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

In re:	**2012 Small and Large Group Rate Factor Review**	)	
	Blue Cross & Blue Shield of Rhode Island	)	
	Tufts Associated Health Maintenance Organization, Inc. & Tufts Insurance Company	)	**OHIC - 2012 - 02**
	UnitedHealth Care of New England, Inc. & United HealthCare Insurance Company	)	

COMMISSIONER'S 2012 RATE FACTOR REVIEW DECISION

Introduction

The Commissioner of the Office of the Health Insurance Commissioner ("the Office") has considered and acted upon the 2012 Rate Factor Review filings of the health insurance issuers with significant enrollment in the small and large group markets in this state ("Issuer" or Issuers"). An explanation of the manner in which the filings were considered and acted upon, and the rationale for modifying the filings and thereby reduce the rate increases requested, is set forth below.

The three Issuers subject to the 2012 Rate Factor Review are Blue Cross and Blue Shield of Rhode Island ("Blue Cross"), Tufts Associated Health Maintenance Organization, Inc. and Tufts Insurance Company ("Tufts"), and UnitedHealth Care of New England, Inc., and United HealthCare Insurance Company ("United"). The Rate Factors filed and approved by the Commissioner in the 2012 Rate Factor Review will be applied to calculate small and large group health insurance plan premiums, both new and renewal) offered and issued during calendar year 2013.

The Commissioner has conferred with the actuarial, analytical and legal staff of the Office, and has considered the following information and analysis in connection with his review of the 2012 Rate Factors filed by the three Issuers:

1. The Commissioner's Filing Instructions. Office of the Health Insurance Commissioner ("OHIC"), April 19, 2012; supplemented on May 7, 2012 and May 16, 2012.
2. The Rate Factor Filings made by each Issuer. May 18, 2012.
3. Public Comments (oral and written) offered with respect to Issuer filings. June, 2012.

4. Notice and Public Comments offered with respect to proposed amendments to Commissioner's hospital contracting conditions. Office of the Health Insurance Commissioner, June 29, 2012; July 21, 2012.
5. "2012 Insurer Rate Review: Small Group and Large Group Rate Changes ", OHIC staff report, May, 2012.
6. "2012 Insurer Rate Review: Historical Experience Analysis ", OHIC staff report, June, 2012.
7. "2012 Insurer Rate Review: Administrative Cost Analysis", OHIC staff report, July, 2012.

Legal and Regulatory Standard of Review

The Commissioner is charged by statute with the exclusive responsibility and authority to regulate health insurance issuers. R.I. Gen. Laws §§ 42-14-5(d) and 42-14.5-3(e). In carrying out these regulatory responsibilities, the Commissioner has been directed to accomplish the following legislative purposes: (1) guard the solvency of health insurers; (2) protect the interests of consumers; (3) encourage fair treatment of health care providers; (4) encourage policies and developments that improve the quality and efficiency of health care delivery and outcomes; and (5) view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. R.I. Gen. Laws § 42-14.5-2. A key element of these legislative purposes is the affordability of health insurance. In acting upon requests for rate increases, the Commissioner may consider whether the health insurer's products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products. OHIC Regulation 2, Section 9(b). Blue Cross Blue Shield of Rhode Island v McConaghy, (R.I. Superior Court, No. PC 04-6806, 2005); Hospital Service Corp of Rhode Island v West, 308 A2d 489, 495 (1973). The Commissioner may approve, disapprove, or modify the rates requested by a health insurance issuer after consideration of whether the Issuer had demonstrated that requested rates are "consistent with the proper conduct of the [Issuer's] business and with the interests of the public." R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-62-13.

Modification of the Rate Factor Filings

The Commissioner proposed modified rate factors for each Issuer in letters dated August 2, 2012, as supplemented and clarified in letters dated August 15, 2012, and August 27, 2012. The Issuers accepted the Commissioner's modified rate factors, resulting in reductions in rate increases for each Issuer, in each market. The following table summarizes the Issuer's requested rate increases, as compared to the modified rate increases approved by the Commissioner:

2013 Small and Large Employer Average Premium Increases: Requested and Approved

Small Employers

Insurer	Requested	Approved
BCBSRI	4.15% *	1.65%
Tufts	6.00%	5.30%
United	6.20%	2.54%

Large Employers

Insurer	Requested	Approved
BCBSRI	5.88% *	3.98%
Tufts	6.00%	4.50%
United	7.80%	5.53%

* Only BCBSRI's requested average expected premium increases include Affordable Care Act assessments of 1.80% for small employers and 1.60% for large employers. BCBSRI did not submit a scenario for OHIC to consider that did not include these assessments.

