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Briefing: What Can States Do to Control the Rapid Rise of Health Insurance Premiums
Kaiser Family Foundation
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LARRY LEVITT: Well, I think we're going to go ahead and get started, hopefully everyone is well fed. Good morning, everyone, I'm Larry Levitt from the Kaiser Family Foundation and welcome to the Barbara Jordan Conference Center.

Today we're talking about how the states and the federal government will be reviewing or have been reviewing health insurance premium increases and we're doing this under the auspices of our very awkwardly titled new initiative, the Kaiser Initiative on Health Reform and Private Insurance, led by myself and Gary Claxton who you'll hear from later. And now that rate review has been in effect for oh, you know, three weeks or so, we thought it was time to step back and do an in depth assessment of how it's working [laughter].

Seriously, even though rate review is under the Affordable Care Act, it technically didn't start until September 1st of this month. States have a lot of experience to share from their years of work on this issue. Many states have in fact been reviewing premium increases in the health insurance market for many years, but the provisions of the health reform law will mean that insurance increases in every state will be reviewed in one form or another and that the results will be quite a bit more transparent.

Any proposed increase over 10% will be reviewed by state or the federal government and consumers will be informed if an increase is determined to be unjustified. But federal law, as in many areas of the Affordable Care Act leave states a lot of room to take very different approaches, some are requiring insurance, insurance companies to submit proposed rate increases, reviewing those increases, and disclosing the results to consumers. Others however are taking a more aggressive regulatory approach, requiring prior approval of proposed rates by the state before they can take effect.

Federal grants have been given to states to provide resources to significantly increase their capacity, to conduct reviews and HHS just announced this week an additional round of grants, which Gary Cohen from the department, I'm sure will be talking about. I don't know if there's been a flood of graduating math students lining up to take the actuary exams yet, but I'm sure that's coming.

What we'd like to do here today is sort of pull back the curtain on rate review and look at how it works and what it means. And to give you a road a map for the morning, let me throw out some questions that I think our speakers, who are terrific, are going to address.

What is the potential for rate review to moderate increases in health insurance premiums, which I think is the

thing that most people are looking for it to do? Can it also put pressure on to reduce the underlying cost of healthcare as well? How much of doing rate review is an art and how much is it a science? I don't know that people think of actuaries as artists, but maybe. How does rate review relate to other aspects of the Affordable Care Act, like the medical loss ratio rules and health insurance exchanges which will be coming on in 2014? And what is the appropriate role for public input in the process for rate review. And there will be a special prize at the end for anyone who can, in their own words, explain what deductible leveraging is [laughter].

We have, I think, more current and former insurance commissioners in this room than we've ever had before. We're going to start with a presentation from Donna Novak, who is an actuary we're working with who's been consulting with states on related issues, and she's going to provide some context and explain in English, I promise, how insurers put together proposed rate increase requests and the factors they use, and how states go about reviewing them.

We'll then hear from three regulators, first from two states that take different approaches, somewhat different approaches to rate review. Teresa Miller, the Administrator of the Insurance Division in Oregon, and Susan — I thought it was —

SUSAN EZALARAB: Ezalarab.

LARRY LEVITT: Ezalarab, thank you. The Director of Market Regulation in the Insurance department in Wisconsin, and then Gary Cohen, the Acting Director of the Office of Oversight in CCIIO, in HHS, which will both be conducting reviews under the ACA in states that do not have effective rate review mechanisms, and also communicating results to the public.

At that point we'll pause for some questions from you all and then get some reaction from two former insurance commissioners, providing a consumer and industry perspective on all this, moderated by my colleague, Gary Claxton. So, with that let's start with Donna.

DONNA NOVAK: Good morning. I promise not to speak actuary, but we will be going through a few issues that may be a little bit more detailed than are typically presented, just to get a feel for what goes into a rate increase and what goes into reviewing a rate increase. So, I'm going to talk this morning about what is driving premium rate increases, the factors that have impact above just healthcare cost on the claims cost, and what states do when they review rates, so pretty high level.

