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# REPORT OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES ON THE WORKGROUP FINDINGS RELATED TO RANGE OF RATES

## In Accordance with House Bill 2605 (2015)

The Department of Consumer and Business Services (DCBS) is pleased to submit this report to the Legislative Assembly, as directed by ORS 192.245. Paper copies of this report may be obtained at 350 Winter St. NE Salem, OR 97302. Electronic copies of this report may be downloaded at http://dfr.oregon.gov/pages/index.aspx.

## INTRODUCTION

Since 2015, when the Legislative Assembly first revisited the rate review process in the post-Patient Protection and Affordable Care Act (PPACA)[1] regulatory environment, the overall health care market in Oregon has experienced a number of challenges. The number of health insurers domiciled in Oregon shrunk by three, in large part due to the involuntary supervision and subsequent insolvency of the two health care cooperatives. Additionally, several carriers downsized service areas, leaving some counties with limited competition for health care business. The department did work to ensure Oregonians enjoyed health insurance competition for their premium dollars in all areas of the state, urban and rural alike.[2] At best, however, the department's efforts constitute a short-term solution. And finally, those insurers remaining in the health insurance market initially proposed substantial rate increases, particularly for the individual market.[3]

These market stability challenges can have an impact on the financial viability of health care payors and thus relate to the rates Oregon law allows those payors to charge their customers. It became clear to the department that a more comprehensive look at how the rate review process operates is increasingly necessary, and the department commits to bringing together core

[1] 42 USC § 18001 *et seq*.
[2] *See* Oregon Dept. of Consumer and Business Svcs., *Health insurers agree to serve rural counties in 2017* (August 11, 2016), available at http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1299.
[3] *See* Oregon Dept. of Consumer and Business Svcs., *First look at 2017 proposed health insurance rates* (May 03, 2016), available at: http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1096.

stakeholders and policymakers to continue this important work. The department remained mindful that the scope of the workgroup's activities was limited to studying a narrower solution to rate review, so the department did not engage in a broad set of conversations with gathered stakeholders concerning reform of the rate review process. While this report does make the findings the Legislative Assembly required when it passed the original Act, we believe this document serves only as a point of reference in the larger discussion of setting actuarially justified, sound, and sustainable rates for the individual and small group health insurance markets.

# BACKGROUND

The Legislative Assembly has long entrusted the Department of Consumer and Business Services (DCBS) with the responsibility to ensure that rates for health insurance plans remain reasonable and not excessive, inadequate, or unfairly discriminatory.[4] To carry out this responsibility, DCBS consider an insurer's overall profitability rather than just the profitability of a particular line of insurance in which it conducts business. Companies must also separately report and justify changes in administrative expenses by line of business and provide detail about salaries, commissions, marketing, advertising, and other administrative expenses.

The Legislative Assembly enacted significant reforms in 2007[5] and 2009[6] to confer on DCBS the responsibility to conduct rigorous and transparent rate reviews for individual and small group health insurance plans. Federal reforms under the ACA became effective six months after Oregon's major rate review reforms were implemented in April 2010.

In Oregon, insurers must submit rate requests for prior approval in the individual and small group markets before the policies are initially introduced and on an annual basis thereafter, even if no increase or decrease is requested.[7] All rate filings are a matter of public record and are made available through a system called the System for Electronic Rate and Form Filing (SERFF), a multi-state system developed and run by the National Association of Insurance Commissioners.[8] Additionally, all rate filings are posted at our rate review website, www.oregonhealthrates.org. The Oregon process also affords an opportunity for the public to attend hearings, provide oral testimony, and file subsequent written comments. All of this public testimony is made available through the department's website.[9] Additionally, the Director posts a detailed rate filing decision covering the primary drivers of the rate change for every filing.

## House Bill 2605

In 2015, the Oregon Legislative Assembly enacted House Bill 2605,[10] which primarily modified Oregon's rate review process by delaying the start date for the public hearings to later in the process. This change allows Oregonians, the insurance carriers, and other interested parties to review DCBS' preliminary rate decisions and provide comment for consideration before final rate decisions are made. By adopting a later start date for the public hearings, the process benefits from a more focused discussion on key elements of the filing. The Act also authorized

[4] ORS 743.018(4).
[5] *See* 2007 Or Laws ch 391 (Enrolled House Bill 3103) (required public disclosure in rate filings)
[6] 2009 Or Laws ch 595 (Enrolled House Bill 2009)
[7] *See* 45 CFR § 156.80 (d)(3) (2015)
[8] *See* http://www.serff.com/
[9] *See* http://dfr.oregon.gov/public-resources/healthrates/Pages/index.aspx.
[10] 2015 Or Laws ch 88

insurance carriers to appeal the final decisions directly to the Director of DCBS, and then to the Court of Appeals.

