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TESTIMONY OF ERIC CIOPPA
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DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

In Opposition to L.D. 83 "An Act To Protect Health Insurance Ratepayers from Undocumented Rate Increases"

Sponsored by Senator John Patrick

In Opposition to L.D. 102 "An Act To Improve Health Insurance Transparency"

Sponsored by Representative Adam Goode

In Opposition to L.D. "161 An Act To Prohibit a Health Insurance Carrier from Establishing a Separate Premium Rate Based on Geographic Area"

Sponsored by Representative Louis J. Luchini

In Opposition to L.D. 225 "An Act To Restore Consumer Rate Review for Health Insurance Plans in the Individual and Small Group Markets"

Sponsored by Representative Nathan Libby

In Opposition to L.D. 681 "An Act To Improve Oversight of Insurance Rates and Ensure Consistency with Federal Law"

Sponsored by Representative Sharon Treat

In Opposition to L.D. 1176 "An Act To Require Health Insurers To Use One Geographic Area as Permitted by the Federal Patient Protection and Affordable Care Act"

Sponsored by Senator Geoffrey Gratwick

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Before the Joint Standing Committee on Insurance and Financial Services
April 4, 2013 at 1:00 p.m.

Senator Gratwick, Representative Treat, and members of the Committee, I am Superintendent of Insurance Eric Cioppa. I am here today to testify against LDs 83, 102, 161, 225, 681, and 1176.

These bills amend the Insurance Code in several areas. All of the bills would reverse some of the changes made recently with respect to individual rate filings--making all individual health insurance rates subject to prior approval. With the exception of LD 83, these bills would extend the same prior approval process to small group rates. LD 225 would require hearings, including public comment meetings in three locations, on every individual and small group rate filing. LD 681 would tighten the restrictions in current law with respect to rating variations based on age, geographic area, and tobacco use in the individual and small group markets. LD 681 would also increase the statutory loss ratio standard for prior approval. I will address each topic separately.

Before 2011, all individual health insurance rate filings required prior approval before they could be implemented. PL 90, enacted in 2011, created an exception for certain rate filings. To qualify for the exception, the filing must not require rate review under the federal Affordable Care Act (ACA). The ACA does not require review of rate increases if the average increase over the previous year's rates does not exceed 10%. The ACA rate review for a new product would not require approval but would require review for compliance with new market reform regulations.

Due to new federal requirements taking effect in 2014, we anticipate that health insurers will replace their existing products with new ones to incorporate the required essential health benefits and limits to cost sharing. Both the coverage and the premiums will increase significantly in most cases, but because the products are new the filing would not be considered a rate increase. In May of 2011, Gorman Actuarial studied the impact of the ACA in Maine for the Bureau. The report is available under archived reports on our website. They estimated that the average premium would increase 37% for the individual market and 12% for the small group market. The average deductible in the individual market was $6,300. (In 2012, 44% of Anthem's policyholders had a $15,000 deductible plan.) In the small group market, 89% of employer groups were predicted to experience increases.

Maine's current law also provides that in order to qualify for the exception to prior rate approval, the insurer must guarantee an 80% medical loss ratio, or "MLR." However, that condition no longer operates as an additional restriction on eligibility because that is now the minimum MLR required by the ACA for all health insurers in Maine. The MLR is the proportion of premiums net of taxes that are paid out to medical providers or used to improve quality of medical care. Under both the federal ACA and state law, rebates must be paid to policyholders if the MLR is less than the minimum standard. The minimum standard for the MLR in the individual market is now 80%, with the remaining 20% available to cover the insurer's administrative expenses and profit. There is a credibility adjustment for insurers that cover only a small number of Maine policyholders, to compensate for the wide fluctuations in experience that can be expected. At the time PL 90 was enacted, Maine had a waiver from the U.S. Department of Health and Human

Services under which insurers were only required to guarantee a minimum MLR of 65%, but that waiver is no longer in force.

For filings that are subject to prior approval, Maine law currently requires an expected loss ratio of at least 65%. This differs from the 80% guaranteed loss ratio requirement in three ways. Most obviously, the minimum loss ratio is much lower. Second, the 65% expected loss ratio requirement is a prospective standard, based on anticipated future experience. Under a prospective standard, no rebates are required if actual loss ratio turns out to be lower than the loss ratio anticipated in the filing. Third, the formula used to calculate the expected loss ratio does not include the adjustments for quality improvement expenses and taxes. These adjustments generally add two to three points to the ratio. Therefore, the 65% standard is roughly equivalent to a 67% or 68% adjusted MLR under the formula that is used for rebate purposes.

