adverse Selection
 - More pronounced in voluntary, guaranteed-issue markets
 - But “death spirals” can occur
- Fragmented Individual Markets
 - Lack of risk pooling, closed blocks
- Lax Oversight of Rate-Setting

Key Questions When Considering a Rate Increase

- How is the insurer pooling enrollees for the purposes of determining premiums?
 - Smaller, older pools mean higher costs
- What is the actual medical loss ratio for the last 12-month period and the anticipated loss ratio?
 - Is the insurer trying to unreasonably lower medical loss ratios?
- Are actuarial assumptions justified by data?
 - What assumptions is the insurer making to project costs?
 - Is the medical trend in line with past increases in claims?
 - Is the increase in line with medical trend?
- Is the increase justified in light of the insurer's overall financial condition?
 - Example: is the insurer pricing to achieve an unreasonable profit margin when it already has high levels of surplus?
- What is the consumer hardship?
 - E.g., have consumers with this policy had consecutive high increases?

PPACA Rate Review

- HHS and state review of “unreasonable” increases
- Insurers post public “justification” of unreasonable increases
- HHS defining “unreasonable” (proposed rule is 10% or higher in a 12 month period)
- State monitoring and reporting to HHS
- Rate review grants
- **Extent of rate review authority and process is left to states**

Summary of Illinois Grant Application

- **Additional Legislative Authority:** Illinois currently does not have explicit rate review authority. The State intends to seek authority to review and approve premium rates and to disclose premium filings.
- **Expand the Scope of Health Insurance Premium Review:** Illinois will initiate rate review and approval for all forms of major medical coverage.

IL Grant to HHS (continued)

- **Improve the Health Insurance Premium Review Process:** Illinois currently does not have explicit rate review authority. Illinois will develop the capacity to conduct prospective actuarial review on all major medical premium increases. The State will develop new rate filing and review protocols. Additionally, new IT systems will be developed and additional staff will be hired in order to conduct premium reviews.

IL Grant to HHS (continued)

- **Make More Information Publicly Available:** Premium filings are not currently available to consumers. Illinois will start posting filings. Additionally the State will conduct public hearings on proposed rate increases. It will also develop interactive tools to help users navigate insurance premium information on its website. Illinois will also translate web and print health insurance information into Spanish, Polish and Korean.

Key Elements of Model Act

- Prior approval of rate hikes before they go into effect
 - Notice to the public of proposed rate hikes with public comment period
 - Hearings for rate hikes greater than 10% in the individual market
 - Consumer and consumer representative participation in hearings
 - Public disclosure of complete rate filings with readable summaries of the justification for rate hikes

Model Elements (continued)

- Standard rate filing format, documentation
 - Detailed justification for all rate increases, including data on how much medical costs are rising
 - Approval of rate hike must take into account company profits, existing surplus, rate increase history and impact on policyholders
 - Notice to policyholders and the public of approved rate hikes at least 60 days before the effective date

Key Indicators for Consumers

- Avg. increase and min/max increase
- Effective date
- Number of people impacted
- Brief explanation of largest factors leading to need for an increase
 - Oregon example: “Medical costs increased by 12.6% between 2007-2008.”
- Breakdown of how premium will be spent on medical (including quality as defined in regs) administrative and surplus/profit, and show last period results for same categories, identifying time period used for comparison
 - Show premiums received, claims paid, profits made for policies during the prior period
- Five-year rate increase history
- Overall profit margins for last calendar year and most recent quarter

Key Indicators for Advocates

- Number of people in each policy or block subject to an increase and the overall number of people impacted by the increase.
- Medical loss ratio for past period and anticipated loss ratio for rating period
 - What percentage of the increase is targeted for medical claims, quality activities, administration, taxes, and profits/surplus?
 - How do these targets compare with actual loss ratio data for experience period?
- Medical trend and other assumptions
 - Insurer should present trend for unit cost increases and utilization
 - Insurer should present trend broken down by categories:
 - Hospital inpatient, outpatient, physician services, pharmacy, imaging, laboratory, emergency room, other
 - Allows advocate to see where rates of cost increase are highest and possibly identify broader market problems
 - Insurer should identify other factors added to predict costs (e.g., duration, leveraging)

Key Indicators for Advocates Continued...

- 5-year rate hike history
- Average increase, plus minimum and maximum increase for any member
- Insurer's 5-year claims and profit history for the policy or block, and for the line of business (e.g., entire IL individual market)
- Insurer's overall financial condition, including surplus, reserves, and investment earnings (annual statement 5-year history page)
- Current data on insurer market share for individual/small group
- Is the block closed or open?
- Generally, the NAIC draft Disclosure Form, if adopted, provides good information for advocates to analyze rate increase

Resources

- [Consumers Model Law on Rate Review](#)
- [Consumers Union's Toolkit for Advocates](#)
- [IL grant application to HHS](#)