February 10, 2011

The Honorable Dave Jones, Commissioner
California Department of Insurance
300 Capitol Mall
Sacramento, CA 95814

Re: Guidance 1163:2, draft release date February 3, 2011

Dear Commissioner Jones,

AARP. the California Pan-Ethnic Health Network, CALPIRG, Consumers Union, and Health Access submit these comments regarding Guidance 1163:2 and the accompanying plain language rate filing description and long rate filing form. Our organizations support those provisions of the Guidance that provide more transparency and accountability for health insurance carrier premium rates, consistent with Chapter 661 of 2010 (SB1163), as well as Section 2794 of the Affordable Care Act and 45 CFR Part 154.

We appreciate the speed with which this guidance was issued and recognize that guidance pursuant to SB 1163 is subject to additional refinement over time. We offer the following comments and suggestions, some of which are formulated to assure that the Guidance is consistent with statutory authority, including the intent of the law, and some to provide both the Department and consumer organization greater clarity as well as information necessary to permit analysis by the Department of Insurance (CDI), outside experts, consumer groups, and consumers. Our comments reflect our best thinking during this abbreviated comment period: as we review the Guidance and forms, we may provide further comments.

Section A: Unreasonable Rate Increases

In the first instance, our organizations commend the following provisions of the guidance that correctly interpret SB 1163, Chapter 661 of 2010:

- It applies to both new and existing products. Nothing in SB1163 exempted new products from its provisions. We recognize that some data or information may not be available for new products, but the basic provisions such as the requirement that rate justifications be proven by "substantial evidence" applies to new products as well as existing products.
- It applies to rates and rate increases both. SB1163 is not limited to rate increases, it applies to rates generally.
- It applies to rates effective on or after January 1, 2011. It is customary in California laws applying to health insurance to specify a delayed effective date of July 1 in order to allow the regulators and the industry time to come into compliance. No provision of SB1163 provides for delayed implementation. SB1163 took effect on January 1, 2011 and applies to any rate in effect on or after that date.
- It provides for an additional 60 day notice if the rate filing is revised which is consistent with federal guidance and provides appropriate further specification of the California statute that offers both the regulated industry and affected purchasers of coverage greater clarity.

Secondly, our organizations commend CDI for incorporating the provisions of federal guidance on rate review issued December 21, 2010 in Section A. Existing California law, SB1163 (Chapter 661 of 2010), authorizes the California Department of Insurance ("CDI") to adopt guidance that is consistent with federal law and guidance under that federal law. We suggest some additional factors for CDI's consideration that support the intent of the federal law and would strengthen consumer protections.

SB 1163 has requirements that apply in particular to "unreasonable" rate increases.[1] "Unreasonable rate increase" has the same meaning as that term is defined in Patient Protection and Affordable Care Act (PPACA)."[2] Under the proposed federal Department of Health and Human Services (HHS) regulations, rates will not be deemed unreasonable before they are reviewed. Instead, HHS will adopt a state's determination of unreasonableness if HHS determines that the state has "an effective rate review program." HHS will review increases for states that are not determined to have an effective review program.[3] It is thus in the state's interest to have a robust review process.

We strongly support factors 1-10 enumerated in the Guidance Section A, and in particular the requirements that assumptions be supported by "substantial evidence" and that rates of return, including investment income, are considered with any proposed rate increase. In order to comport with SB 1163, the guidance should also note that the "substantial evidence" test applies to "rates" as well as "rate increases." Factors 1-5 track HHS's proposed standards for review and would require analysis of important factors, such as the reasonableness of all assumptions, including cost projections. Factors 6-10 are additional criteria that we agree are necessary for an effective review of reasonableness.

We have suggestions regarding two of the factors.