LD 681 would replace the 65% loss ratio minimum with the same standard used for rebates. I have no objection to this change.

First, these bills would all eliminate the exception created by PL 90 and require prior approval of all rate filings. Prior approval requirements, as contemplated, add cost and timeliness issues to the process. Prior to PL 90, public hearings were held on many rate filings. When prior approval is required, the law requires a notice to all affected policyholders that they have a right to request a hearing, although the request does not have to be granted. Either the Superintendent or the Attorney General can require a hearing. Other parties can participate as intervenors. Hearings typically involve numerous attorneys, actuaries, and consultants. This has a significant cost and greatly extends the time between when rates were filed and when they were implemented. For example, in

2011, Anthem filed its individual rates more than five months in advance of the effective date in order to allow time for the hearing process. The further in advance rates are filed, the less certainty there is as to what health care costs will be during the rating period.

Going forward, rates will have to be filed early because of the timetable for health insurance exchanges. While in the past, rates could be implemented within one to two months of approval, this year rates will need to be finalized by July 31 in order to be offered on the exchange for coverage beginning January 1, 2014. If prior approval is required, rates would need to be filed even earlier.

Even filing well in advance does not assure that the process will be complete in time to implement rates on schedule. For example, in 2010 Anthem filed rates on January 4 for a July 1 effective date, but was unable to implement rates until October 1 due to delays in the hearing process. If that were to happen in the future, the product might not be offered on the exchange.

LD 225 would also add a requirement for hearings on every filing, including public comment meetings in at least three locations. This would greatly increase the cost over both the current law and the law prior to 2011. The Bureau would likely need additional staff to handle this function.

Even in the absence of a requirement for prior approval, there are safeguards against unreasonable rates. The Bureau continues to conduct a thorough review of rates to ensure that they comply with all Maine laws, including the requirements that rates not be excessive, inadequate, or unfairly discriminatory. Recent filings have included coordinated review with the AG's Office and their consulting actuaries. If rates were found not to be in compliance, the Bureau would take action. Our review includes verifying that medical trend assumptions are

reasonably consistent with past experience and with trend assumptions used by other insurers. We also review all assumptions for reasonableness and consistency with historical trends. We determine whether administrative expense assumptions are consistent with past assumptions and with actual administrative expenses. One key assumption is the impact of the new reinsurance program, which we review to determine whether the carrier's methodology is appropriate and the resulting estimate is reasonable. We review the methodology used to develop the age factors used in the filing and verify that the changes were revenue neutral. We request the average rate increase for each product, consistent with the requirements of the federal regulation, to determine whether each increase is below the 10% threshold.

In addition to rate review, another safeguard, as noted above, is that rebates must be paid to policyholders if the credibility-adjusted MLR is below 80%.

For these reasons, I am opposed to the proposed change in procedures for individual rate filings.

Three of these bills, for the first time, would require prior approval for all small group rate filings, with the possibility of rate hearings. In the case of LD 225, hearings would be required on every filing.

Prior to 2003, all small group rates were filed for informational purposes only. Starting in 2003, some small group rate filings were subject to prior approval. However, insurers covering more than 1,000 lives were given the option to avoid prior approval by guaranteeing a 78% loss ratio and paying rebates if it was not met. Rates would then be filed for informational purpose and reviewed for compliance with other applicable laws. All of the major carriers opted for the guaranteed loss ratio.

Beginning in 2011, the ACA requires all small group carriers to pay rebates if the MLR is below 80%. This standard was roughly equivalent to Maine's optional 78% loss ratio standard. The Maine Legislature changed Maine law to be consistent with federal law with respect to the way the MLR is calculated and when rebates must be paid. The only carriers now subject to prior approval are those with very small blocks of small group policies and therefore no credible experience on which to base rebates. This is not much different than the situation prior to 2011, since all the major carriers had already elected the optional guaranteed loss ratio approach, leaving only the smallest carriers subject to prior approval.

I believe this procedure has worked well in the small group market and therefore oppose changing it at this time.

