

HCCA Managed Care Compliance Conference

State Division of Insurance Rate Disapprovals:
Preparing for the Onslaught

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Pressure to hold down rate increases

Los Angeles Times

*Obama blames insurance companies as
he campaigns for healthcare overhaul*



Consumer Watchdog

*Time for Obama to get tough on
insurers with rate freeze via Executive
Order*

HHS.gov

FOR IMMEDIATE RELEASE

Sebelius calls on health insurers to stop
misinformation and unjustified rate increases



A Note About Rate Adequacy

Overview

- **Part I** - Examples of recent rate disapprovals
 - Focus on the Massachusetts experience
- **Part II** - New HHS Rate Review Regulations
 - Overview of the new regulations
- **Part III** - Important Questions for Health Insurers
 - Preparing for the onslaught

3

Part I – Recent State Disapproval Proceedings

- Maine
 - 0% profit margin only for Anthem (“adequacy” does not entitle insurers to a mandated profit margin)
- Connecticut
 - Commissioner Flip Flop; 0% rate increase for Anthem
- Rhode Island
 - Tied rate approvals to caps on hospital reimbursement (hospital group then sued Commissioner for interfering in contract negotiations with United)
- Massachusetts
 - Disapprovals of all increases above 7.7%; protracted litigation; settlements and reversals



4

The Massachusetts Experience

- **Background**
 - 2006 - Massachusetts Health Reform
 - Creation of Merged Market and Mandatory Insurance Coverage
 - 2009 – Merged Market Losses
 - 2010 – Premium Rate Increases Filed
 - Feb. 2010 - Emergency Rate Review Regulations
 - March 2010 – the 7.7% Cap
 - April 2010 - DOI Rate Disapprovals
 - May-July 2010 - Insurer Appeals, Litigation, Settlements
 - **August 2010 - Appeals Panel Rejects Each Reason for Disapproval**

5

Insurance Commissioner's Bases for Disapproving Rates

- **Provider Contracting**
 - Differences in reimbursement rates cannot be justified by provider market leverage
 - Insurers required to “re-negotiate” provider rates
- **Contribution to Surplus/Profit**
 - >1.9% is excessive
- **Medical CPI**
 - Assumed trend >150% of medical CPI (7.7%) is unreasonable
- **Utilization**
 - Must control utilization to meet the 7.7% cap

6

The Administrative Appeals

- High Stakes Gambit
 - Division’s position: carriers must implement year-old rates unless and until new rates are filed and approved, or disapprovals are reversed
 - Significant market confusion and mounting insurance losses (\$100M+ in market losses)
 - Inadequate rates in 2010; even greater increases necessary in 2011
 - Each carrier appealed
 - Carriers – actuarial, provider contracting, other witnesses
 - DOI/AGO – no witnesses at all

7

The Final Agency Decisions

- Appeals Panel rejects the Commissioner’s reasons for disapproval
 - Provider Contracting
 - Carriers have “no realistic option” but to reimburse providers at different rates based, in part, on provider leverage
 - Legal and practical barriers to re-opening existing provider contracts
 - Contribution to Surplus
 - a “rate is not adequate, from an actuarial and regulatory perspective, if it does not cover the sum of the projected costs of covering claims, administrative costs, *and some contribution to reserves/surplus*”
 - 1.9% is not unreasonable given inherent risks in the individual and small group markets

8

The Final Agency Decisions cont...

- Appeals Panel rejects the Commissioner's reasons for disapproval *cont...*
 - Medical CPI
 - “Improper” as a sole criterion to measure costs
 - “Backward-looking (i.e., it looks at past costs) whereas rates are set prospectively”
 - Not carrier-specific - rates should reflect accurately a specific carrier's claims and administrative costs
 - Utilization
 - Credited carriers' cost containment, P4P, and risk-sharing arrangements

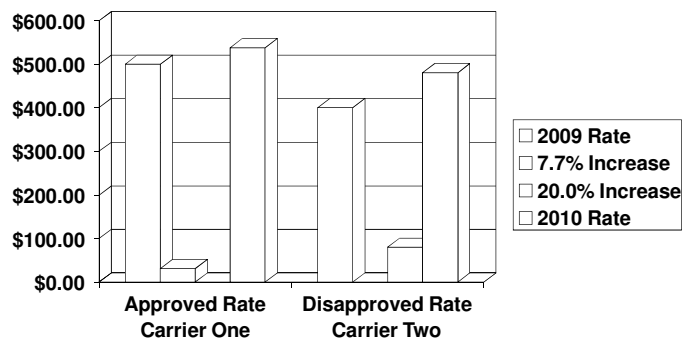
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The Final Agency Decisions cont...