First, for factor 6 – " whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data" – we urge you to adopt a historical time frame of <u>five years, and on a rolling basis,</u> to test validity and ensure that experience data presents an accurate picture of actual trends over time. In our comments on the rate filing form we offer suggestions for additional data CDI will need and should collect to make this determination. Specifically, we support the following:

> 6) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data, <u>for the prior five years estimated on a rolling monthly basis.</u>

Secondly, as to factor 9, we suggest that while the medical cost inflation under the CPI provided in the Guidance may be fine for trend comparisons, the Producer Price Index for the Direct Health and Medical Insurance Carriers Industry (PPI) should be added to compare for rate increases. If a rate increase exceeds either of these measures, the Department should consider this to be an indication that the rate increase may be unreasonable. The contrary inference should not, however, be drawn – in particular, the PPI measure is best used to determine whether a particular increase is significantly greater than the industry norm for a particular year. Because unreasonable increases may be a widespread practice across the industry, specific increases that are equal to or lower than the PPI measure may still be unreasonable. In no case should these inflation comparisons substitute for substantive analysis of the rate filing. Specifically, we seek the following language:

> 9) The degree to which the increase exceeds the rate of medical cost inflation as reported by the United States Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index <u>and also a comparison of the requested increase with the Producer Price Index for Direct Health and Medical Insurance Carriers (PPI).</u>

While we recognize that the Guidance allows for additional considerations not enumerated, we suggest that CDI add some specific factors that would ensure thorough and fair review in the interest of consumers and sufficient data collection, and would better inform HHS regarding the depth of the Department's review. Adding these factors also would result in further discussion and justification of a rate increase in the carrier's independent certification under Guidance Section C. The addition of these factors will provide greater clarity for the Department and interested parties.

[1] Insurance Code Sections 10181.4(a), 10181.6(b)(2) and 10181.11.
[2] Insurance Code Section 10181(d).
[3] 45 C.F.R. Part 154.

As provided in Chapter 661 of 2010, the guidance should include factors specified in federal guidance. Specifically, the determination of unreasonableness should include the additional factors listed in the proposed regulation which HHS proposes to consider in a determination of effective *state* review under 45 C.F.R. 154.301, with particular attention to the carrier's data related to past projections and actual experience. See 45 C.F.R. 154.301(a)(3)(ii). This factor is important to include in the reasonableness determination to discourage inflated cost projections or underestimated revenue projections at current rates.

In addition, the Department should consider factors necessary due to the way that carriers in California price, or appear to be pricing, their products (based on review of rate filings that are currently available online). These include:

- Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of a rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group. This would include considering the minimum and maximum rate increases a policyholder could receive, and how many policyholders will be subject to increases lower and higher than the average. This is particularly important prior to the implementation of new rating rules in 2014 because insurers are allowed to rate based on health status. Post-2014 this information will be important for the department's review to assure consistency with federal law. See companion document showing an example of how CDI collects and displays this data in the automobile insurer context.

- For carriers using assumptions such as leveraging, duration, selection, and others based on risk or demographic mix, whether such assumptions are supported by substantial evidence, and the carrier has shown that the impact of such assumptions was removed from development of the "base" medical trend to avoid "double-counting."

Section B: Filing and Notice

We support all of the filing and notice requirements in the Guidance. Carriers must submit filings for new product rates and rate increases for existing products. We agree that new product filings must be included so that rates can be tested for adequacy and supported with credible data. New products that are under-priced can lure new customers with attractive rates only to result in steep increases in the future. The Department may want to consider removing "increases" and require filings for any rate "change" on existing products to guard against attempts at market share grabs.

Further, we agree that rates implemented on or after January 1, 2011 must comply with SB 1163 to adhere to the intent of the statute and provide immediate protections for consumers who are struggling to afford increases we are already seeing going into effect on or after the first of this year. We also support the 60-day notice requirement for consumers if a rate filing is revised after its initial submission.

Section C: Actuarial Certification

The actuarial certification is statutorily required and is a key document for CDI to assess the reasonableness of rate requests. For the Guidelines regarding actuarial certification, we urge you to add the following language to section C(14)(B)(2) to clarify the level at which the definition of actuarial soundness will be applied:

> A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate **for a particular market segment such as the individual market**.

This clarification is necessary to avoid an interpretation by carriers that revenues must cover costs for each separate product or policy, which would only exacerbate risk segregation and lack of risk pooling in current markets.