Finally, current law restricts age variations to a 3 to 1 range, restricts geographic area variations to a 1.5 to 1 range, and restricts variations based on tobacco use to a 1.5 to 1 range. The Affordable Care Act requires states to define rating areas within the state. Maine recently received acceptance under federal regulations to use four geographic areas based on county groupings generally consistent with current small group geographic factors. I have a chart of the counties that fall into each of the newly approved geographic areas. Carriers may set their own geographic factors within Maine law but are required to use the four established areas beginning January 2014.

LDs 161 and 681 would replace the restrictions on age and geographic rating in current Maine law with a 3 to 1 limit on the combined effects of both variables. LD 681 would also include tobacco use within the combined 3 to 1 limit. Combining age with other variables is problematic due to conflict with federal

rules recently adopted under the Affordable Care Act. These rules require use of specified age factors in rating. Although a state can request approval of a different set of age factors, this would not permit factors that affect rates differently depending on the individual's geographic area and tobacco use. Furthermore, the deadline for requesting approval of different age factors for 2014 has already passed. The federal rules would make it impossible to implement the restrictions in these bills.

The Bureau of Insurance conducted an analysis in October 2012 of the geographic rating factors used by health insurance carriers in the individual and small group markets, and copies of that report have been provided to the Committee. Insurers often base their area factors on either their claims experience or provider reimbursement arrangements in each area. The current 1.5 to 1 band allows for most of the observed regional cost variations. LD 1176, by prohibiting geographic rating in the individual and small group markets, would not allow insurers to reflect these cost differences in their rates.

Other considerations regarding LDs 161, 681, and 1176 include cost transparency. Further restricting the regional rate variation could mask delivery costs and since several rating variables, like group size and occupation currently allowed will not be permitted in 2014, it may be desirable to have as much flexibility as possible in the rating variables that remain. In addition, these bills create timing problems for rate filings for 2014. Rates will need to be filed before June and finalized by July 31 in order to be offered on the Exchange for coverage beginning January 1, 2014.

Thank you. I would be happy to answer questions now or at the work session.

Maine Bureau of Insurance

April 4, 2013

Geographic Rating Areas

Area 1	Cumberland, Sagadahoc, York
Area 2	Kennebec, Knox, Lincoln, Oxford
Area 3	Androscoggin, Franklin, Penobscot, Somerset, Piscataquis, Waldo
Area 4	Aroostook, Hancock, Washington

Bureau of Insurance Review of Anthem 2012 Individual Rate Filing

On April 11, 2012, Anthem filed rates for its individual health insurance plans, to be effective July 1, 2012. In addition to filing new rates for its existing products, Anthem also filed rates for a new product called "HealthChoice Plus," which will be available on July 1. If you currently have an Anthem individual plan, you will have a choice between renewing your current plan or switching to one of the new HealthChoice Plus plans. For the existing products, the rate change varies significantly by age. It varies from a 17.5% decrease to an 18.2% increase, with the average change being a 1.7% increase.

The average rate increase is much smaller than in recent years, primarily due to the effect of a new reinsurance program created by P.L. 90, described below. For further information on the filing, click here. Or to view or comment on the filing, click here, then click on Search Public Filings and enter the tracking number: AWLP-128240760.

The Bureau's Review

While the substance of the Bureau's review of the filing was in many ways similar to previous years, the review process differed significantly from past years due to new state and federal laws. Formerly, under Maine law, an insurer could not implement new rates for individual health plans until those rates had been approved by the Superintendent of Insurance, and there were no federal requirements in this area. Now, under new federal rate review regulations adopted under the Affordable Care Act (ACA), all rate increases averaging 10% or more must be reviewed by regulators. A new Maine law known as P.L. 90 provides that if the insurer agrees to guarantee that it will maintain a medical loss ratio (MLR) of at least 80% - that is, to pay back in claims and quality improvement expenses at least 80% of the premiums it has collected (net of taxes and fees) – then prior approval is only required if the rate increase triggers the federal review requirements.

The relevant features of these new laws are discussed in more detail below. This is the first Anthem individual rate filing that is subject to these laws, and it meets the requirements to be exempt from prior approval. Although no approval by the Bureau is required for this filing, the Bureau reviewed the filing carefully to ensure that the rates comply with all Maine insurance laws, including the requirement that rates not be excessive, inadequate, or unfairly discriminatory. If the Bureau determines that the filed rates do not comply with Maine law, the Bureau will request revised rates that do comply.