Flawed Method/Flawed Results

“Increases” vs. “Actual Rates”

“Looking at a percentage increase, as opposed to the actual rate, is a flawed methodology, from an actuarial perspective, for determining whether a rate is excessive or unreasonable and leads to flawed results.”



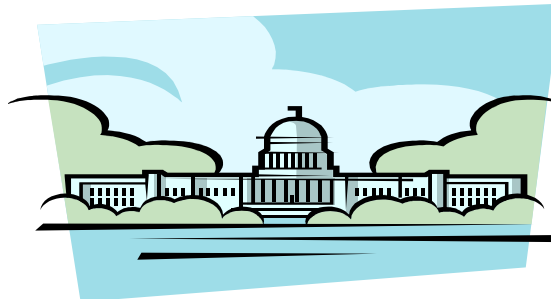
10

Massachusetts Post Script – Legislative “Fix”

- Individual/small group market rates “presumptively disapproved” if:
 - Contribution to Surplus greater than 1.9%
 - Administrative expense increase greater than New England CPI
 - MLR less than 88% (in 2011); 90% (in 2012)
- Consumer rebates in any event
- *Massachusetts – test case for future state rate reviews and/or legislation?*

11

Part II - New HHS Rate Review Regulations



- Background on the new HHS regulations
- Summary of the HHS regulations
- Important questions for insurers

12

Background on the New HHS Regulations

- **PPACA** adds Section 2794 of the Public Health Service Act; requires HHS to establish an annual review of unreasonable premium rate increases
- **April 14, 2010** - HHS seeks comments from, among others, the National Association of Insurance Commissioners (“NAIC”) and AHIP
- **August 16, 2010** - Secretary announces \$1million Health Insurance Premium Review Grants to 45 states and the DC to help them develop or enhance their state’s health insurance premium review processes
- **December 21, 2010** - HHS releases for public comment proposed rate review regulations
- **Comments are due to HHS by Feb. 22, 2011**

13

Summary of the Proposed Regulations

Regulations Overview

- Apply to rate increases in the individual and small group markets filed or effective on or after July 1, 2011
- Initial threshold for mandatory review of any rate increase $\geq 10\%$
- Carriers must submit a "preliminary justification"
- Review and determination of whether increase is "unreasonable" remains with state if state has an "effective rate review program"
- If not an "effective rate review program," then HHS conducts the review
- “Unreasonable” increases subject to public disclosure, and if implemented, public justification
- HHS has *no* authority to disapprove, or require state to disapprove, an “unreasonable” rate increase. State law applies

14

Summary of the Proposed Regulations *continued*

- **Sentinel Effect:**
 - HHS’s intent is to “shine a light on insurance companies.”
- **Criticisms:**
 - Consumer advocates = toothless and ineffective
 - Free market advocates = improperly “impos[ing] price controls on private insurance premiums”
 - Insurance industry = fail to address the underlying forces driving premium increases, like provider costs, increased coverage mandates, and volatile individual and small employer insurance markets
 - The regulations – at least on their face – do little to rationalize the inconsistent application of rate reviews by different state regulators.



15

Applicability and Effective Date

- Non-grandfathered plans in the individual and small group markets
 - markets are defined by each specific state, or consistent with the PHSA, except that small employers are capped at 50 employees
- The regulations will not apply to “excepted” benefit plans, such as separately issued dental or vision policies
- The regulations apply to health insurance premium rate increases filed or effective on or after July 1, 2011

16

Rate Increases Subject to Review

- Rate increases of 10% or more
 - beginning in 2012, HHS may set state-specific thresholds
 - HHS must publish any new state-specific threshold no later than September 15th of the preceding year
- Rate increases for a specific “products”
 - “product” = “a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance carrier offers in a state.”
 - apply the “weighted average increase for all enrollees subject to the increase.”
 - carrier must aggregate all such increases for the past 12 mos

17

State vs. HHS Review

- HHS defers to state review if the state has an “effective rate review program”
 - HHS will adopt that state’s determination of whether or not a rate increase is “unreasonable”
 - HHS will deem a state to have an “effective rate review program” by applying various criteria
 - HHS is required to publicly post a list of the states that have an “effective rate review process”
- Carriers may be subject to concurrent review by both the state and HHS under circumstance where HHS has not deemed the state’s program as “effective”
 - could require different documentation requirements, apply different analyses, and result in conflicting determinations as to whether a rate increase is unreasonable