Further, we support the definition in so far as it includes premium income, reinsurance and risk adjustment cash flows, and investment income in the calculation of actuarially soundness – all of these elements are important for an accurate revenue projection. However, we have concerns that on the cost side of the equation, "the cost of required capital" can result in carriers adding to the cost projection unnecessary profit margins (such as "provisions for adverse deviation") or contributions to surplus, as they may view the meaning of *required* to be whatever they think is necessary. If this element is meant to provide for capital required under California's solvency standards, more specification to that effect is needed.

With respect to Section C(1)(B)(4), the statements of opinion should discuss not only whether benefits are reasonable in relation to the premium charged (i.e., medical loss ratio standards) for the individual health insurance market, but also for the small group market, applying the federal medical loss ratio standards.

Furthermore, we urge that the actuarial certification provide a breakdown of how the rating factors have been applied (e.g. geographic areas, age) and the expected effect on various populations, i.e. showing which consumers will have the greatest increase and which will have the least broken out demographically. The companion document hereto shows how this is displayed in the automobile insurance context.

Section D: Filing Requirements

In order to meet its statutory obligation to assess whether a rate is reasonable and actuarially sound, the Department may require information in addition to the 24 items listed on the California Rate Filing Form and the form should state that the Department may require such additional information as is necessary to determine whether the rate is reasonable and actuarially sound. For example, if an insurer is proposing a rate increase in a specific geographic area, determining whether the applicable rating factor is reasonable will require specific experience data in that geographic area. While the "including, but not limited to" language in Section A implies that CDI may consider additional information, it would be better to make explicit that additional information may be required beyond what is submitted by filling in the blanks on the filing form.

The "California Plain-Language Rate Filing Description"

SB 1163 recognizes that there is a strong need for translation of complex rate filings into plain language for the public and for individual consumers who will be confronted with rate increases. The detailed data and insurance terminology will be essential for CDI to make its determinations and for organizations and their own actuaries to plumb the data to evaluate assumptions and conclusions. But average consumers, the media and others will need—and SB 1163 requires—simple to read and understand summary information, devoid of jargon and at an appropriate literacy level. This intent should be expressed explicitly in the Guidance. [4] Further, the plain language summary should be provided in languages other than English and the burden should be on the insurers to provide this important document in languages other than English.

The "California Plain-Language Rate Filing Description" attached to the Guidance omits critical information on administrative costs and profit. These should be specified both in the aggregate as a percent of premium and as per member per month costs for the standard administrative costs (salaries,

[4] The Oregon rate review statute provides an example of such plain language disclosures. See http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YjN1k

commissions, legal and consulting fees, lobbying expenses etc.). It also omits any reference to "cost containment and quality improvement efforts," as does the "California Rate Filing Form", though this is required by SB 1163, along with an estimate of cost savings due to such efforts.[5] As all levels of government seek to sustain and improve upon our health care system—and the health and well being of Californians—both containing the ever upward-spiraling costs and improving the safety and quality of health care delivery will be essential. This data element needs to be added to both forms.

Furthermore, the plain language filing should report two sets of contrasting numbers to convey the impact of any proposed increase. The first would include the projected total premiums collected, total claims paid, total administrative costs, and total profit, as dollars and percentages. The second set would illustrate the difference the rate increase will make by stating the same numbers (by dollars and percentages) under the proposed rate increase.

The California Rate Filing Form:

Under Chapter 661 of 2010, Section 10181.3 of the Insurance Code, an insurer is required to disclose to the department information. In order to permit the department to carry out its responsibilities under state law and federal law as well as to provide adequate information and clarity to the department, we propose additional specific items of information that should be disclosed by the insurer to the department.

- Experience Period: Dates and Duration for Experience Period, Total Premium Revenue, Total Incurred Claims, Total Admin Expenses, Total Profit or Reserve, Enrollment, Member Months [or show Per Member Per Month (PMPM) basis for each item]; Loss Ratio.

- Projected at Current Rates: Total Projected Premium Revenue, Total Incurred Claims Projected [should correspond with the medical trend data], Total Admin Expenses, Total Profit or Reserve, Enrollment, Member Months [or show PMPM basis for each item]; Anticipated Loss Ratio

- Projected with Rate Increase: Total Projected Premium Revenue, Total Incurred Claims Projected [should correspond with the medical trend data], Total Admin Expenses, Total Profit or Reserve, Enrollment, Member Months [or show PMPM basis for each item]; Anticipated Loss Ratio.