While the Commissioner's modifications have significantly reduce the rates requested by the Issuers, it is important to note that these approved rates of increase are averages; some actual premiums may be higher and some actual premiums may be lower. For small employers (one to 50 employees), premiums can vary based on the age and gender profile of a business' employees. For large employees, premiums can vary based on the historical and predicted experience of the firm's employees.

Administrative Costs

The Office undertakes a careful review of each Issuer's administrative costs. Unlike medical expenses, in which an Issuer's influence on costs is more complex and challenging, administrative costs can be more directly affected by Issuer decisions. The Commissioner's consideration of Issuer administrative expenses during the 2012 Rate Factor Review has taken into account administrative cost comparisons with other issuers in the New England region, as well as comparisons among Rhode Island Issuers. The Commissioner determined that administrative expenses should be capped at the weighted average of the administrative expenses of Rhode Island Issuers. Consequently, Blue Cross' administrative expense factor (on a per member per month basis) was reduced from $62.60 to $59.11 in the small group market, and from $55.04 to $53.47 in the large group market. Tufts administrative expense factor was

reduced from $62.10 to $59.11 in the small group market, and from $60.22 to $53.47 in the large group market. No modifications were made to the administrative expense rate factors filed by United, because United's filed factors were already below the Commissioner's administrative cost benchmark.

Affordable Care Act Assessments

The Patient Protection and Affordable Care Act enacted by Congress in 2010 will result in the imposition and collection of corporate taxes on Issuers in 2014. An annual, federal retrospective premium-based assessment is payable by Issuers no later than September 30, 2014 based on a calculation of premium revenue earned in calendar year 2013. An additional reinsurance program fee will be paid by Issuers quarterly for three years, beginning on January 15, 2014. Tufts did not request a charge on 2013 premiums. Blue Cross requested a rate factor of 1.80% and 1.60% in the small and large group markets respectively to reflect proposed charges on policies issued in calendar year 2013, to pay for the assessment and fee to be imposed in 2014. United initially did not request a charge on 2013 premiums, but later modified its request in a manner similar to Blue Cross' request.

The Commissioner has determined that consumers should not be charged in 2013 for a corporate tax that is not imposed and payable until 2014. The approved rate factors reflected in the table on page 3, above, do not include any Affordable Care Act assessments chargeable to 2013 premiums. The Commissioner observes that no national guidance has been provided by either the federal government or by the National Association of Insurance Commissioners ("NAIC") with respect to how these 2014 assessments should be treated for 2013 rate purposes. The NAIC has determined that for financial accounting purposes, the expense attributable to the assessments should not be recognized on the Issuer's financial statements until the year in which they are owed (2014) (Issuers have been instructed to notify regulators in their 2013 financial statements of their anticipated tax liabilities in 2014. SSAP No. 35R. Disclosure of federal assessments as Material Type II, SSAP - Subsequent Events) The Commissioner also observes that the corporate parent of United, and the umbrella organization for Blue Cross both supported the NAIC's financial accounting determination. The Commissioner's decision not to include 2014 assessments in 2013 premium is consistent with national financial accounting standards, and is consistent with the interests of the public. *See* Letter of Interested Parties to the Statutory Accounting Principles (E) Working Group, March 30, 2012. The 2014 assessments will need to

be addressed and accounted for, but the time for doing so is properly during OHIC's 2013 Rate Factor Review.

Medical Expense Factors

The Commissioner's review of Issuers' medical expense rate factors has taken into consideration the perspective and expectations of the Health Insurance Advisory Council and the Commissioner with respect to the affordability of health insurance. As explained in his letter to Rhode Island health insurance Issuers on December 1, 2011, the Commissioner noted that a major policy initiative of the Office has been its Affordability Standards - four expected sets of activities to be engaged in by Issuers to help reform a medical care delivery system. See http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Nov/1337_Bailit_using_ins_standards_policy_levers_build_high_perform_hlt_sys_ib_rev.pdf

The Commissioner further observed that the effects of the Affordability Standards have yet to be felt in the pricing of health insurance premiums. The Rhode Island trend of health insurance premium increases is not sustainable for purchasers and consumers, and represents an economic burden for businesses looking to recover from the recent recession, remain in Rhode Island, and increase profitability and employment opportunities. After reviewing this experience and national and regional data, the Commissioner communicated in his letter his expectation of Issuers (and the health care providers with whom they contract) that aggregate predicted medical trends for the 2012 rate filing (for purposes of calculating rates for policies renewed in 2013) should not exceed 4 percent.