What goes into premium rates, claim cost obviously is the largest component and driver of premium rates and rate increases, and claim cost result directly from healthcare cost,

and we'll talk a little bit about why actually claim costs will go up faster than healthcare costs do. The marketing and distribution cost, administrative expenses, taxes, fees and assessments and profit margins, and Larry had asked me to talk a little bit about the proportion of these, the proportion varies significantly. Some of the old rules of thumb for claims costs were that on the individual market it was about 72 percent of the premium dollar and in the group market it was closer to 80 to 85 percent. Those numbers are going to be changing because of the medical loss ratio rebate.

The marketing distribution costs were always higher in the individual market, they — they're higher in the first year, and then at renewal years, and that's because in the individual and the small group market, the insurance brokers spend a lot of time with each one of their clients. In the large group market, the marketing and distribution costs take more of a form of benefits consultants, the larger groups hire benefit consultants to help them design their plans, understand what's driving their cost and to shop for insurance.

Some of the large group market as a percentage of premium was quite a bit lower, this is changing right now, because of the medical loss ratio formula, there's a lot of anecdotal information that insurers are renegotiating their brokerage agreements and are cutting commissions, bringing that

work in house and we'll have a little bit to say about that later. Administrative expense, 10 to 15 percent, as I say, very wide ranges, taxes, fees and assessments, premium taxes are usually in the range of two percent. Fees and assessments can vary significantly, especially if there's a guarantee fund in a state, a guarantee fund is a fund that insurers pay into when there's an insolvency in the state to cover the damage from that insolvency, and it can vary from state to state and from year to year.

Profit margins, three to five percent is pretty much the rule of thumb for profit margins, although again for a particular block of business or a particular insurer, in a particular state it can vary significantly.

What are the biggest drivers? This font isn't even in proportion of what the biggest drivers are, the biggest driver is — is claims classed, and claims classed equals the cost of health care, the cost of paying the doctors, the hospitals, plus the cost sharing, the amount of deductibles, co-pays, co-insurance that's paid by the insured. And I thought I'd comment just a little bit on how some of these may change, because of healthcare reform, because that is one of the primary focuses today.

Marketing and distribution cost may decrease under healthcare reform. One, for the reasons I was just stating,

with rebate formula, insurers are incentivized to decrease these cost, and also under the exchanges we don't know yet how the exchanges are going to charge for their services, but it may be less than the old brokeraged system, we don't know.

Administrative expenses will, and I didn't even put a weasel word of may in there, administrative expenses will increase, we don't know by how much, but there are a lot more requirements for filing, both with the federal level, the state level and with the exchanges for those insurers that we'll be offering through the exchanges. Taxes, fees and assessments will increase some, because of exchange fees, but again there might be some trade off with marketing there. And the profit margins to cover the cost of capital and solvency protection may decrease under ACA, just because of the rebate formula which will in years where there are large profits, those profits will be returned in the form of rebates, so there's a direction I don't have any answers on magnitude.

What factors impact the claims cost, in addition to healthcare cost? Random fluctuations, average health of the population, changes in the benefits covered and as Larry pointed out, deductible leveraging, which hopefully my example will be simple enough that everybody can explain it.

A little bit more detail on that, random fluctuations, the smaller a block of business, so either a small insurer or

an insurer that has a small block of business in a state can experience large fluctuations in healthcare costs, just as an individual or a small group, you can imagine experiences large fluctuations from year to year, and what their claims cost is. What small insurers do is they purchase reinsurance in order to be able to predict their healthcare cost better, but that adds cost to the system, because reinsurers are in business to make a profit or at least not lose money, so overall it will add some cost to the premiums for small blocks of business. These random fluctuations are also the reason why there's accredibility adjustment in the medical loss ratio rebate formula. And I put what up there to remind myself to explain that a little bit. The medical loss ratio rebate formula, as you probably all know is for individual and small group, any loss ratio below 80 percent will trigger an insurance company to provide a rebate back to the insured individuals. In the large group market that percentage is 85 percent, medical loss ratio is the percentage of claims divided by the premium, so the carriers are required to spend $0.80 on the dollar in the individual and small group market on claims and in the large group 85 percent. But on the NAIC realized that small insurers, because of these large fluctuations may be vulnerable to having to pay a rebate in one year, because claims lost were a lot lower than they predicted and in the next year have a