- "Projected Premium Revenue": including the information contained in questions 21 and 22 (impact of enrollment changes and cost-sharing); and premium trend. CDI should know, for example, whether the insurer has accounted for the number of people that will age into a higher category. Projected investment income also should be requested for that calculation.

- Expected change in enrollment for each product due to rate increases. This is important to assessing the stability of the risk pool: this information would also be appropriately added to question 8. In addition, CDI should ask for an estimate of the number of people expected to drop coverage if the increase takes effect and the number expected to "buy-down" to products with more narrow benefits and/or higher cost-sharing.

CDI should also ask for the number of covered lives, broken out by dependents to aid in determining the impact of guaranteed issue for children and claims relevant to guaranteed issue for children. AB2244 was enacted at the same time as SB1163: the information collected regarding rates should provide the Department with the necessary information to assure that insurers are complying with the rating rules under AB2244 (Feuer).

[5] Insurance Code Sections 10181.3(c)(3), 10184.3(c)(3)_____

For closed blocks (question 7), CDI should require a description of how the insurer complied with statutory requirements regarding notice or blending of blocks.

On question11, CDI needs carriers to identify the experience period used to develop the rates from month/yr to month/yr. This could be accomplished by simply adding data lines as follows:

- Experience Period Used: (date to date)
- Rating Period: (date to date)

For the "annual rate increase" (questions 13-15), insurers should be required to provide a breakdown of their calculations, showing minimum and maximum increases and grouping to show how many people will be getting these rates. They should also disclose how much of the rate increase is targeted for profit, how much is due to medical trend, how much due to changes in the demographic composition of their risk pool, etc.

Regarding question 19 on "projected medical trend", a line should be added indicating the total (as opposed to by aggregate benefit category) for trend used, then broken down by unit cost, utilization, plan design, mandates, risk factors, etc., as well as the weights used to calculate total projected trend. We have not previously seen "administrative and other non-claims expenses" included in the medical trend and wonder if this is an error.

For question 20, "comparison of claims cost and rate of changes over time," the form requires historical data for the most recent 12 month period (or if available two most recent 12 month periods). We recommend instead requiring a five year period, if available (the only circumstances in which it would not be available is where the product is less than five years old), and on a rolling month-by-month basis. Also, again this question requires the data to be submitted by benefit category, which is wise, but should also be shown as totals. Without totals, the regulator will be unable to tell how the carrier has totaled up the historical rates of increase based on the weight of each category, etc.

For question 21, "changes in …cost-sharing", much greater specificity is warranted. We urge a breakdown, for example, of cost-sharing percentage increases and absolute amounts as well as what is exempted and what has newly imposed cost- sharing (e.g. emergency room visits have not always had higher co-payment requirements). Similarly, for question 22 on changes in benefits, specificity is critically important as this goes to both the heart of what health insurance is for and to the appropriate cost therefore.

Question 24 on administrative costs asks only about changes in administrative costs, not about absolute amounts. It also states that it does not apply to new products. We urge that this question specify that it requires absolute dollar amounts as well as changes. New products should be included here. The NAIC model "rate filing disclosure form" contains useful detail questions on administrative costs, including annual compensation and brokers commissions as well as other general and administrative costs, and we recommend that CDI consider adopting these.

Additional items from the NAIC model form that CDI should consider adding include those for:

- Insufficiency of prior rates
- Separate out medical benefit changes required by law from those not required by law
- Underwriting gain/loss both as an absolute number and as a percentage of premiums
- Annual average rate changes requested and implemented over past three calendar years.

Finally, we suggest that CDI require insurers to submit charts and tables in electronic spreadsheet format as well as in pdf, to facilitate Department analysis and review.

Conclusion

The undersigned organizations applaud the Department's prompt Guidance and efforts to fully implement existing California law contained in SB 1163 and to anticipate and comply with the federal statute and guidance. We look forward to further refinements of this Guidance, and expect that we as well will have further suggestions to ensure that Californians have affordable, quality health care coverage.

Very truly yours,

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cc: Senator Mark Leno, author, SB1163
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