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Oversight Hearing Health Insurance Rates: Are Massive Increases Threatening Consumers? February 23, 2010 – 1:00 pm Room 4202

Health insurance premium increases are rising faster than the annual percentage increases in wages and inflation. According to a 2009 Kaiser Family Foundation report, family premiums rose about 5% in 2009, which is much more than general inflation (which fell 0.7% during the same period, mostly due to falling energy prices). Workers wages went up 3.1% during the same period. As increases in health insurance premiums continue, employers are dropping or reducing coverage – pushing people into the individual market, where affordable health insurance coverage is often unattainable. The weakened economy, coupled with rate increases in the individual market, is forcing individuals and their families to drop coverage, adding to the 6.6 million uninsured in California. The Assembly Committee on Health is conducting this oversight hearing in order to shed light on recent proposed rate increases and to inform a measured policy response. The hearing will include testimony from consumers, health care providers, regulatory agencies, and the health insurance industry.

Anthem Blue Cross 2010 rate increases

In November 2009, the state's largest health insurer in the individual market, Anthem Blue Cross, notified the California Department of Insurance (CDI) of their intention to raise rates by up to 39% for policyholders in the individual market. The decision by Anthem Blue Cross to implement these premium increases after similar increases during last year caused great concern not only in California, but across the nation.

In addition to this hearing of the Assembly Committee on Health called by Assemblymember Dave Jones, U.S. Representative Henry Waxman has called a hearing of the House Energy & Commerce Subcommittee on Oversight and Investigations on the premium increases. Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services (HHS), wrote to the president of Anthem Blue Cross asking for a detailed justification for the increases to the public. Secretary Sebelius also requested that Anthem Blue Cross make public information on the percent of the company's individual market premiums that is used for medical care versus the percent that is used for administrative costs.

Wellpoint (Anthem Blue Cross' parent company) sent a response to Secretary Sebelius on February 11, 2010, stating that an independent actuarial firm concluded that their rates are actuarially sound and necessary, reflecting the expected medical costs associated with

the membership in their plans, and that they satisfy or exceed the medical loss ratio required by California law. The letter went on to state that rate increases reflect the increasing underlying medical costs in the delivery system which are unsustainable. Specifically, Wellpoint explained that rates in the individual market were rising faster than medical inflation due to a number of factors, including: 1) a less healthy risk pool; 2) individuals moving to lower-cost options; 3) individuals aging into a higher age category; and, 4) "deductible leveraging," when enrollee deductibles and co-payments do not increase with medical inflation, and medical costs increases disproportionately fall on the premiums.

In response to Wellpoint's letter, Secretary Sebelius made the following statement:

“It remains difficult to understand how a company that made \$2.7 billion in the last quarter of 2009 alone can justify massive increases that will leave consumers with nothing but bad options: pay more for coverage, cut back on benefits or join the ranks of the uninsured. High health care costs alone cannot account for a premium increase that is 10 times higher than national health spending growth. Without comprehensive reform, fewer people will be able to afford health insurance and Anthem's decision to raise their rates only demonstrates the urgent need for real reforms that fix our broken health insurance system. Reform will end the worst insurance company practices and put doctors and patients -- not insurance companies -- in charge of medical decisions. If we fail to implement reform, insurance companies will continue to prosper while families will continue to struggle.”

At the request of Insurance Commissioner Steve Poizner, Anthem Blue Cross has agreed to delay the increases until May 1, 2010 to allow an independent actuary to review their rates.

Health insurance regulation in California

Regulation and oversight of health insurance in California is split between two state departments, the Department of Managed Health Care (DMHC) and CDI. DMHC regulates health care service plans (health plans), including health maintenance organizations (HMOs) and some Preferred Provider Organization (PPO) plans. CDI regulates multiple lines of insurance, including disability insurers offering health insurance, generally PPO plans and traditional indemnity coverage.

Although DMHC and CDI both regulate carriers providing health coverage, each department approaches that regulation very differently. At the heart of the difference between health plans and health insurers is the “promise to pay” versus the “promise to deliver care.” DMHC-licensed plans, often referred to as Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) health plans, arrange for and organize the delivery of health care and services through contracted or owned providers and facilities and are required to cover all medically necessary services. Disability insurers protect against (indemnify) the expense or charges (losses) associated with illness or injury and typically provide coverage for defined benefits that may be specifically limited in the policy, such as number of visits or annual dollar limits. The distinction between the two regulatory frameworks has blurred over time because of the historical exceptions made for two large PPO carriers, Blue Cross and Blue Shield, who offer PPO products under both DMHC and CDI, but fundamental differences remain in the expectations and regulatory oversight by each regulator. In general, DMHC has greater authority and responsibility to

review and approve health plan products and benefit designs than CDI has to review health insurance products under its purview.