large loss, because they were higher, and that would result potentially in small insurers become insolvent, and in order to protect that market place, they recommended to HHS that there be an adjustment for smaller blocks of business, and a block of business for the medical loss ratio is defined as individual business in a state, in a particular insurer or small group in a state for a particular insurer, so if that block was smaller than a certain amount and this is graduated, the medical loss ratio is adjusted and it can get as low as 75 percent from the 80 percent.

The average health of the population, I don't think everybody knows it's not a mystery that our population is aging and as the population ages the individuals use more healthcare. A friend of mine likes to quote a joke that says, you know you're getting older when you've got a specialist for every body part, as the population ages we will be using more specialists as a population. Due to self selection of the insureds, especially when there's an opportunity for open enrollment, if an individual cannot have coverage or have very low benefit coverage with high deductibles, until they go to the doctor and get a diagnosis and then they can — the picture often quoted is that there's a kiosk in the doctor's office where they can go change their insurance or sign up for insurance. That means that the blocks of insurance that are

covering more healthcare costs have higher premiums relative to the value of that coverage on an actuarial basis and also can experience very high rate increases, because of that self selection, when there's an opportunity for open enrollment or to move from one coverage to another.

Due to the movement of the uninsured population, one of the goals of the new healthcare reform is to move the currently uninsured into the being insured in the marketplace. We don't really know the average health of those individuals, we know quite a few of them are young and relatively healthy, and haven't purchased insurance, because they don't feel they need it, but there's another group that have healthcare problems and can't afford the insurance in the current marketplace, because of their health conditions. We don't know what that average is right now and it could mean that there's going to be a shift in the average claims cost going forward.

Closed blocks of business are in the current market place quite a problem, because once a block of business isn't taking new members and that's when it's closed, there's no new individuals being insured, but the current insured block, as it ages or it becomes less healthy, the healthier members in that block can go into an underwrited product and get a lower premium, but the less healthy individuals probably cannot get insurance in the current marketplace or can't get it at a lower

rate, so the cost of that block of business, the claims cost starts increasing more than the healthcare cost in the marketplace.

There is a hope that under healthcare reform that won't be true, because of the ability to move, but in reality experience shows that individuals that have health problems really hesitate to change their insurance. They don't want to move to the unknown, they know what their coverage is, who they can go to, their doctors and hospitals, and they hesitate to move, so it still will continue to be a bit of a problem.

Changes in the benefits covered, employers right now are passing more of the cost to employees through higher cost sharing, and thus reducing the premiums to the employer and to the employee, but increasing the overall out of pocket cost, if you will, of the employee. Insurers are doing the same thing, in order to keep their premiums competitive, keep their rate increases down, they can change the benefits that increase the cost sharing and therefore decrease the premium.

Deductible leveraging, as promised, what is deductible leveraging? When you have fixed cost sharing, such as deductibles and co-pays, as healthcare cost increased, that increase all goes onto the claims cost and not onto the cost sharing, so as an incredibly over simplified example, if you had healthcare cost of $1,200 with a $500 deductible, if your

healthcare cost, the cost paid to the providers goes up 10 percent or $120, the actual claims cost goes from $700 to $820, so it increases 17 percent. So, an increase in overall spending on healthcare of increase of 10 percent, can easily result in a 17 percent increase in claims cost and therefore in premiums, and that's something I'll expand on in a minute.

How do states review rates? The regulatory authority to review rates are in the state laws and regulations. State laws, I don't think I have to explain this to anybody in the room, but just as a summary, state laws are controlled by the legislatures in the state. Regulations are more under the control of the different departments in the state. And the reason I mention that is that these things are changing and that's where those changes will take place.

