Consumer Guide to Rate Review in Montana

Health Insurance Reform in Montana

Since 2014, many significant changes have happened in healthcare reform. These include:

- Most individuals must have health insurance.
- Everyone is eligible for health insurance, regardless of current or past health status.
- Public programs (such as Medicaid) expanded and federal tax credits and cost sharing reductions helped others afford private health insurance.
- Health plans for individuals and small employers must contain basic (essential) benefits and specified cost sharing levels and are easier to compare.
- The online Health Insurance Marketplace, at www.healthcare.gov, offers one-stop health insurance shopping and links that enable Montanans to locate the financial assistance programs for premiums and out-of-pocket costs that they are eligible for.

About the Plans

Coverage

Health insurance must now cover a basic range of services, reducing the likelihood that customers will fall into unexpected gaps in coverage. All insurance products must cover services in the following ten categories, known as **essential health benefits** and every plan in the Marketplace must cover them:

- Hospital visits and surgery;
- Doctor's office visits;
- Prescription drugs;
- Maternity and newborn services;
- Mental health and chemical dependency services;
- Lab work and imaging;
- Rehabilitation services and habilitative services intended for skill acquisition, like speech therapy for a child who is currently non-verbal;
- Dental and vision care for children;
- Preventive care and management of chronic diseases, like diabetes;
- Emergency services.

Consumer Cost Sharing

All health insurance plans sold in the Marketplace will be rated based on something called "actuarial value." Under Obamacare, a plan's actuarial value looks at the share of medical spending paid by your insurance company compared with the amount paid by you. Plans with higher actuarial value will cost more every month in premium, but they will cost you less at the doctor's office when you pay your co-pay or coinsurance amount and you will pay a smaller portion of your total health care bill. For example, all silver plans pay an estimated 70 percent of the average person's "in-network" covered medical costs up to the maximum out-of-pocket limit.

Classification and Maximum Out-of-Pocket

Plans are classified into "metal tiers" to help Montanans compare similar insurance products. Insurers can offer more than one plan in each category. However, all plans, even bronze plans have a maximum out-of-pocket (MOOP) amount that is set by the federal government every year. For 2016, no health plan can have a maximum out-of-pocket greater than $6,850 for an individual or $13,700 for a family for covered "in-network" healthcare services. Most plans sold in Montana have a MOOP that is much lower than this.

Lowering Your Costs

When you purchase health insurance through healthcare.gov, you may be eligible to lower out-of-pocket costs on your private insurance plan. Financial help is based on your household size and annual income. Learn more about lowering your costs at montanahealthanswers.com.

Health Insurance Rate Review in Montana

Overview

Montana has effective rate review authority for individual and small employer group health insurance. Health insurers must file complete information with the Commissioner of Securities and Insurance (CSI) every year that details how they built their rates, as well as describes factors that justify, in their opinion, a rate increase or decrease. The Commissioner has contracted with a qualified actuary who reviews the rate filings and then asks questions and/or requests more information.

This rate review process, established by the Montana Legislature in 2013, ***does not*** give the Commissioner the authority to disapprove rates or prevent them from taking effect.

If the commissioner finds a rate increase to be excessive or unjustified, the insurer can voluntarily lower the rate increase.

The CSI posts the insurer's justification of the proposed rate change on its website before the final rate review is complete. Consumers may comment on the proposed rate increase using an online form available on the CSI website.

After the review and negotiation process, the insurers submit their final rate increase information. The Commissioner will post findings of the review on the CSI website, the CMS website.

If the Commissioner finds any rate increase "unreasonable" and the insurer does not voluntarily decrease the rate, the finding of "unreasonable rate increase" will be published on the CSI website, the CMS website and in the media.

After the rate review is complete, the entire rate filing is made available to the public, except for pieces that are redacted for trade secret reasons. Those rate filings can also be found on www.healthcare.gov

What is a rate?

The base price for a health insurance market is known as a base rate. A premium is then calculated from the base rate, and is the specific amount a policyholder pays for insurance coverage. Your actual premium will be higher or lower than the base rate, depending on several key factors.

Your family's health, however, is not a factor in how much you pay for health insurance. You are part of a "community rated" insurance risk pool. The entire pool's medical costs influence overall rate increases from year to year. Other factors that determine what you pay depend on your insurance plan choice and only four other factors: your age, where you live, family composition and whether you use tobacco.

What is the law?

Montana law requires that rates cannot be excessive, inadequate, unjustified, or unfairly discriminatory.

- Rates may be considered *excessive* if they cause the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage.

- Rates may be considered *inadequate* if the rate is unreasonably low for the coverage provided, and the commissioner may consider if the rate would endanger the solvency of the insurer.
- A rate many be considered *unjustified* if the insurer provides data or documentation in connection with the increase that is incomplete, inadequate, or fails to justify the proposed increase.
- A rate may be considered *unfairly discriminatory* if people in similar circumstances do not pay similar rates and if rate increases are not shared appropriately between different groups of policyholders. If a rate is found to be *unfairly discriminatory*, it cannot be implemented.