The terms used in the rating law mean:

- Rates are **excessive** if they are unreasonably high in relation to the benefits provided under the coverage. For this filing, the anticipated "pure" loss ratio (claims divided by premiums) is 87.1%. After the required ACA adjustments, the anticipated MLR is 92.1%, which significantly exceeds the required minimum of 80%. The rates are expected to result in a profit of 3% of premiums.
- Rates are **inadequate** if they are insufficient to sustain projected claims and expenses and will tend to create a monopoly in the market or cause serious financial harm to the insurer.

- Rates are **unfairly discriminatory** if the premium differences between insureds do not reasonably correspond to differences in expected costs or are based on factors that are prohibited by law. For example, Maine law prohibits charging higher rates for people who have health problems or who have had larger claims.

Some of the specific steps in the review included:

- We reviewed a draft notice to policyholders and provided suggestions to Anthem about making it more informative.
- We posted answers to Frequently Asked Questions on our website.
- We requested more information about how the rates were developed, including medical trend assumptions, commission schedules, past and projected future financial results, and the number of members enrolled in each plan. Anthem requested that this information be held confidential, but the Bureau determined that it is public information under Maine law.
- We verified that the age variations were within the legally allowed range, which is 2 to 1 for the existing plans and 3 to 1 for the new plan that will be available July 1, 2012.
- We verified that the difference in rates for different deductibles did not exceed legal limits established by the Bureau's Rule 940.
- We reviewed all assumptions for reasonableness and consistency with historical trends. The medical trend assumption is consistent with past experience and with trend assumptions used by other insurers. The administrative expense assumption was also consistent with past assumptions and with Anthem's actual administrative expenses. One key assumption was the impact of the new reinsurance program discussed below. We found that Anthem's methodology was appropriate and the resulting estimate was reasonable.
- We reviewed the methodology used to develop the new age factors used in this filing and verified that the changes were revenue neutral.
- We requested the average rate increase for each product, consistent with the requirements of the federal regulation, to determine whether each increase was below the 10% threshold.

Based on our review, we concluded that the proposed rates are not excessive, inadequate, or unfairly discriminatory.

P.L. 90

P.L. 90 affects this filing and the review process in several ways:

- Under the old law, as discussed above, all rates for individual health policies had to be approved in advance by the Bureau of Insurance before they could be implemented. P.L. 90 eliminates the prior approval requirement if (1) the average rate increase is less than the federal rate review threshold; and (2) the insurer agrees to pay rebates to policyholders if the MLR is below 80%. Anthem met these conditions and therefore the filed rates will be implemented with no

approval required. However, as described above, the Bureau has reviewed the filing for compliance with all Maine insurance laws.

- P.L. 90 created a new subsidized reinsurance program that begins July 1, 2012. This reduces the cost of insurance in the individual market by reimbursing insurers for a portion of the claims paid for high-risk individuals. Anthem estimated that its participation in the program will reduce total claims for its individual products by about $11 million, resulting in a much smaller rate increase than would otherwise have been needed. The filing projected that without the reinsurance subsidy the indicated premium increase would have been 21.6%.
- P.L. 90 made the limits on age rating factors less restrictive, consistent with federal standards. This allows Anthem to charge less for younger members and more for older members than under the old law. As a result, younger members receive decreases in their rates, while older members receive larger increases.
- P.L. 90 allows insurers to "close their block" of policies issued prior to July 1, 2012. This means that those policies can be rated separately from newer policies.

For further information about P.L. 90, click here.

Affordable Care Act (ACA)

Federal regulations adopted under the ACA require review of all "potentially unreasonable" rate increases to determine whether the increase is unreasonable. This review is conducted either by the state, if the federal government finds the state to have an effective rate review mechanism, or by the federal government otherwise. Maine was found to have an effective rate review mechanism. The federal regulations currently define a rate increase as potentially unreasonable if the average increase is above 10%. Under P.L. 90, prior rate approval is still required for these increases. However, Anthem's increase is below the threshold.

The ACA also requires coverage to be sold on a "guaranteed loss ratio" basis. This means that if an insurer fails to meet a required minimum MLR, it must provide rebates to its customers to make up the difference. For these purposes, an insurer's MLR is calculated by dividing the claims paid, plus amounts paid for activities that improve health care quality, by the premium collected, net of taxes and fees. For the individual market in Maine, the minimum MLR is currently 65%. However, as noted earlier, Anthem has agreed to guarantee an 80% MLR.