DEPARTMENT OF CONSUMER & BUSINESS SERVICES

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Final 2016 Rate Decisions for Individual Health Benefit Plans

Background
Insurance companies offering individual health benefit plans in 2016 are required to file proposed rates with the Department of Consumer and Business Services' Insurance Division for review and approval before plans can be sold to consumers. Rates reflect estimates of future costs, including medical and prescription drug claims costs and administrative expenses, and are based on historical data and forecasts of future trends.

Rates must be "actuarially sound" – essentially, they need to adequately cover costs without being too high, too low, or unfairly discriminatory. Insurance companies have a responsibility to develop rates that meet these requirements, but the Insurance Division also has a responsibility to protect the public by ensuring that rates are actuarially sound. It is easy to understand why the division would be concerned about rates being too high, as consumers should not be overcharged for their insurance coverage. But it is just as critical for the division to ensure rates are not too low so consumers can count on the coverage they purchase.

2014: First Year of Data under the Affordable Care Act
When the division approved rates for 2014 and 2015 individual health benefit plans, actual data reflecting the cost to provide coverage in the individual market was not yet available. We had to estimate the impact of significant changes in the market, particularly the elimination of medical underwriting, on these costs. The results in 2014 and 2015 were some of the most competitive individual health benefit plan rates in the country.

Earlier this year, insurance companies filed their 2014 financial statements, showing that the total cost to provide coverage for individual plans was $830 million, while premiums were only $703 million. This means that costs exceeded rates by $127 million, or an average of $624 per person in 2014.

Rates for 2015 did not change much relative to 2014 – some increased, but many decreased. While little information is available about 2015 costs, insurance companies' first quarter financial statements show that costs continue to exceed rates. The division is concerned that like 2014 rates, 2015 rates are inadequate and will continue to fall short of covering costs through year-end.

Market Overview
As Oregon's health insurance market has become more transparent and competitive, price – in the form of rates – has been a large driver of consumer choice and of significant competition among insurance companies. This is often a good thing, as it drives companies to find efficiencies to deliver value to consumers, but it can also be problematic, especially if actual costs exceed the rates being charged.

Charging a rate below cost can make sense in some situations – growing companies may decide to take a loss initially to gain membership and spread out large fixed costs. But when it becomes widespread and persists over a period of years, competitors are driven to set rates too low to gain or retain market share. This type of competition is not sustainable, and consumers will ultimately bear the consequences. For example:

> *Consumers could face large rate increases in future years.* If insurance companies need to increase rates after a period of time of not covering costs, the result will be large rate increases all at once. This makes it more difficult for consumers to plan and adjust than if insurance companies take smaller increases as they are needed.
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> *Consumers could have fewer and less diverse health insurance options.* Insurance companies may decide to leave the market if they cannot cover their costs. Companies with less capital will go out of business if they do not have enough money to pay claims and other expenses. Both scenarios lead to consumers having fewer insurance companies and plans from which to choose and may hinder smaller companies' ability to compete for consumers' business.

Consumers may have to switch to a new insurance company and plan with little notice. If a company does go out of business because it cannot pay claims and expenses, consumers will have to switch to a new insurance company immediately. This can be stressful and even costly for consumers, particularly if they are in the midst of treatment, have to pay a higher rate for a different plan, or have to meet a new deductible mid-year.

2016 Filing Review, Public Comment, and Final Decisions

In addition to reviewing insurance companies' own projections for 2016, division actuaries prepared an independent analysis of average claims costs across the Oregon individual market for 2014 and a projection of average claims costs for 2016. Division actuaries expect the average health of the individual market population to improve by 5% in 2016. However, the average cost of medical services and prescription drugs is expected to increase, and government programs that help pay for large claims will pay less in 2016 than in 2014. These assumptions led the division to project 2016 market average claims costs of $321 per member per month. The division found that most rate filings projected average claims costs below our estimate. In total, we estimate that claims costs and expenses could still exceed rates by more than $120 million in 2016 on individual plans if we approved rates as filed – another year of losses averaging more than $500 per member.

After reviewing insurance companies' rate filings and public comment received to date, the division released its preliminary rate decisions on June 18. Preliminary decisions reflected findings that some projections lower than our estimate were still within a reasonable range, but that others were too low for a variety of reasons. Some filings included a number of aggressive assumptions about how 2016 experience will compare to 2014, some appear to include technical errors, and some include plans to sustain significant losses to remain competitive and may trigger payments from a federal program designed to help companies with larger than expected losses. If the total impact of the division's adjustments for a particular filing was less than +/-2%, we determined that the filed rates were within a reasonable range and did not adjust the rates.

The division held public hearings June 23-25 to discuss the preliminary decisions and continued to receive public comment through June 25. We received comments from members of the public and the Oregon State Public Interest Research Group (OSPIRG), an advocacy organization with which DCBS contracts to participate in the rate review process on behalf of consumers. OSPIRG provided written comments, citizen petitions, in-person testimony on four filings, and general testimony regarding the division's preliminary decisions to increase some rates above those requested by the insurance company. Comments focused on affordability, the magnitude of the requested rate changes and the division's preliminary decisions.

The division shares the concern about the impact of large rate changes on consumers and considered this in both the preliminary and final decisions. We evaluated the possibility of phasing in rate increases more gradually, but this approach raises several concerns that may outweigh any potential benefits. Deliberately allowing rates to fall short of covering costs may shift the cost burden to federal programs designed to guard against mispricing, and continued rate inadequacy may lead to significant adverse effects for consumers in the future, including larger rate increases, fewer choices, and insurance company insolvencies.

The division's final rate decisions reflect a range of projections and allow for the possibility that 2016 costs will be lower than anticipated. The final rate decisions also reflect reductions relative to the preliminary decisions for four insurance companies, based on clarifications made during the public hearing and public comment. Final decisions are unchanged from the preliminary decisions for the remaining companies.

It's important to put the final rates in perspective. Looking past the percentage increases, the resulting rates are comparable to current rates in other states and offer a range of options for consumers. For example, half of the insurance companies offer a silver plan for less than $300 per month for a 40-year-old in the Portland area. Also, nearly 40% of Oregonians qualified for a tax credit in 2015, and this may help offset some of the rate increase for eligible individuals. And, finally, insurance companies have to pay rebates to consumers if they don't spend at least 80 cents of every premium dollar on medical costs.

Ultimately, the division's final decisions focus on protecting Oregon's insurance consumers against the risk of large future rate increases and the risk of companies not being able to pay claims, while also protecting consumers from being charged more than the cost of coverage.