Evaluating Rate Requests

In Montana, health insurance rates must be filed AT LEAST 60 days before use so that the CSI can review the rates to determine if they are justified. The Montana Insurance Department is guided by the following key principles:

- The approved rate and rating factors generate premiums that are fairly priced considering the benefits provided. Reasonable rates are usually adequate to cover the costs of paying for medical services claims and for operating the company.
- The Commissioner will not allow rates to be unfairly discriminatory. This means people in similar circumstances should pay similar rates and that rate increases should be shared appropriately between different groups of policyholders.
- The Department fosters a marketplace that keeps more people insured and also ensures that insurance companies continue to operate and pay claims. We must balance consumers' interests in having both the most affordable health care coverage possible and a stable and reliable insurance market.
- The Department cannot control larger economic forces that also affect the marketplace, but it attempts to navigate in the public's best interests as it reviews rate requests.
- The Department seeks to balance both the conservative and aggressive assumptions and projections of insurance company actuaries. For example, the division scrutinizes company assumptions about increasing medical claims costs and administrative costs.

Bottom line: Rates must cover the cost of benefits plus the insurance company's costs to operate without being overpriced.

Key Factors

In weighing a rate request, the CSI considers such factors as an insurance company's:

- Financial position, including reserves, surplus and contribution to profit and reserves
- Historical and projected administrative costs
- Historical and projected claims experience
- The historical and projected loss ratio (the ratio of claims paid to the premium earned)
- Changes to the benefits covered or the health plan design (affecting the consumer's cost sharing)
- Insurer solvency and future rate stability
- Executive compensation data

Surplus/Reserves

- Insurance companies have minimum amounts of capital and surplus so they can pay policyholders' claims. Surplus includes profits accumulated by for-profit and nonprofit companies.
- Companies might use surplus to invest in new technology, protect against adverse conditions such as unexpected claims, or take on additional enrollment and new risk.
- Insurers need to have enough reserves, but also not excessive amounts of reserves.

Administrative costs

- The CSI looks at a company's administrative costs as well as its projected growth in administrative costs. Companies must report these costs by type of insurance (individual or small employer health plans, for example). They must break out what they spend on salaries, agent commissions, marketing, advertising, and other expenses.
- Administrative costs are generally higher for individual and small group health insurance compared to large groups. They are typically higher for insurers that write fewer policies.

Medical services costs

Recent and future costs of medical care and prescription drugs drive insurance rates. Thus, the CSI closely examines the assumptions behind insurance company estimates about future claims costs, particularly:

- How much will any benefit changes increase or decrease costs?

- Are new contracts with hospitals, doctors, and other providers increasing the unit costs? Why do companies expect policyholders to use more or fewer medical services or a different type of service in the coming year?
- How many policyholders are likely to switch to a higher deductible plan so they can still afford coverage (resulting in less premium to the company)?
- Is there any "margin" or padding in the company's projections?
- To what extent are a company's members aging or are other demographic characteristics changing? How will those changes affect claims?
- What are the average Montana and national trends in medical claims costs?

Minimum Loss Ratio

- Insurance companies must pay rebates to individual and small-group policyholders when they fail to spend at least 80 percent of premiums collected on medical care and quality improvement versus administrative costs. They must spend at least 85 percent of premiums on these activities in a state's large group market or pay a rebate.

Factors that Determine your Premium

Individual plans (for those who do not have job-based coverage).

- Age
- The benefits you choose
- The number of family members on the plan
- Where you live in Montana
- Tobacco use

What does a rate cover?

An insurance rate covers:

1. Claims for medical services (hospitals, doctors, pharmacy, lab, and other patient care)
2. Insurer administrative costs
3. Profit (sometimes)

What drives claims costs?

Many factors influence the actual claims costs and the predicted claims costs. The most important are:

1. Unit cost
2. Utilization

1. **Unit cost:** This measures medical services inflation. How much more the same services cost one year versus the next is the single largest factor affecting claims costs. Inflation is largely caused by unit price changes in contracts that insurers have with doctors and hospitals as well as increased charges for laboratory services, diagnostic imaging, and other medical services.

2. **Utilization (use of medical services):** Utilization describes underlying factors that influence the type and quantity of medical services people use. Examples include:
    - Aging population
    - Increasing number of people in poor health (obesity, for example)
    - Changes in how doctors and hospitals diagnose conditions (such as increased use of CT and MRI diagnostic imaging)
    - New technologies, new treatment patterns
    - New medical equipment to treat conditions

These two items (unit cost and utilization) combined are often referred to as the "trend."

Health insurance premiums reflect the costs of health care. Controlling health care costs is key to stabilizing health insurance rates.