Section 1 of the Act also directed DCBS to convene a workgroup to consider modifying the standards for rate review. The workgroup's charge under the Act was to determine whether the director's rate review discretion should be limited to disapproving rates falling outside a pre-set range. The Act requested review of whether the range of rates should be established based on the following factors:

- Rates within a range that is computed to be actuarially sound;
- Rates that are determined to be reasonable and not excessive, inadequate or unfairly discriminatory; and
- Rates that are based upon reasonable administrative expenses.

## *WORKGROUP PROCESS:*

The workgroup met on January 29, 2016. Workgroup participants included actuaries for seven domestic insurers and one consumer advocate representative. The workgroup members were:

- Jennifer Halttunen, Moda Health Plan, Inc.
- Paul Harmon, Regence BlueCross BlueShield of Oregon
- Shamsher Plaha, UnitedHealthCare Insurance Company
- Sharon Howe, Providence Health Plan
- Mark Florian, PacificSource Health Plans
- David Liebert, Kaiser Foundation Health Plan of the Northwest
- Jesse O'Brien, Oregon State Public Interest Research Group

Michael Sink, Life and Health Actuary, and Jeannette Johnson, Senior Policy Analyst, staffed the committee for the department.

Upon analysis of the Act's assignment, the workgroup identified several potential, appropriate interpretations of "range of rates," which are summarized under the "Findings" section of this report. The workgroup interpreted the language of the Act as assigning the task of defining "range of rates" to the workgroup. In order to discuss options, the workgroup needed to first identify and define them.

In the meeting, the group discussed:

- The meaning of "range of rates" within the context of HB 2605.
- The potential implications of rates falling outside of this range.
- How unique plan designs fell within the scope of "range of rates".
- The implications of rate disapproval, in general.
- The consequences for a state if it does not meet the criteria of an Effective Rate Review program, as defined by the Centers for Medicaid and Medicaid Services (CMS).
- Which option(s) would result in no change to the current rate review process.

In addition to discussing each of the points listed previously, following this meeting, DCBS staff sent a survey to the workgroup asking members to rank the feasibility and preference of the

proposed options. Due to clear consensus among the workgroup in the January meeting and in the subsequent ranking of options, no additional in-person meetings were scheduled.

## *WORKGROUP CONSIDERATIONS:*

In its assessment of the various interpretations of a "range of rates," the workgroup identified key areas for consideration and the potential implications of each option with regards to being actuarially sound, their effect on marketplace competition and ultimately their impact on the state's effective rate review program.

### *Actuarial Soundness & Professional Responsibility*

The workgroup discussed how filings based on "range of rates" might put actuaries at odds with their profession. As a function of their professional designation, actuaries submitting rate filings certify that they follow the Actuarial Standards Board's Actuarial Standards of Practice (ASOP).[11] All of the options discussed in this report potentially allow a carrier to set rates based on a competitor's filed rates. Setting rates solely based on a market competition strategy would likely constitute a violation of some, if not all, of the ASOPs.

### *Rate Setting Based on Competition*

One significant concern about allowing carriers to modify their rate filings after seeing a competitor's filings centered on the impact on market-wide competition. This option to modify a filing could result in "shadow pricing," which refers to a practice where a carrier lowers their premiums below its competitors for the sole purpose of gaining market share. Generally, the revised premium is lower than the original filing, but may not be sufficient to ensure that the company remains solvent. To make up for the loss in revenue, the carrier generally depends on negotiating better provider contracts once they have a larger membership, thereby lowering costs later in order to return to profitability. This practice is not actuarially sound or sustainable as it leads to significant financial losses, resulting in subsequent large rate increases, potentially disrupting the entire market for years. This practice may violate ASOP #8, 3.11.1.[12]

Furthermore, the workgroup discussed the impracticability of filing based on other's filed rates. The ACA introduced a uniform filing deadline for all carriers[13]. As a result, no insurance company has an advantage of seeing the competitors' rates before submitting their own requests. "Range of rates" would remove this protection provided under federal law. Further, a state-specific range of rates requirement may not be enforceable if it conflicts with federal law under the ACA.

### *Maintaining an Effective State-Based Rate Review Program*

The Centers for Medicaid and Medicaid Services (CMS), the office within the United States Department of Health and Human Services responsible for overseeing implementation of the ACA, also determines whether a state meets the definition for having an "effective rate review system."[14] When a state "lacks the resources or authority to conduct the required rate reviews,

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[11] The Actuarial Standards of Practice are guidelines set by Actuarial Standards Board. The Board, representing a broad range of backgrounds and areas of actuarial practice, establishes and improves standards of actuarial practice. http://www.actuarialstandardsboard.org.

[12] ASOP #8, 3.11.1 states that "Rates may be considered adequate if they provide for payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency or profit margins."

[13] 45 CFR § 154.220 (2015)

[14] *See* 45 CFR Part 154.