The review steps include, one, making sure that the filings complete, that everything that's required is there. Review of just the overall filing, the actual memorandum to understand what's actually driving this rate increase that's almost always healthcare cost, but is that because of utilization or is it because of cost, is it because of hospitals, you know, what are the underlying drivers, because that's what a rate reviewer is going to want to drill down, and really see what's driving this rate increase, and therefore the next step would be to look at the detailed assumptions that are

the real drivers of the rate increase. And almost always there's a request for additional information or a challenge of the rate increase or a challenge of the assumptions, and some negotiation with the carrier, and then after additional information is received and changes are made in the rate filing there's a final determination made.

I've had the privilege of reviewing literally thousands of rate increase filings for a project that I'm doing. And one of the things that's become really obvious is that in past filings it was very hard to tell what the steps the filing had gone through what the original rate increase request was versus the final. Now a days that is becoming much, much more transparent and with the filings in the NAIC system, SERFF, there is an audit trail of the original filing and all of the changes, and all of the requests, but in the past the public didn't know and really didn't have access to information about what the path this rate review had taken.

Most states have some review authority, not all and not in all markets, there's often much more review in the individual market than the small group, but many states have some of the language in their laws that allow them to review the completeness of the filing. If the rate is excessive, if the rate is insufficient and regulators will challenge a rate that is potentially insufficient and might threaten the

solvency of a carrier, determine if the rate is discriminatory, and if it's reasonable in relation to the benefits provided, and usually that test is a medical loss ratio test.

If a state has the authority to approve rates then they can do a more extensive review, they can look at all of the assumptions and the reasonableness of them are the trends consistent with other carriers in the market. Are there specific situations that maybe increased claims cost for the period in the past that aren't going to repeat themselves and those can be challenged, such as very large claims that wouldn't repeat themselves. The actual real soundness of the methodology, it's often, always actuaries that are reviewing rates or individuals with that type of training. There also may be rate band, which is the difference between rates that are allowed in a state, the lowest rate charge for a particular coverage and the highest. There might be rate band requirements or medical loss ratio requirements. The medical loss ratio requirement often means that rate reviewers are not looking at the non-benefit expense and carriers don't provide a lot of information on non-benefit expense, but once we are at an 80 percent loss ratio or 85 percent loss ratio, as healthcare costs go up and drive even higher claims cost, there may be reason that regulators want to look at the non-benefit expense, because if you have claims costs going up 17, 20

percent, you probably don't have you administrative cost and your profit margins needing that type of increase. So, many regulators are starting to ask for the information, not necessarily challenging it yet, but in the future that might be an area of more research.

The final determination is one based on the legal authority that the regulator has, even without approval authority, even in states where there's [inaudible], regulators often have the ability to bring some pressure on carriers where they think a rate increase isn't appropriate, and historically there's been a lot of negotiation kind of behind the scenes. That as I said, is going to be a little bit more transparent going forward.

The legal authority is changing in states, as I'm sure you all know, that there is a lot of activity in some states to change the authority of the commissioner or director in the insurance departments or bureaus. Also the interpretation of regulations is changing from my experience. In states that didn't interpret their regulations as giving them as much authority as they would have liked are now going back and looking at those regulations and saying, okay, I've got a medical loss ratio regulation here, but that doesn't mean that I have to accept all of your trends and if we put in a more appropriate trend in you won't pass the medical loss ratio

test. The final determination is also based on actuarial principals and actual soundness of the rate, not the rate increase, but the final rate, so sometimes a rate increase can look pretty absurd, but after analysis it is actuarially sound. And as you know that analysis of the actuarial soundness is getting more and more rigorous. And the transparency of the final determination is increasing significantly to the point where some states will send out emails if you're on the email list of the proposed rate increase and the final determination, which is — and with that I'm going to let other panelists correct everything that I said wrong [laughter].

LARRY LEVITT: Thanks, Donna. Teresa?

