



Wayne Goodwin, Commissioner

*Update on NCDO Health Care  
Reform Activities*

*Presentation to the Health Benefit Exchange and  
Insurance Oversight Workgroup*

*February 16, 2011*

*New Grant Opportunity*

# Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges

- Cooperative agreement funding opportunity to give States multiple opportunities to apply for funding as they progress through Exchange establishment.
- Funds are available to support grants as necessary to fulfill the purpose of the funding opportunity to the 50 states and DC.
- Funding is available under Level I and Level II Establishment Grants.

## Determination by DHHS

- DHHS must make a determination regarding a State's ability to establish an Exchange and the Exchange's readiness to commence operations.
- In order to fund continued grant awards, DHHS must find that the State is making progress towards:
  - establishing an Exchange
  - implementing insurance market reforms
  - and meeting other benchmarks as specified by DHHS.

## Program Requirements

- States and Exchanges must work toward
  - Certification by January 1, 2013,
  - Start of operations and health insurance coverage for enrollees on January 1, 2014, and
  - Self-sustainability by 2015.
- Milestones are suggested in 11 Establishment Core Areas to help a State/Exchange reach the goals above.

## Program Requirements (continued)

- The Establishment Core Areas (ECAs) are:

Background Research

Stakeholder Consultation

Legislative/Regulatory Action

Governance

Program Integration

Exchange IT Systems

Financial Management

Oversight/Program Integrity

Health Insurance Mkt Reforms

Business Operations

Providing assistance to Individual and Small Business,  
Coverage Appeals and Complaints

## Level I Establishment Grants

- Open to States that received Exchange Planning grants.
- Provides up to one year of funding to States that have made some progress under their Exchange planning grant but are not yet able to meet the eligibility requirements for Level II Establishment Grants.

## Level II Establishment Grants

- Open to States that received Exchange Planning grants.
- Funding is provided through 2014.
- Designed to provide funding for applicants that are further along in establishment and who can demonstrate achievement of the following criteria.

## Level II Establishment Grants (cont.)

- Criteria for Level II Grant:
  - Must have necessary legal authority to establish and operate an Exchange that complies with the Federal requirements.
  - Must have established a governance structure for the Exchange.
  - Must submit:
    - A completed budget that runs through 2014
    - A financial sustainability plan for 2015 and on.
    - A plan that outlines steps to fight abuse, fraud and waste.
    - A plan describing how capacity for assisting individuals and small businesses will be created, continued, and/or expanded, including provisions for a call center.

*Update on Other Insurance  
Related Provisions*

## Child Only Coverage

- PPACA provides that no child under age 19 may be subject to a pre-existing condition limitation.
- A pre-existing condition limitation as defined in the federal law includes a denial of coverage based upon the child's health status or health history. Therefore an insurer cannot refuse to cover a child under age 19 under health insurance coverage for reasons related to the child's health status.
- Child only coverage is health insurance coverage issued to just cover a child (or children), usually who is under the limiting age of 19.
  - Parents sometimes purchase this coverage because they cannot afford to cover themselves and their children under insurance or dependent coverage is more expensive through their employer plan (e.g. NC state employees).
- NCDOI began receiving anecdotal evidence that insurers had ceased sales nationwide of child only health insurance coverage.

## Child Only Coverage

- NCD OI did a survey of individual health insurers in the Fall of 2010.
- Of the 21 insurers polled, 19 responded.
- All but one of the 19 responding insurers indicated they do NOT currently market “child only” coverage in NC.
- 14 insurers indicated that they had ceased issuing the coverage after the passage of PPACA.
- The majority of the insurers indicated that a standardized open enrollment period might encourage them to market these plans in NC again.

## Other Updates

- The Office of Consumer Information and Insurance Oversight (OCIIO) has been moved under the Centers for Medicaid and Medicare Services which is part of DHHS. The new name is CCIIO – Center for Consumer Information and Insurance Oversight.
- Not sure of impact upon reform efforts – move was purported to protect CCIIO from budget issues as a stand-alone division under DHHS.
- CCIIO issued recent proposed regulation on Student Health Insurance Plans.
- CCIIO will issue regulations on Exchanges and the Essential Benefits Package in early Summer and Fall of 2011 respectively.

# *Ombuds Program Update*

*PPACA Sec. 1001*

# *Medical Loss Ratio*

*PPACA Sec. 1001*

## What is a Medical Loss Ratio (MLR)?

- MLR is basically the percent of premium that an insurer spends on medical care
- MLR can be defined in a variety of ways, for example:
  - What is considered spending on “medical care”
  - What is the time period for calculation (lifetime, multi-year, single year)

## Why set a minimum MLR?

- To limit the amount of money insurers can spend on administration, marketing and profits
- To protect consumers, especially in non-competitive markets
- To improve transparency to consumers through reporting requirement

