



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony

Insurance and Real Estate Committee

February 24, 2015

Re: Committee Bill 11 An Act Concerning the Duties of the Connecticut Health Insurance Exchange

Chairmen Crisco and Megna, Ranking Members Kelly and Sampson, and members of the Insurance and Real Estate Committee, the Insurance Department (Department) respectfully submits comments on **Raised Committee Bill 11: An Act Concerning the Duties of the Connecticut Health Insurance Exchange**. This bill seeks to amend section 38a-1084 of the general statutes to provide authority to the Connecticut Health Insurance Exchange (the Exchange) to negotiate premium rates with health carriers offering or seeking to offer qualified health plans through the Exchange.

If passed, SB 11 would give the Exchange the ability to negotiate different benefit designs, a different network composition, or different administrative expenses, provided the adjustments made to the index rate are actuarially justified. However, because of the application of the federal Affordable Care Act requirements premium rates cannot be "negotiated" in the same way a large employer currently negotiates rates with an insurance carrier. (Department staff have had extensive discussions with officials from Health and Human Services (HHS) who are charged with responsibility for implementation of the ACA, to ensure that CID has a full comprehension of the ACA requirements.) HHS has confirmed that the index rate or base rate cannot be negotiated and must be calculated in accordance with the requirements in the federal final rule. (The index rate must also apply equally to the entire market including plans both in and outside of the exchange.)

The Department submits that this bill could delay the readiness of the Exchange for open enrollment. (The Department has the authority to approve rates on individual health insurance products sold in Connecticut, and executes with distinction this authority, both on the Exchange and off the Exchange. It should be noted that the Department performed its duties with thoroughness and diligence for the products offered through the Exchange for both 2014 and 2015, and approved rates at levels significantly lower than submitted by the health insurers participating on the Exchange (Please see the attached chart for illustration of this fact).

It should be noted that the Exchange is dealing with even shorter timeframe for 2016 open enrollment that had not existed before. For next year's coverage, carriers operating both inside and outside of the exchange must now simultaneously file rates by April 30th. By comparison the Department reviewed four carriers' filings (Exchange only) in 2014 for the 2015 plan year. The new federal rules will require the CID to review 20 carriers' filings in 2015 for the 2016 plan year during that same timeframe. With this in mind, any negotiation would have had to be completed prior to Feb. 19 so the Exchange Board could approve the plans. Once published, carriers then need time to put the filings together and submit them to the Department by April 30th. The Department requires approximately three months to review and approve all filings. The Exchange then needs approximately two months to certify plans, load the rates and test the system. If the negotiation is not complete by the Board meeting, all of these dates get pushed forward, jeopardizing the Exchange's ability to meet its deadlines in time for the 2016 open enrollment that begins October 1, 2015.

As it currently stands, the federal timeframe for the rate review and the upload of plans and rates to the Exchange platform are compressed. Open enrollment for 2016 begins on October 1, 2015, whereas for 2015 open enrollment did not begin until November 15, 2014. (Key dates for the 2016 plan year as identified by Access Health CT, include:

- Feb. 19: AHCT Board meeting to present and get approval for plan designs
- Feb. 20: AHCT Publishes standard plan designs
- April 30: Form and Rate filings due to CID
- July30-Aug.7: CID deadline to approve rates
- July 30-Sept. 12: AHCT Certification of QHPs
- Oct. 1: Open enrollment begins)

The Department has worked closely with the Exchange, to coordinate our efforts to ensure the exchange is open for business as of the open enrollment date. Connecticut's Exchange has been a model for the rest of the nation, most recently exceeding enrollment goals by signing up more than 200,000 individuals for health insurance coverage this year. Adding this negotiation process would not only delay the timeframe for the Department and exchange to complete their reviews and upload all of the data, but would also limit the amount of current claims experience that could be considered in the rate development. Lack of current claims experience in the development of rates is already a concern with the current compressed timeframe, but the addition of the rate negotiation process that would have to pre-date this timeline would exacerbate the problem.

Below is a summary, the federal statutory and regulatory requirements that apply to the negotiation process.

Affordable Care Act (ACA):

Under section 1003 of ACA that amends section 2794 of the Public Health Service Act (PHSA), HHS will review rate increase requests from health insurance issuers (health insurers and HMOs) under the ACA unless HHS has determined that a state has an effective rate review process. HHS has awarded Connecticut this recognition and approval as a state with an effective rate review

process. It is important to the state of Connecticut that the Department maintains this status so that rates can be reviewed with local expertise, rather than through federal bureaucracy. It is imperative that Connecticut's effective rate review designation remain intact.

Furthermore, section 1312(c) of the ACA requires a health insurance issuer to consider all enrollees in health plans offered by such issuer inside and outside the exchange to be members of a single risk pool for a market (individual or small group) for plan years beginning on and after January 1, 2014.