TERESA MILLER: Good morning. My name is Teresa Miller and I'm the Administrator of the Insurance Division in Oregon. As Larry mentioned, I think the goal today was to give you a little bit of a sense of how different states are approaching rate review, and I think Oregon was asked to be here, because we are at least one state that has a very strong rate review statute and we use it. And we also have been working very hard over the last few years to increase the transparency of our process and as Donna mentioned, I think in Oregon, I think everything she mentioned is certainly true, in terms of we've been working very hard to try to make our decisions more transparent and give people — and I'll talk about this a little

bit later, but give people a little bit of a window into our process, because I think historically there's been a lot of good scrutiny happening on the part of the regulators, but if people don't see that, what I've learned is that they don't know it's happening and they don't have the comfort that somebody is actually looking at these rates and is scrutinizing them, so part of what we've been focusing on is really opening up that process and giving people a sense of what we're doing. And just to talk real briefly about our statute, I think Oregon has one of the strongest statutes in the country in terms of the authority that it gives the regulator. We do have — and in 2009 we brought a regulation forward or a proposed legislation forward that the regulation passed to increase our authority and give us an even stronger statute, so we now in statute list a variety of factors that we look at and use to determine whether or not a rate is reasonable. We also gave ourselves authority to look very carefully at an insurers administrative expenses to get at the issue I think that Donna raised, that administrative expenses shouldn't be rising at the same level as medical claims and medical costs are rising, so we look especially at that and really have a different standard for increases and administrative expenses, which I think is the right thing to do. And the other thing that our statute give us that I don't know that many or any other states have is we

have explicit authority in our statute to look at an insurers profitability, overall profitability, so rather than just looking at the line of business, we can look at the company's overall profitability, we can look at surplus levels and investment income, so we can really take into account when we're looking at a particular rate filing, for example in the individual market, we can look at that rate filing and look at how the company is doing overall, as we make a decision in that rate filing, so again very strong statute and we use it.

So, we were given, when I was asked to present, we were given a list of questions, as Larry mentioned, to answer, and I actually thought that would be kind of a good way to organize my presentation, because I thought the questions were really good and allow me to talk a little bit about some of the things we're doing in Oregon.

So, the first question was, you know, why is it important to have the authority to disapprove rates, which I think is a really good question today that states are all looking at and nationally we're all asking. And I could probably go on with a number of factors, but I think it boils down for me at least to two major factors in terms of why it's important to be able to disapprove rates.

First I would say it gives regulators the authority to curb excessive rate increases, and to protect consumers against

excessive rate increases, and second I think having the ability to disapprove rates, also give the public confidence that somebody is looking out for them. I think having an independent entity, who's reviewing rates, whether they end up ultimately improving the requested increase or not, I think really does give people a sense that okay, somebody outside the company, somebody independent is looking at this and is saying, we think what you're proposing is reasonable. So, and I'll give you an example to just put this in context of — kind of where I'm coming from and why I think those two reasons are important.

We had a very large increase this summer come in for one of our major carriers, region's Blue Cross Blue Shield, and the requested increase was in the individual market and it impacted about 60,000 Oregonians, and the request rose for 22.1 percent in terms of an increase. That's a big increase for people and obviously it impacted a lot of people, and that was the largest segment of individual policy holders in Oregon. So, one of the things I would say, is first of all we ultimately ended up approving a 12.8 percent increase, so going back to my first point about curbing excessive increases and that being one reason why you want to be able to disapprove rates, I mean there's a good example, so we took a 22 percent increase and turned it into a 12.8 percent increase. To the

other point about the public having confidence, I will tell you something very strange that happened to me, after we approved that 12.8 percent increase. For the first time, I think ever, I had a consumer email me and thank me for a 12.8 percent increase.

And if you think about that, that has never happened to me before, and what we did in that filing was not significantly different than what we had done in other filings, the difference, and again this gets to why transparency's important, which I'll talk about later, but the difference is, that filing was something that was a huge matter of public interest, so it got a lot of media coverage, we also had a public hearing, which was the first public hearing we'd had in 20 years. We had about 150 to 200 people present, so we were making our decision really in the public eye, and I think because of that, the same individual who emails me on an occasional basis about a lot of things. Had emailed me when we got the 22 percent increase in, and said, you know, please don't approve this, I can't afford this increase, which was the normal kind of emails I get, so that made sense. And then when we ended up approving the 12.8 I got this thank you from her, and it was just, thank you for doing your job, thank you for scrutinizing this, and looking really carefully at it, and thank you for only improving a 12.8 percent increase.