The Commissioner has accepted the medical expense factors of both Blue Cross and Tufts as filed. Both Issuers have made a good faith effort to align their medical expense factors with the expectations of the Commissioner, after taking into consideration the effects of pharmacy benefit contracting changes, and the recognition of adjustments in experience observed in 2011.

The Commissioner has declined to accept the medical expense factors filed by United. At a time when national and regional experience is showing rates of medical inflation lower than in many years, and in economic circumstances where Rhode Island's employers and employees are having increasing difficulty affording high rates of premium increases year after year, United has failed to meet its burden of demonstrating that it's filed medical expense factors of 10.38% and 10.50% in the small and large group markets are consistent with the proper conduct of its

business, and in the interests of the public. United is a large and profitable national health insurance company. The Commissioner expects that with its national resources and expertise, United can and must do more as an industry leader to design benefit plans and negotiate provider reimbursement contracts with the goal of reducing the rate of increase in its medical expense rate factors, and thereby positively affect the affordability of health insurance for Rhode Island residents and businesses. Accordingly, United's aggregate medical expense factors are reduced from 10.38% to 7.5% in the small group market, and from 10.50% to 8.7% in the large group market.

Rate Cap

During the last several years of rate factor reviews by the Office, it has become apparent that different Issuers have had different understandings concerning the meaning and regulatory effect of the "Expected Overall Average Premium Trend" approved by the Commissioner each year for each Issuer, in each market. The approved Expected Overall Average Premium is calculated by aggregating approved rate factors for medical trend, administrative costs, and contributions to reserves. Some Issuers construed the Expected Overall Average Premium Trend to mean that the weighted average premium increase for same-product renewals offered during the relevant calendar year period could not exceed the Expected Overall Average Premium Trend. In effect, these Issuers construed the Expected Overall Average Premium Trend to be a rate cap. One Issuer had a very different understanding of the "bottom line." This Issuer used the Commissioner's approved medical expense rate factors when developing premiums, but then made adjustments to account for more recent claims experience and the actual demographic composition of groups. In effect, the Commissioner's Expected Overall Average Premium Trend was a number used for informational purposes only, with no regulatory or capping effect.

It is the Commissioner's responsibility to establish regulatory standards for Issuers that can be applied consistently. In the absence of consistently applied standards, some Issuers will be at a competitive disadvantage to others. The Commissioner believes that when a "bottom line" rate increase is approved, that approval should have actual meaning and regulatory effect. Consequently, the Commissioner has clarified that the Expected Overall Average Premium Trend means a "rate cap", as set forth, in further detail in the Commissioner's letter to the Issuers dated August 27, 2012, attached hereto and incorporated by reference herein. In the event of a conflict between the text and meaning of the rate cap as defined and set forth in this Decision,

and the text and meaning of the rate cap as defined and set forth in the Commissioner's August 27, 2012 letter, the latter shall control.

Three points should be made with respect to the establishment of the Expected Overall Average Premium Trend as a rate cap with regulatory effect. First, Issuers will be at risk for demographic provider price, and utilization shifts from what was forecast by the Issuer, in the absence of extraordinary circumstances demonstrated by the Issuer to the Commissioner's satisfaction. If Issuers were not at risk for such changed circumstances, the Commissioner's prior approval of rate factors would have little practical positive effect on the interests of the public, because Issuers would be able to simply pass along to ratepayers the costs of any miscalculation, or any increase in medical inflation. Second, if an Issuer sees evidence that it may be in non-compliance with the Commissioner's approved rate cap, the Issuer has options to address the situation: the Issuer can take appropriate actions with respect to provider contracting and administrative management; or in situations, as one example, where the financial condition of the Issuer may be in jeopardy the Issuer can request amendment of its approved rate factors and rate cap. The Commissioner has no intention of permitting an Issuer to become insolvent, and thereby causing harm to consumers, patients, health care providers, and the Rhode Island health care system. Guarding the solvency of Issuers, however, must be balanced with the interests of the public in the affordability of health insurance and health care. Third, as is the case with any administrative enforcement matter, the Commissioner has no intention of imposing negative consequences on an Issuer who has exceeded the approved rate cap despite its diligent, reasonable, and good faith efforts to keep within the cap. What constitutes evidence of diligence, reasonableness, and good faith will depend upon the circumstances in a particular case.

