Office of the Health Insurance Commissioner
Health Insurer Rate Factor Review
Public Comment Solicitation: September 1, 2009

Summary:

Rising health care costs affect all of us. The Office of the Health Insurance Commissioner (OHIC) is soliciting public comment on the proposed rate factors to be used by Tufts Health Plan 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 September 15, 2009. 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 other lines of business.

2. More Public Accountability of Health Plans
    - Under Rhode Island Statute, health insurers are accountable for remaining financially solvent, protecting consumers, treating providers fairly, and making efforts to improve the affordability, quality and accessibility of the health care system. A publicly accessible rate review process helps hold insurers accountable for these sometimes-conflicting goals.

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 110,000 enrollees in this market.
    ii. "Large Groups" (51 or more employees) – about 400,000 enrollees.
- Self Insured Groups (200,000 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 main components 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- 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 (as established under OHIC statute)
- At its discretion, hold public meetings and/or formal hearings.

What are the rating factors health plans must submit and the standards to consider in the new oversight process?

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.[1] (http://www.ohic.ri.gov/Regulation2OHICPurposes.php)

Rating Factor	Standards for OHIC to Consider [2]
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) • Soundness of affordability report, submitted as part of the filing. • Alignment of the affordability report with "Affordability Priorities and Standards" document from OHIC's Health Insurance Advisory Council.

Once acted upon, when would revised rating factors go into effect?

Tufts Health Plans would use these rating factors when determining rates for new and existing employer customers, starting in January 2010.

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[1] Summarized as Attachment 1

[2] Citations given are illustrative but not exhaustive.

II. Summary of Rate Factors Submitted by Health Plans for the Large Group market

Summary documents consisting of the following are attached to this solicitation:

- Rate factor review template for three submitting health plans for large group market
- Rate factor review template for three submitting health plans for small group market

Available at www.ohic.ri.gov are the guidance given to the health plans in April for this rate filing, each health plan's affordability plan, plus other non-proprietary information submitted as part of the filing.

Reviewers should note the following

- Health plans have asked that certain parts of their submissions be redacted from public viewing. OHIC is honoring that request.
- Starting this year, the efforts of health plans to promote affordable high quality health care in RI will be guided by the "Proposed Affordability Priorities and Standards" recommended to OHIC by its Health Insurance Advisory Council. These are also on the same web page.
- A survey of provider attitudes towards health plan practices is being compiled by OHIC, as is a health plan hospital rate analysis. These will be considered as part of this review and analyses will be made public in the future.

III. 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:
    1. Particular rate factors based on the standards identified in this document.
    2. The affordability report document for each insurer.
    3. Assessment of health plan performance in areas of "General Conduct" and "Efforts to Improve Affordability " as defined in Attachment 1.
    4. Any possible conditions or comments to be attached to a decision.
- Written public comments should be submitted by September 15, 2009 via either:
    1. email to healthinsinquiry@ohic.ri.gov (preferred) or
    2. 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

Rate factor review template for three submitting health plans for large and small group markets

Attachment 1: Regulatory Standards for Plan Conduct.
(Summary of OHIC Regulation 2)[3]

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.

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

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.