So, people appreciate what we do, and they appreciate knowing somebody's scrutinizing it, so I'm going to move on, otherwise I'd just start going on and on.

One question that wasn't asked, but I wanted to answer, so since I have the microphone I'm going to. And I guest this a lot for reporters when I get contacted is, you know, does rare review politicize the process, and especially as we make things more transparent, and we have public hearings, does all that, that were doing in Oregon, does that politicize the process. And I think, as Donna pointed out, you know, regulators follow criteria outlined in state law, and for us we have a lot of rules on this as well, based on the statute. So, we're making our decision based on statutory guidelines. Performing rigorous rate reviews of requests, and question insurers assumptions that are contained in those requests, I just think is a fundamental responsibility of regulators, and as is making sure regulators are financially sound, so there's a balancing act there, but I think that's what people think of their regulators and I don't think that's political, I think that's just us doing our job. I also think shedding light on the inner workings of an insurer company and letting people know why their rates are going up, and what is driving rate increases, which again, as Donna pointed out is, you know, primarily medical costs. I think that's also part of our job

as part of rate review. But I think it's also important for people to know that administrative costs are under control and that companies aren't profiting excessively at a time when people are losing their jobs and losing insurance coverage. And what I found in Oregon is, you know, every percentage point of an increase matters to consumers and so it matters to us.

So, the next question I wanted to address is, you know, does state regulation of rates make a difference, especially if we know that premiums are really driven by healthcare cost, does it make a difference and how effective has our authority been? So, I think depending on a variety of factors in the world, frankly what's going on with the company individually, what's happening in the market, what's happening just generally with the economy, you know, it's going to vary in terms of how much this might make a difference to consumers, but I will tell you that our law that we passed, our loss strengthening or our statute strengthening, our rate review law, that passed in 2009, it was effective in April of 2010, and so we've had a year or over a year of that law being in effect, and so after that year we looked back and said, okay, what difference did this make to consumers, and we found that in 50 percent of the cases or the filings, we approved something less than what was requested. So, the flip side of that is after looking at these very closely we still approved 50 percent of the increases as

they were requested, but 50 percent of the time we were pairing them back somewhat. On average we were pairing them back by about four percentage points, so a 16 percent increase would have turned into a 12 percent increase, for example. And this resulted in savings of more than $25 million for consumers, which average out to be about $10 per person on a monthly premium. So, is this the be all end all for consumers? Absolutely not, but does it help? I would say absolutely, you know, rate review and what regulators can co in terms of protecting consumers through the rate review process I think is certainly part of trying to solve this problem, it's certainly not the only answer.

The next question I just wanted to address very briefly, how far can a state go in using its disapproval to drive down premiums, and can rate review play a role in driving down the growth and underlying costs. And cause I've been giving the warning of three minutes, I'm going to try and be really brief, and just say, this is actually something that in Oregon, we're very, very interested in. WE are in the middle of a study that we're using federal rate review grant dollars to pay for, to look at ways that we might be able to use rate review to get at underlying healthcare costs.

And when we get to Q&A or afterwards I'm happy to talk to folks about kind of what we're thinking about there, but I'm

actually very excited about that, because to me that's a way we might be able to make much more of a difference for consumers.

And then the last question I just wanted to address is, you know, the role of transparency and public engagement, you know, Oregon has been opening up our process since before transparency was cool. We've been doing it since about2007. We started making rate filing information available on our website in 2007. In 2009 we added public comments to our process, so people can, as Donna mentioned, people can sign up on our web site to get emails of rate increases when we receive them, and then they can go look at the entire filing now, and then they can provide comments. And beginning in October we are going to be doing public hearings on pretty much all individual and small group filings, which is where our rate review authority exists.