Affordability - Hospital Contracting Conditions

The Commissioner takes very seriously his legislative mission to promote the affordability of health insurance and health care in Rhode Island. In order to create the conditions where the goal of affordability can be achieved, the Commissioner has adopted a set of Affordability Standards designed to (1) expand and improve the primary care infrastructure in Rhode Island, (2) promoting the adoption and expansion of a medical home model of provider practice focused on improving the quality and efficiency of care for patients with chronic conditions, (3) encouraging the adoption of an electronic medical records system, and a health information technology communications system, and (4) working towards comprehensive payment reform

across the health care delivery system. This last affordability standard has been implemented by the Office by means of hospital contracting standards imposed on Issuers as conditions to the approval of rate increase requests. The hospital contract standards require Issuers to include prospectively in their hospital reimbursement contracts terms relating to alternative service payment methodologies, price increases aligned with Medicare price increases, quality and efficiency incentives, administrative efficiency, care coordination, and contracting transparency.

During this year's rate factor review, the Commissioner solicited comments from the public and from stakeholders concerning proposed amendments to the hospital contracting standards. After considering the public and stakeholder comments, the Commission amended the hospital contracting standards to encourage Issuers to innovate with more effective price agreements with hospitals, to ensure that efficiency and quality performance incentives are paid based on demonstrated results, and to align care coordination contracting terms with the care coordination measures utilized by Rhode Island's Medicare Quality Improvement Organization. See Rate Approval Conditions, attached hereto.

Medical Expense Trend Target

As noted above, the Commissioner in a letter dated December 1, 2011 established an expectation that the aggregate medical expense trend factors filed by Issuers during this Rate Factor Review process should not exceed 4 percent, based on the recommendation of the Health Insurance Advisory Council ("the Council"). The Council continued with its work developing an affordability target, and concluded its work in June, 2012. The Council found that commercial health insurance premiums have continued to grow at a pace that is unaffordable for Rhode Island businesses and consumers. The Council further found that this growth has occurred despite rigorous implementation of Affordability Standards by the Office. The Council made the following recommendations:

1. First, medical expense trend should grow no faster than general inflation, as measured by the Consumer Price Index for All Urban Consumers Less Food and Energy.
2. Second, the medical expense trend target should be phased in over 3 years, in order allow Issuers the time needed meet the target, such as by changing contracting arrangements with health care providers.

An important element in the successful implementation of a medical expense trend target will be to establish regulatory consequences for an Issuer's non-compliance with the medical expense trend target. Without regulatory consequences, a medical expense trend target is purely advisory, with no practical effect on Issuers, and most importantly with no practical effect on health care cost inflation, which is the fundamental, driving force in the currently unsustainable rate of increase in commercial health insurance premiums. A medical expense trend target with actual consequences for non-compliance is a regulatory standard. A medical expense target with no actual consequences for non-compliance represents mere words and numbers with no meaning.

Consistent with the recommendations of the Council and the Commissioner's December, 2011 letter, the Office intends over the months leading up to the 2013 Rate Factor Review to develop and implement a medical expense trend target as a regulatory standard, with real consequences for non-compliance with the standard. Part of the work of the Office will be to implement an audit process to closely monitor actual renewal rates offered by Issuers. Each Issuer will be required to report to the Office, each quarter specific data on health insurance rates renewed during the prior three months. The Office will work with Issuers to better understand underlying health care reimbursement prices and utilization, to explore with Issuers to how to influence health care provider economic behavior, and to urge Issuers to change how health care providers are paid through innovative benefit design, alternative payment methodologies, and realigned economic incentives. Some of these actions will require increased public accountability on the part of providers for their performance at improving overall affordability. As the largest medical provider institutions, hospitals are often expected to assume this responsibility. Some of this public accountability can be accomplished indirectly through health issuer oversight and some through provider oversight; but some may require new statutes to establish clear responsibilities.

As stated by a member of the public in his comments during the 2012 Rate Factor Review, Issuers must "not simply reduce what they pay providers, but [they] must change the way they pay them. [Ultimately], control of rates lies in this area of payment reform. We need to orient the rate review process toward encouraging new and innovative contracting methods between payers and providers such as tiered networks, bundled payments, pay for performance, and

ultimately some form of risk sharing to allow for more global budgeting." Ted Almon, President and CEO, Claflin Co., June 8, 2012 Public Comments.

Conclusion

The rate factors in this decision represent the lowest approved by this Office in recent history. This is a relief for employers and others who purchase health insurance. However, without persistent efforts to improve health insurance affordability in the ways set forth by the Office – rebuilding primary care, expanding the comprehensiveness of primary care, adopting health information technology and accomplishing payment reform that promotes accountability for population health – this relief will be temporary. As patients, providers, employers, employees and citizens we all have a stake in seeing that this work is accomplished successfully.

Dated at Cranston, Rhode Island this 20th day of September, 2012.

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

CERTIFICATION

I hereby certify that on this 20th day of September, 2012 a copy of the within Commissioner's 2012 Rate Factor Review Decision was sent by first class mail, postage prepaid and certified mail, return receipt requested to:

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