In California, health insurance is generally not subject to rate regulation, with few exceptions. Medicare supplement policies and contracts sold by both health plans and insurers are subject to prior approval and regulation of their medical loss ratios (MLRs), the ratio of benefits to premium. Health plans and insurers are subject to specific marketing, underwriting, and rating rules relating to health coverage sold to small employer groups of 2-50. Both regulators ensure compliance with the small group rating rules primarily in response to complaints. CDI-regulated insurers are subject to filing and review of rates, referred to as "file and use" and must meet minimum MLR standards, but only for individual products. The MLR requirements do not apply to Knox-Keene plans. Knox-Keene plans are limited to no more than 15% administrative costs, but DMHC does not include profit as an administrative cost.

Health insurance rate increases

According to a study published in the journal *Health Affairs* in 2007, premiums paid by employees for small group coverage (2-50 employees) in California increased 53% between 2003 and 2006, from \$250 to \$382 per month, and premiums for individual coverage rose 23% between 2002 and 2006, from \$211 to \$259 per month. In 2006, a single person age 32–52 earning the median income who purchased individual insurance spent, on average, 16% of income on premiums and out-of-pocket medical expenses. In addition to an increase in premiums, for individual insurance, the share of medical expenses paid by insurance as opposed to patients declined from 2002 to 2006. In 2003, individual market policies paid 75% of medical costs on average. That figure had dropped to 55% just three years later. In the small-group market the proportion of claims paid by insurers for a standardized population remained constant. Small group market policies retained their actuarial value, paying for roughly 83% of medical expenses across a similar period.

Health care spending

The 2009 edition of the California HealthCare Foundation's "Healthcare Costs 101" (based on the latest health spending information available from the U.S. Department of HHS, Centers for Medicare and Medicaid Services) stated that although there has been some moderation in health spending growth in recent years, its share of the economy continues to grow. In 2007, national health care spending reached \$2.2 trillion (\$7,421 per person). If left unchecked, health care spending is projected to reach 20% of the country's gross domestic product (GDP) by 2018. The report also highlighted the following trends:

- Health spending grew 6.1% in 2007, the smallest increase since 1998, extending a five-year decelerating trend. Nevertheless, health spending continues to outpace inflation and is projected to reach \$2.5 trillion this year.
- Projections indicate that the recession will more than offset the recent moderation in health spending. Health care's share of the GDP is expected to rise rapidly, to 17.6% of GDP this year.
- Nationally, per-person costs for health care increased 81% between 1997 and 2007.

Previous legislation

There have been a number of attempts by state lawmakers to establish health insurance rate regulation in California:

- AB 1218 (Jones) of 2009 and AB 1554 (Jones) of 2008 would have required health plans licensed by DMHC and health insurers certificated by CDI, to annually submit for prior approval to the respective regulator any increase in the rate charged to a subscriber or insured, as specified, and imposes on DMHC and CDI specific rate review criteria, timelines, and hearing requirements. AB 1218 failed passage in the Assembly Health Committee and AB 1554 failed in the Senate Health Committee.
- SB 425 (Ortiz) of 2006 would have required health plans and insurers to obtain prior approval for a rate increase, defined in a similar manner to rates under AB 1218 of 2009. SB 425 did not have a hearing, at the author's request, and died in the Senate Health Committee.
- SB 26 (Figueroa) of 2004 would have required health plans and health insurers to obtain prior approval of rate increases from DMHC and CDI, as specified, and would have potentially required significant refunds of premiums previously collected. SB 26 died in the Senate Insurance Committee.

Federal health care reform proposals

The federal health reform proposals currently under consideration by Congress contain rate regulation provisions.