18

Carriers' Preliminary Justification of Rate Increases

- Every carrier must submit a “*preliminary justification*” for each product affected by the increase and subject to review, *whether the rate increase is subject to HHS review or state review*
- The “preliminary justification” must include:
 - a “rate increase summary” (Part I)
 - a “written description justifying the rate increase” (Part II)
 - If the rate increase is subject to HHS review (as opposed to state review), the “preliminary justification” must also include specific “rate filing documentation” (Part III)
- HHS will publicly post Parts I and II; portions of Part III

19

Carriers' Preliminary Justification of Rate Increases continued

- Parts I and II of the “preliminary justification” must include:
 - rating methodology and most significant factors causing the increase
 - employee and executive compensation data
- Part III requires specific detailed documentation “sufficient to permit HHS to conduct a review to determine whether the rate increase is an unreasonable rate increase,” including:
 - whether the projected MLR will be less than the new federal MLR requirements under PPACA, and if so, the carrier’s justification

20

HHS Review and Determination of “Unreasonable” Rate Increases

A rate increase subject to HHS review is “unreasonable” if it is “excessive,” “unjustified,” or “unfairly discriminatory”

- **Excessive Rate Increase:** An increase that causes the premium to be unreasonably high in relation to the benefits provided under the coverage
 - projected MLR that is less than the federal standard
 - assumptions that are not supported by substantial evidence
 - unreasonable assumptions underlying rate increase
- **Unjustified Rate Increase:** documentation is incomplete, inadequate, or otherwise does not provide a basis upon which to assess the reasonableness of the increase
- **Unfairly Discriminatory Rate Increase:** results in premium differences between insured individuals within similar risk categories that are not permitted under applicable state law or do not reasonably correspond to differences in expected costs

21

HHS Review and Determination of “Unreasonable” Rate Increases continued

- No timeframe for HHS to complete its review
- HHS publicly posts its determination and a brief explanation of its analysis within five business days
- If HHS determines that the rate increase is “unreasonable,” that determination and the explanation will also be provided to the health insurance carrier

22

Rate Increases Deemed “Unreasonable”

- Rate increases deemed “unreasonable” - the carrier can:
 - decline to implement the rate increase
 - implement a lower increase (which may or may not be lower than the mandatory review threshold), or
 - implement the “unreasonable” rate increase
- If the decision is to implement a lower rate increase that *nevertheless meets or exceeds the threshold for mandatory review*, the carrier must file a new preliminary justification under the regulations

23

Final Justification and Implementation of Unreasonable Rates

- **Carrier’s submission of “Final Justification”** - If carrier implements the “unreasonable” rate increase, must, within the later of 10 days after the implementation of the rate increase or receipt of the Secretary’s final determination:
 - (i) submit to HHS a “final justification” for the rate increase, and
 - (ii) prominently post on its website for at least three years the public portions of the preliminary justification, the HHS or state final determination and explanation, and the carrier’s final justification. This information will also remain available to the public for three years on the HHS website
- **Implementation of “Unreasonable” Rate Increase** - the regulations do not prohibit the carrier from implementing, or continuing to offer the product at, an “unreasonable” rate increase
- **The ability of a carrier to implement an “unreasonable” rate increase will be subject exclusively to applicable state law**

24

Part III - Important Questions for Insurers – Preparing for the Onslaught

- Will your rate increases be subject to review at all?
 - 10% or greater increase, will be reviewed by HHS, State(s), or both
 - Less than 10%? May still be subject to State review
- Which agency (HHS and/or State(s)) will be reviewing your rate increases?
 - Could have significantly different implications
 - Awaiting HHS determination of which States have “effective rate review programs”
- What is the authority and approach of the agency reviewing your rate increases?
 - Carriers could be subject to different reviews, standards, and consequences
 - HHS – no authority to “disapprove” an “unreasonable” rate increase
 - States – some have authority to disapprove, and have used it
- Are you prepared to justify your rate increases?
 - Demonstrate actuarially sound basis for developing rates, and justifying increases
- Are you prepared to litigate a disapproval of your rate increases?
 - What are the consequences and options if your rate increase is “disapproved”?

25



The End

26