Regulations under ACA:

On February 27, 2013, HHS issued a final rule concerning health insurance market rules and rate review under the ACA. One section (45 CFR 156.80) of this final rule details the requirements for a single risk pool. A health insurance issuer is required to establish an index rate for the state individual market and for the state small group market based on the total combined costs for providing Essential Health Benefits (as that term is defined under ACA).

The index rate must be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state and Exchange user fees. The premium rate for all of the health insurance issuer's plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to the following plan-level adjustments (emphasis added). For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors (emphasis added):

- (i) The actuarial value and cost-sharing design of the plan.
- (ii) The plan's provider network, delivery system characteristics, and utilization management practices.
- (iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.
- (iv) Administrative costs, excluding Exchange user fees.
- (v) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.)

Summary:

In summary, there are strict federal rules requiring a single risk pool for a health insurance issuer's individual market and small group market, including inside and outside the Exchange, and strict rules concerning the calculation of the index rate to be used by a health insurance issuer. (Final premium rates of a health insurance issuer are calculated by adjusting the index rate based on negotiation of one or more of the specified factors cited above that are required to be actuarially justified. Any plans that a health insurance issuer offers in the Exchange must also be offered outside the Exchange to comply with the guaranteed availability requirements under section 2702 of the PHSA. The premium rates for these plans must be the same both inside and outside of the exchange under section 2701 of the PHSA.)

The enactment of Committee Bill 11 will allow the Exchange to negotiate benefit designs, network compositions and/or administrative costs, but a compressed HHS-mandated timeframe would make for a challenging process. To avoid such delay, any negotiation would need to occur very early in calendar year prior to the effective date of the rates so that the Insurance Department and exchange can complete their reviews prior to open enrollment.

The Department thanks the Insurance Committee Chairs and members for the opportunity to provide this testimony.

About the Connecticut Insurance Department: The mission of the Connecticut Insurance Department is to protect consumers through regulation of the industry, outreach, education and advocacy. The Department recovers an average of more than \$4 million yearly on behalf of consumers and regulates the industry by ensuring carriers adhere to state insurance laws and regulations and are financially solvent to pay claims. The Department's annual budget is funded through assessments from the insurance industry. Each year, the Department returns an average of \$100 million a year to the state General Fund in license fees, premium taxes, fines and other revenue sources to support various state programs, including childhood immunization.

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2014 Connecticut Insurance Rate Filings For On/Off Exchange 2015 Policies

Individual Market

<u>Company</u>	<u>Requested Change</u>	<u>Approved Change</u>	<u>Effective Date</u>
Aetna Life Insurance Co.	9.4%	4.60%	1/1/2015
Celtic Insurance Company	0.00%	-6.50%	1/1/2015
ConnectiCare Benefits, Inc.	12.8%	3.10%	1/1/2015
ConnectiCare Inc.	-21.50%	-21.50%	1/1/2015
ConnectiCare Insurance Co.	1.40%	1.30%	1/1/2015
UnitedHealthcare Ins. Co.	0.00%	-9.30%	1/1/2015
Golden Rule Insurance Co.	0.00%	-6.91%	1/1/2015
HealthyCT, Inc	-8.60%	-8.50%	1/1/2015
Time Insurance Company	25.00%	6.00%	1/1/2015
Cigna Health and Life Insurance Company	15.23%	8.82%	1/1/2015
Anthem Health Plans	12.5%	-0.10%	1/1/2015
UnitedHealthcare Life Insurance Company	0.00%	-9.20%	1/1/2015

Estimated savings for consumers in Individual Market:

\$79,099,427

Small Group Market

Company	Requested Change	Approved Change	Effective Date
Aetna Life Insurance Co.	5.90%	5.90%	1/1/2015
Anthem Health Plans	6.00%	4.40%	1/1/2015
HealthyCT, Inc*	-13.40%	-13.40%	1/1/2015
UnitedHealthcare Ins. Co.*	2.50%	2.50%	1/1/2015
ConnectiCare Inc.	-1.40%	-5.00%	1/1/2015
ConnectiCare Insurance Co.*	7.00%	7.00%	1/1/2015
Harvard Pilgrim Healthcare of CT	2.80%	-12.00%	1/1/2015
HPHC Insurance Co.*	-3.40%	-9.40%	1/1/2015
Oxford Health Insurance*	10.20%	10.20%	1/1/2015
Oxford Health Plans (CT)	10.20%	9.00%	1/1/2015

*CID has review authority but not approval authority over these filings

Estimated savings for consumers in Small Group Market:

\$9,448,203

Estimated savings for combined Individual & Small Group Markets:

\$88,547,630