# What are Some Issues with the MLR?

- Setting minimum MLR can provide a disincentive for insurers to make investments in programs and services that might benefit members
- MLRs can reflect more than just the “value” of a plan, they also generally vary by
  - Level of benefits: richer plans = higher MLR
  - Age of covered population: older = higher MLR
  - Utilization of covered population: higher utilization = higher MLR
  - Provider reimbursement: higher reimbursement = higher MLR
  - Maturity of business: newer policies = lower MLR
  - Size of carrier: larger carrier = higher MLR (due to economies of scale)
- Setting a minimum MLR implicitly assumes that administrative costs and profits increase at the same trend as medical claims



# What are the Current MLR Standards in North Carolina

	Individual Market	Group Market
<b>Full-Service HMO</b>	65% minimum incurred loss ratio 80% maximum incurred loss ratio	75% minimum incurred loss ratio 90% maximum incurred loss ratio
<b>Medical Service Corporation (BCBSNC)</b>	No standard set in statute or administrative code. Incurred loss ratio is approved by NCD OI as part of rate review process*	
<b>Other</b>	60% minimum lifetime loss ratio	N/A

\* BlueAdvantage incurred loss ratio is ~82%; BlueOptions incurred loss ratio is ~77%

# MLR Interim Final Rule Basics

- Beginning with reporting year 2011, health insurers must meet the following minimum loss ratio standards or pay a rebate to consumers
  - Individual: 80%
  - Small group (50 lives or less in NC until 2016, then 100 lives or less): 80%
  - Large group: 85%
- Health insurers will also be required to report publicly on how premium dollars are spent

## Federal MLR Basics

- The federal standard is retrospective; there is no requirement that premiums be set to achieve the required minimum loss ratio, the rebate is the enforcement mechanism
  - Plans must report their calendar year MLR to HHS by June of the following year
  - Rebates must be paid by August 1<sup>st</sup> of each year (2011 rebates will be paid by August 1, 2012)
  - Rebates for each enrollee are proportional to the premium amount paid by that enrollee

# Federal MLR Formula

- The MLR for the new federal standard is calculated as:
  - Incurred claims plus quality improvement expenses, divided by
  - Earned premium less Federal and State taxes
- The calculation is adjusted by an additive credibility factor based on number of covered lives and average deductible
- Rebates are not required if plan has fewer than 1,000 life years
- For reporting years 2013 and beyond, the MLR is calculated using three years of experience
- Exceptions are made for mini-med and expatriate plans, as well as newer plans, to reduce barriers to entry

# What is Considered a Quality Improvement Activity?

- To qualify as a quality improvement expense, the activity must be designed to:
  - Improve health quality
  - Increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results and achievements
  - Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees, as long as no additional costs are incurred due to non-enrollees
  - Be grounded in evidence based medicine, widely accepted best clinical practice, or criteria issued by other recognized entities
- HIT costs to support these activities are also included

# What is Considered a Quality Improvement Activity?

- Quality improvement activities must be primarily designed to:
  - Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations
  - Prevent hospital readmissions through a comprehensive program for hospital discharge
  - Improve patient safety, reduce medical errors and lower infection and mortality rates
  - Implement, promote, and increase wellness and health activities
  - Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of HIT

# What's NOT Considered Quality Improvement?

- The following are examples of activities specifically excluded from quality improvement:
  - Those designed primarily to control or contain costs
  - Upgrades in HIT designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., ICD-10)
  - Retrospective and concurrent utilization review
  - Fraud prevention activities
  - Provider contracting
  - Marketing

## How is the MLR Enforced?

- ACA gives the Secretary direct enforcement authority for MLR requirements
- HHS may accept the findings of a State audit of MLR reporting and rebate obligations under certain circumstances
- If insurer fails to comply, there is a civil monetary penalty of \$100 per entity, per day, per individual affected

# Potential for State MLR Adjustment

- The Commissioner of Insurance can request an adjustment to the MLR standard for the individual market for calendar years 2011 – 2013
- To qualify for adjustment, States must demonstrate that the 80% requirement is likely to destabilize the individual market and could result in fewer choices for consumers
- To request an adjustment, States must submit certain information to the Secretary, some of which is at the carrier level
- The Secretary of HHS makes the final determination

# Results of Carrier Surveys

- NCDO surveyed carriers in November regarding MLR adjustment
  - 15 responses
  - All but one carrier favored a full or transitional waiver of MLR requirement
  - Rationale for waiver included
    - 80% minimum would reduce choices for consumers
    - Carriers would need to reduce agent commissions considerably to meet requirement
    - 80% minimum would result in financial losses
    - Carriers would need to cease or suspend marketing, and reduced sales were likely to result in increased premiums for existing blocks of business
    - Carriers needed time to transition to new expense structure
    - Smaller carriers relying on agents would not be able to compete

## Results of Carrier Surveys

- In late January, NCDO surveyed the 13 carriers with 1,000 or more lives in the individual market
- NCDO is still in the process of analyzing responses

## Are Other States Requesting an Adjustment?

- Three states have requested an adjustment to the MLR requirement (ME, NV, NH)
- According to POLITICO Pulse (2/15/2011):
  - Nine states are leaning towards requesting an adjustment (AL, AK, GA, IA, LA, MS, OK, SC, WV)
  - Eighteen states are leaning towards not requesting an adjustment (CA, CO, DC, ID, KS, MA, MD, MT, NJ, NM, NY, OH, OR, UT, VT, WA, WI, WY)

# What might Carriers do in Response to Requirement

- Cut commissions to brokers/agents
- Reduce administrative costs/profits
- Stop marketing plans or sell less new business (first year commissions tend to be much higher than later commissions)
- Exit the market

## MLR Adjustment in NC

- How should NCDOI determine whether to request an adjustment to the 80% MLR in the individual market for 2011 – 2013?