And why are we big believes in transparency? I mean fundamentally it's pretty simple, consumers are demanding it, and they deserve it, and they want to understand what's driving these rate increases. They just want to understand, why are my rates going up double digits every year. I — nothing else in my world does that happen, I don't pay, you know, 10 percent more for groceries every year, but for my health insurance premium it's going up at double digits, and they just want to understand why. So, I think through our process, you know, we

— transparency also holds us accountable for our decisions, but I think it provides us a great opportunity to give people good information about really what is going on with health insurance and what's driving those premiums, and I think in Oregon we've been working very hard to try and get consumers good information on that. And I'll tell you and then I'm going to wrap up. When we did the public hearing this summer, that was a great learning experience for me as a regulator, because I couldn't believe, first of all, how many people came, but I also couldn't believe how many people just so appreciated the information, the way we set up the hearing, we did a little presentation at the beginning that kind of went through some of the information Donna went through, where we talked about, you know, how do we do rate review, what does our process look like, what are some of the factors driving premiums, then we had the company present their filing, and then we had a consumer group that we fund with rate review grant dollars present their thoughts on the filing. And I'll tell you, we had people come in who were very, very upset about this. The 22 percent got people, as you can imagine, very excited. We had people come in who were so upset, signed up, couldn't wait to get up there and comment, and after they heard some of the presentations, they got up and crossed their name off the list, and said, thank you so much for this information, this was so

helpful. They heard me question the company. I asked the company about 10 questions. We heard people say things like, you know, I didn't understand the questions that were being asked, but I just so appreciate that they were being asked. And people said things like, I have more confidence in the work the insurance division is doing now that I saw this. So, again for me, that was a realization that I see every day, the questions that we're asking companies, but if the public doesn't see that, they don't necessarily have the confidence that regulator is, is asking those questions. So, with that I will wrap up and thank you very much.

LARRY LEVITT: Thanks, Teresa. We'll have to pole insurance commissioners and see who gives out their emails. Susan?

SUSAN EZALARAB: Wisconsin is at a different place on the spectrum than Oregon, and I think that's part of the reason that I was asked to come here to present today. Our market, individual and small group market is very competitive. We have quite a few insurers in each market.

Our state is also unique in that we have a really good mix of insurers in our health insurance market. We have state only HMOs that operate in certain regions of the states. We have two insurers who have a large share of the market, who only operate in Wisconsin, and then we also have the national

companies that operate there as well. In the individual market we have around 28 companies. It kind of comes and goes a little bit. We're doing another study now to get the exact numbers. We have 30 some companies in the small group market, and then also the association market, which we're now looking at, as a component of the individual market. We have 10 companies that are in that market as well.

So, in Wisconsin, we're very interested in preserving the competitive nature of the market and doing what we can. To do that, balance that with making sure that the premium — the rates are appropriate for consumers. We've got about 330,000 members in our small group market, 60 percent of those groups have five or fewer employees, and the average age in the small group market is 33, the average deductible is $1,500. In our individual market, we've got about 160,000 members, the average age is only 35. And the reason for that is we also have a high risk plan, where we now have about 20,000 folks in that plan. And that plan will of course be going away under the Affordable Care Act. We've got about 20,000 people there and the average age there is in the 50s. So, our individual market right now has people who can pass underwriting and who are healthier, and therefore that affects the premiums a little bit as well.

Our rate review regulatory structure goes along a little bit with what Donna was talking about in the beginning,

and this is common language in many states, rates cannot be excessive, inadequate or unfairly discriminatory. And we have an additional piece in that rates are presumed not to be excessive if a reasonable degree of competition exists at the consumer level in the market. We have the authority to disapprove rates, if they're found to be excessive, inadequate, or unfairly discriminatory, but in order to disapprove a rate filing based on excessiveness, the office must fine that the market in which the rates apply does not have a reasonable degree of price competition, so that's the individual or the small group market.

