pennsylvania
INSURANCE DEPARTMENT

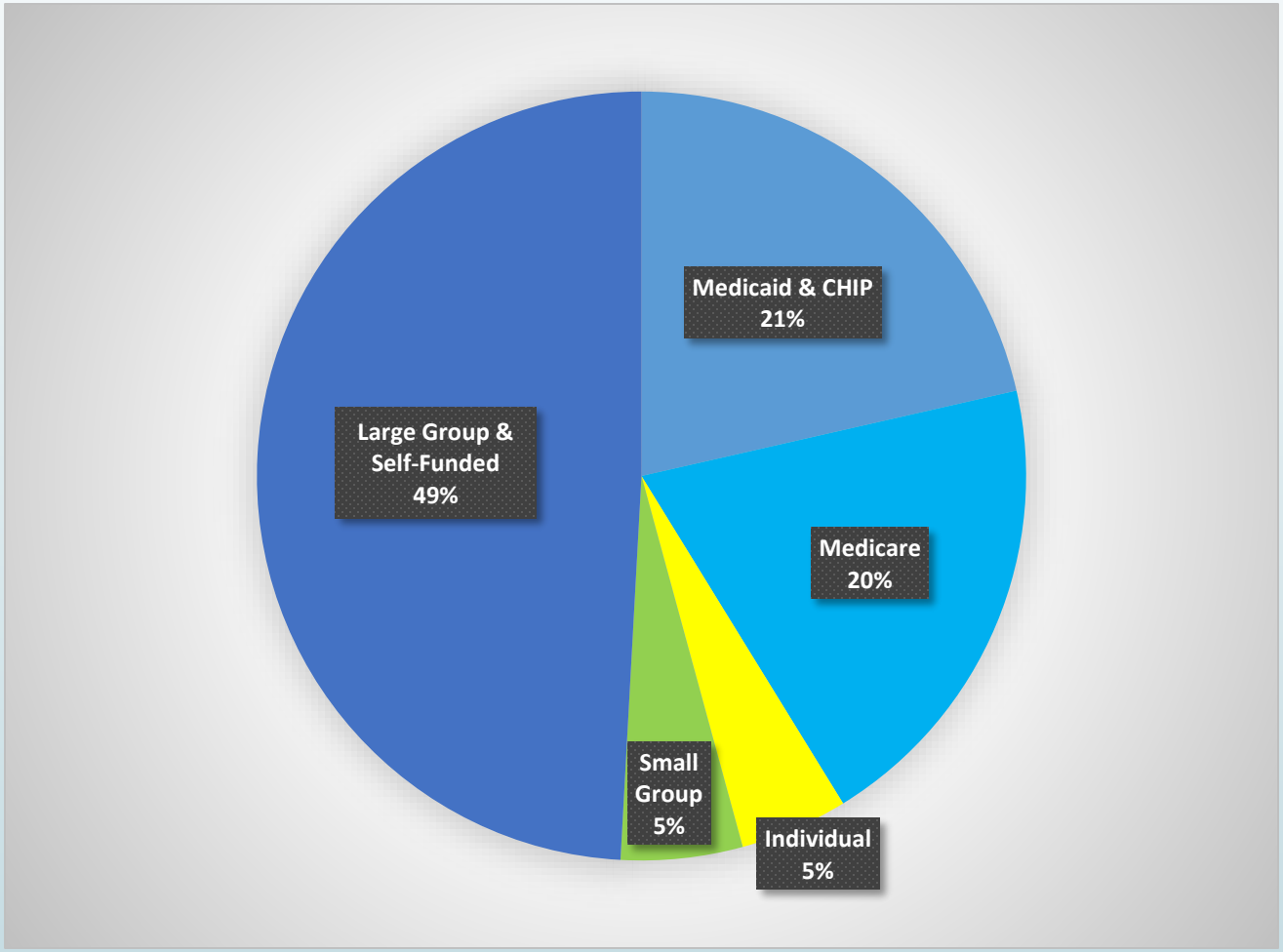
Health Insurance Rate Review Process

July 27, 2016

Insurance Department Rate Review Authority

- ☑ **Individual** Health Insurance – Dept. Reviews & Approves Rates
  - Insurance plans purchased by individuals who don't get coverage through an employer, Medicaid, or Medicare.
  - These plans may be purchased through Healthcare.gov or directly from an insurance company.
- ☑ **Small Group** Health Insurance – Dept. Reviews & Approves Rates
  - Insurance plans purchased by small employers (50 or fewer employees)
- ☒ **Large Group** Health Insurance & **Self-Funded** Health Plans
  - Coverage provided by large employers (more than 50 employees), who typically negotiate prices directly with insurers, or by employers who use their own money to fund health benefits directly ("self-fund").
  - The Department does not have authority to regulate large group and self-funded rates.

Distribution of Health Insurance Coverage in Pennsylvania, 2015



Annual Timeline

- **May:** Insurers file rate change requests with the Department for rates starting 1/1 of the coming year
- **May/June**: The Department publishes filings in the PA Bulletin and on our website for public comment
- **October**: The Department publishes final rate determinations and rate filings on our website
- **November 1 – January 31**: Open enrollment
  - Enroll by **December 15th** for coverage starting January 1

What is a rate and how do insurance companies develop rates?

- A rate is the base price for a health insurance plan.
- Each year, companies look at experience from the past year and project rates for the upcoming year based on that experience and estimates about how future costs and enrollment will change.
- Rates can't make up for past losses
- Companies typically consider these factors when calculating rates:

Medical Costs

Insurers must spend at least 80 cents out of every premium dollar on medical costs and activities that improve health care quality

- How much services cost
- How often people use services

Non-Medical Costs

The remaining 20 cents can be used for operating expenses and profit

- Admin. expenses
- Profit

What is a premium and how do insurance companies calculate premiums?

- A premium is calculated from the base rate, and is the specific amount that a policyholder pays for insurance coverage.
- An insurer can apply four factors to the rate in order to determine the premium.
  - Age: Older people can be charged up to 3x more than younger people.
  - Location: Pennsylvania is divided into 9 geographic areas that insurers can use to vary rates.
  - Tobacco use: Insurers can charge tobacco users up to 1.5x more than those who don't use tobacco.
  - Family size: Insurers can charge more for a plan that covers a spouse and/or dependents.
- These are the only four factors that insurers can use to adjust premiums. That means insurers can't charge more because of gender or health status.

What is in a rate filing and what do we evaluate when reviewing filings?

- The rate filing contains the data, methods, and assumptions the insurer used to develop and justify the requested rates.
- Broadly, we evaluate the following when reviewing rates:
  - The past and projected **medical costs**
  - The past and projected non-medical costs, including **administrative expenses, taxes and fees,** and **profit**
  - The company's **financial condition**
  - The **history of rate changes**
  - **Public comments** on proposed rates

Rate Review Considerations

What is the impact on consumers?

- Rates must not be excessive
  - Plans should be fairly priced considering the benefits provided.
- Rates must not be inadequate
  - The Department strives to maintain a stable, competitive market in which insurers want to participate.
    - If an insurer's rates are inadequate (below cost), that can destabilize the market as enrollees are drawn to low-cost plans but later face increases when the insurer brings rates up to a sustainable level.
    - Insurers may also decide not to participate in a market if they can't charge rates sufficient to cover their costs. This can reduce competition in the market.
- Rates must not be unfairly discriminatory
  - Differences in rates should correspond to differences in expected costs, and should comply with state and federal law limiting the factors by which health insurance rates can vary.

If requested rates do not meet these standards, we work with the insurer to modify its request before we approve the rates.