Questions?

*Premium Review Grant*

*PPACA Sec. 1003*

# Premium Review Grant

- In August 2010 NCDOJ was awarded a \$1 million grant to help improve its oversight of proposed health insurance rate increases and improve public transparency
- This was the first of five expected years of grants
- For the first year, the grant is funding new positions at NCDOJ and consulting to provide recommendations for enhancing NCDOJ's rate review process in light of the changes under ACA
  - One of the changes is the disclosure and review of unreasonable increases

# Premium Review Grant Conditions

- As a condition of the grant, NCDOT is required to:
  - *Provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and*
  - *Make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.*

## Future Requirement of Premium Review Grant

- *in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.*

# Medical Reimbursement Data Center Functions

- *Develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;*
- *Use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;*
- *Regularly update such fee schedules and other database tools to reflect changes in charges for medical services;*
- *Make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and*
- *Regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.*

*Disclosure and Review of  
Unreasonable Rate Increases*

*PPACA Sec. 1003*

# Disclosure and Review of Unreasonable Rate Increases

- From PPACA (Sec. 1003):
  - *(1) IN GENERAL – The Secretary, in conjunction with the States, shall establish a process for the annual review, beginning with the 2010 plan year, and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.*
  - *(2) JUSTIFICATION AND DISCLOSURE – The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.*

## Disclosure and Review of Unreasonable Rate Increases

- HHS released proposed regulations in December
- Rules apply to non-grandfathered individual and small group insurance plans (large group is excluded)
- HHS will accept a State's determination of whether or not a rate increase is unreasonable IF it is determined that the State has an "effective rate review program"
- Otherwise, HHS will make determination

# What is Subject to Review?

- Based on proposed rule, review is of rate increases, NOT premium increases
- HHS sets a threshold for which rate increases are “subject to review” for unreasonableness
  - 10% in 2011
  - State-specific beginning in 2012 or when better data is available
- Review applied to rate increases filed on or after July 1, 2011, or effective on or after July 1, 2011 in States that don’t require rates to be filed

# What is Considered “Unreasonable”?

- State definition/standard applies in cases where State has an “effective rate review program”
- If HHS performs the review, “unreasonable” is defined as:
  - Excessive: premium is “unreasonably high in relation to the benefits provided”
  - Unjustified: data or documentation “does not provide a basis upon which the reasonableness of an increase may be determined”
  - Unfairly discriminatory: premium differences for insured within similar risk categories are “not permissible under applicable state law, or if no State law applies, do not reasonably correspond to differences in expected costs”

# What is Required for an “Effective Rate Review Program”?

- Legal authority to obtain data and documentation necessary to conduct an effective review
- State conducts an effective and timely review of documentation
- Review process includes an examination of reasonableness of assumptions and validity of data and past projections compared to actual experience
- Determination of reasonableness based on a standard set forth in legislation or regulation

# What Data Must be Collected and Reviewed?

- Medical trend by major service category
- Cost sharing changes by major service category
- Benefit changes
- Changes in enrollee risk profile
- Over- or understatement of medical trend in prior periods
- Changes in reserve needs
- Changes in administrative costs related to programs that improve health care quality
- Changes in other administrative costs
- Changes in taxes, licenses and fees
- Medical loss ratio
- RBC relative to “national standards”

# What are Insurers Required to Disclose?

- For rate increases that are above the threshold, or “subject to review,” insurers must
  - Submit to HHS (who will post on their website) preliminary justification which includes
    - A rate increase summary with prescribed data elements
    - A narrative justification of the rate increase
  - If HHS performs the review, the insurer must also submit more detailed information, similar to what might be provided in a rate filing to the State
  - If the insurer wants to implement a rate increase that is found to be unreasonable, the insurer must submit a final justification with a response to HHS’ or the State’s determination

# What is NCDOJ's Current Rate Review Authority

- NCDOJ has prior rate approval authority over all initial accident and health insurance rates
- Prior rate approval authority over rate revisions varies as follows:

	Individual Market	Small Group Market	Large Group Market
HMOs	Yes	Yes	Yes
Medical Service Corporations (BCBSNC)	Yes	Yes	Yes
All Other	Yes	Rating factor changes only	No

- NC standard is that rates are “not excessive, not inadequate, and not unfairly discriminatory; and exhibit a reasonable relationship to the benefits provided by the policies”

Questions?