	“Patient Protection and Affordable Care Act” as passed by the Senate on December 24, 2009	“Affordable Health Care for America Act” as passed by the House on November 7, 2009
Premium Variance/ Rating Provisions	<p>Premium rates for group and individual health insurance may vary with respect to the particular plan or coverage involved only by:</p> <ul style="list-style-type: none"> • family structure; • community rating area; • age (but not more than 3 to 1); and • tobacco use (but not more than 1.5 to 1). <p>Prohibits premium rates from varying with respect to the particular plan or coverage involved by factors not listed above. [Sec. 1201 of the Act/Sec. 2701 of PHSA]</p> <p>Directs the state to define the rating areas and requires the HHS Secretary to review for adequacy. Requires the Secretary to establish standard age bands. With respect to family coverage, rating variations for age and tobacco use shall be applied based on the portion of the premium that is attributable to each family member covered under the plan. [Sec. 1201 of the Act/Sec. 2701 of PHSA]</p>	<p>Applies an adjusted community rating standard for a qualified health benefits plan that allows premium to vary by:</p> <ul style="list-style-type: none"> • Age: Requires the Health Choices Commissioner (Commissioner) to develop age categories, but limits the ratio from exceeding 2:1. • Geographic Area: Allows state insurance regulators to establish premium rating areas, or in the case of Exchange-participating health benefits plans, requires the Commissioner to specify areas in consultation with state regulators. • Family Size: Allows premiums to vary by family enrollment so long as the ratio of the premium for family and individual is uniform and the ratio conforms to state law and rules promulgated by the Commissioner. <p>Requires the Commissioner to conduct a study of the large group insured and self-insured employer health care markets, including the solvency and security of self-funded health benefit plans, the propensity of small and mid-size employers to self-fund to avoid rating rules, and the adverse selection that may result from more employers choosing to self-fund plans. [Sec. 213]</p>

	“Patient Protection and Affordable Care Act” as passed by the Senate on December 24, 2009	“Affordable Health Care for America Act” as passed by the House on November 7, 2009
Oversight of Health Plans / Prior Approval of Rates	<p>Requires the Secretary to establish a process for the annual review (beginning in 2010) of unreasonable premium increases. Carriers will be required to submit a justification for an unreasonable increase prior to implementation of the increase, and the information shall be posted on the issuer’s website.</p> <p>Directs the Secretary to establish a program to award grants to states over a five-year period to carry out the review of premium increases, and provides \$250,000,000 to fund the grants. As a condition of receiving a grant, a state must provide the Secretary with information regarding trends in rating and premium increases.</p> <p>Requires the Secretary to award grants to states from fiscal year (FY) 2010 through FY 2014 to assist in reviewing and approving premium increases; providing information and recommendations on rate reviews; and establishing centers to collect, analyze, and organize medical reimbursement information from health insurance issuers.</p> <p>Establishes functions of medical reimbursement data centers. Beginning with plan year 2014, directs the Secretary and the states to monitor premium increases of health insurance coverage offered both in and out of the Exchange. [Sec. 1003 of the Act/Sec. 2794 of PHSA]</p>	<p>Initial Premium Review Process: Requires HHS, in conjunction with the states, to establish a process for the annual review of increases in premiums for health insurance coverage beginning in 2010.</p> <p>Justification and Disclosure: Requires insurers to justify any premium increases prior to implementation of the increase. Requires such information to be prominently posted on the insurer’s website. Requires the HHS Secretary to ensure the public disclosure of information on such increases and justifications for all health insurance issuers.</p> <p>Continuing Premium Review Process: As a condition of receiving grants in support of the review process (see “Grants” below), requires a state, through its insurance commissioner, to:</p> <ul style="list-style-type: none"> • Provide the Commissioner with information about trends in premium increases in health insurance coverage in premium rating areas in the state; and • Make recommendations, as appropriate, to such Commissioner about whether particular health insurance issuers should be excluded from participation in the Health Insurance Exchange based on a pattern of excessive or unjustified premium increases. <p>Monitoring of Premium Increases: Beginning 2014, requires the Commissioner, in conjunction with states and in place of the monitoring by HHS, to monitor premium increases of health insurance coverage offered inside and outside the Health Insurance Exchange. In determining whether to make additional larger employers eligible to participate in the Exchange, requires the Commissioner to take into account any excess of premiums growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the states.</p> <p>Grants in Support of Process: The Secretary may award grants to states for 5 years, beginning in 2010 to assist states in carrying out the initial review process. Appropriates \$1 billion for grants under this section. Prohibits a state from receiving a grant of less than \$1 million or more than \$5 million. The number of health plans and the population of a state must be taken into consideration when determining the amount of a grant per state. If amounts are not fully obligated, any remaining funds shall remain available for the states for planning and implementation of insurance reforms and consumer protections. [Sec. 104]</p>

Source: America's Health Insurance Plans (AHIP) "Immediate Reforms in Federal Health Reform Proposals (as of January 6, 2010)"