Health and Human Services (HHS) will conduct them." CMS provides strict criteria[15] for what a state must do to demonstrate "effective rate review." If a state does not meet these criteria, it runs the risk of losing its independent ability to review rates charged to its citizens. As the "range of rates" process would result in new rates being selected after rate review is complete, much of these criteria could not be completed.

# FINDINGS RELATED TO HB 2605

Listed below is a summary of the most feasible options falling within a reasonable interpretation of "range of rates," as generated by the workgroup and department staff.

### *Option #1: DCBS sets rates in a numeric range, and the insurer may set rates anywhere within that numeric range.*

The Director may only disapprove rates that fall outside a reasonable range, and may not determine "reasonable" for a specific carrier. Carriers falling outside the range may adjust their rates to fall anywhere within the range. This model would not be actuarially sound as the rates may not be based on an insurer's actuarial data and may lead to market instability. Further, carriers would be allowed to choose rates after seeing their competitors' rates and would not have to justify their own filings.

### *Option #2: DCBS sets a model range of rates, and insurers may then set rates at any level.*

After receiving all rates, the Director determines an approvable range of rates. Following this, all carriers may adjust rates anywhere within the range, not just the carriers falling outside of the reasonable range. This model would not be actuarially sound as the rates may not be based on an insurer's actuarial data and would cause market instability. This option varies from the first option, as it extends the resetting of rates to carriers that otherwise submitted an approvable filing. Option one only allows carriers that are outside of the approvable ranges to reset their rates. This option may result in carriers being incentivized to reduce rates below cost to obtain market share.

### *Option #3: Carrier filings outside the approval range are disapproved.*

Carriers filing outside of the approvable range are disapproved. If a carrier chooses a rate that is not actuarially sound, the Director could elect to disapprove those rates instead of allowing a modification. The disapproval of the filing would result in the carrier being unable to participate in the market for at least one year, with the possibility of a five year ban. While the workgroup discussed the consequences of a ban, it spent very little time discussing options that may result in disapproval and ban. This option does not allow carriers to adjust their rates if they fall outside of the reasonable range.

### *Option #4: Current process*

The Director sets a range for each company that is specific to that company's filing components. This is the current process. For 2016, the department adopted an "acceptable level of variability", meaning that in cases where the department and company actuaries disagree by no more than two percent, the rate filings are approved as filed.

[15] For more information about CMS review criteria, visit https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html#one .

### *Additional Considerations:*

If any of the "range of rates" options, other than the current process, were implemented, the workgroup concluded that Oregon would not meet many of CMS' criteria for an effective rate review state, including, but not limited to:

- Receiving sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases.
- The carriers' overall financial position, including surplus and capital, and reserve needs.
- The impact of over- or under-estimating medical trend in previous years on the current rates.

As a result, Oregon may likely lose its effective rate review status if the "range of rates" process was implemented. The primary result of losing this designation is that CMS would review all filings for the individual and small group market. This raises concerns that Oregon's efforts made to ensure transparency and consumer involvement may decrease, as rate decisions would be made by the federal government. For perspective, as of April 2016, only four states in the country do not enjoy effective rate review status.[16]

## RECOMMENDATIONS FOR FURTHER STUDY

### *CONCLUSION:*

The individual market has suffered significant losses since 2014 due underpricing and anti-selection. In the first two years alone, the individual market has suffered underwriting losses in excess of a hundred million dollars annually. In subsequent years, insurers have made adjustments in the form of rate increases to correct for their actual experience, which should serve to curb some of the volatility in this market. However, the ACA removed or restricted many of the traditional forms of competition for the insurance industry, including underwriting and risk selection, as well establishing robust requirements for benefit design, which continue to place financial pressure on insurers. The "range of rates" proposal does not adequately address the ongoing competitive concerns in the individual market. Nor does "range of rates" take into consideration a company's overall financial position and potential insolvency issues. The workgroup's final recommendation was to preserve rate review as it currently exists.

### *Future Work:*

The workgroup process took place during the first couple months of 2016 so as not to overlap with the rate review season, which began in early May. During this time, industry and department actuarial staff must focus on rate filings. Furthermore, market instability issues related to increased rates and related geographic coverage availability issues were not fully realized until midway through the rate review process. As a result, this report primarily responds to the charge of the Legislature as described in HB 2605 and market conditions that were known in the early part of this year. Due to timing issues and the continually evolving commercial

[16] The four states are Missouri, Oklahoma, Texas and Wyoming. *See* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html.

health insurance landscape the report does not address the instability and insolvency issues affecting the individual health insurance market today.

DCBS recommends that another workgroup be convened, with a broader scope of analyzing and enhancing the rate review process. The workgroup would meet over a longer time period and consider more expansive changes to aid DCBS in addressing market instability issues. DCBS recommends reporting back to the committee at some point during the 2017 Interim Legislative Days.