Our review process prior to the federal rate review grant was pretty much hands off, we have limited expertise, we had no actuaries on our staff. We did not have any contracts with professional actuaries to assist us, so filings were basically reviewed for the documentation that's required under our current regulatory structure. And there really wasn't a lot of analysis of the filings. We also had limited knowledge about our market, about the competition about the marketplace. As part of the first exchange planning grants, our health department commissioned a market study to try to get base line data about our markets, and that base line data, which is available, that study is available on a web site I'll give you at the end, showed that our individual market is healthy and

competitive, and that our small group market is a little bit less competitive, but there are a large number of carriers in that market as well.

As the cycle one rate review grant, we were very fortunate to get this and we were able to expand the scope of our rate reviews. We're just coming on the completion of the cycle one rate review now, that was primarily a planning process for us to look at what did we need to do to improve our rate review structure. So, we've hired some staff, some actuarial analysts who went through the rate filing history that we do have, and these are young people, all of them working on, you know, two or three of our actuarial exams. We also surveyed the individual and small group markets, learned quite a bit from that survey.

And out of that we worked with our actuarial consultant to be begin designing a rate history database, so we would actually be able to look at rate changes and have some basis for looking at the filings as they came in. We also contracted with an actuarial consultant who's helped us develop detailed rate review procedures, along the lines of what Donna talked about early on in her presentation.

And the other piece that we're doing is we're looking at tools to monitor the competitiveness of our markets and particularly in our geographic regions. We have HMOs, as I

said before, that only operate in certain parts of the state. So, we're interested in looking at is the market competitive in each geographic region. And we've identified these are the regions that we're going to be looking at. We're in the process right now of conducting our first rate change survey, which will form the basis in more detail for the competitive study. And we're looking at the products that are sold and the individuals that are insured in each county or zip code within those regions, and we will be doing that on an annual basis.

Enhance rate review, Wisconsin did receive certification as an effective rate review program in the individual and the small group markets. And basically this, as part of the rate review grant, we've built up the infrastructure in order to be able to satisfy those requirements. We met with our industry in July, went over our enhanced filing requirements, and this is essentially what we have to do. The rates have to be filed at least 30 days before they're effective, and then the filing must contain a minimum amount of information, and we have a lot more detail on our web site about what that information is, but basically actuarial memorandum, where we lay out exactly how the company needs to explain the rate filing, historical experience and rate adjustments, projection, assumptions, medical trends, some of this Donna talked about before. And then also have to give us

geographic region information again, because we're looking at the competitive nature of the market, and that's the piece that we would need to do to determine it wasn't competitive, in order to do a disapproval.

Every rate filing is going to be analyzed now for completeness, and we have also worked with our actuarial consultant to determine rate review paths, where internal staff can conduct a review and when it needs to be referred to, our external actuarial consultants for further review.

And some examples of what we look at, the size of the rate increase, the number of people affected, the rate filing history of the insured and the competitiveness of the geographic area to which it applies.

Again, because we have a very competitive market we're looking at the least intrusive way to ensure that the filing contains all the required material, and more in depth analysis included determination of the actuarial soundness of the underlying factors, by our outside actuary. And again we're identifying which of the filings need that additional layer of review. Again this is just going over the requirements in the enhanced rate review process and the things that we have to do in order to satisfy that.

Information for the public about the rate filing process, Teresa really talked about the wonderful things

they're doing in Oregon. We've been looking at what Oregon's doing. We have also, for several years had access to all of our filings, all lines of insurance on our web site, but we found that it's somewhat intimidating for consumers, because we use some technical terms about how you find the product. So, right now we're redesigning that. We're actually in the testing stages now. Expect to roll it out in the first of October. So, it will be easier for consumers, simple search using common terms, so that they can find what they want. There will be n opportunity when they find what they want to ask us a question about the filing, to file a complaint. What we found is rate filing is about the rates. That's really not the premium increase that a consumer sees.

So, when they look at the rate filing, they say that this filing is only X amount, how come my premium went up Y amount? So, we want to give them an opportunity through our complaint process to get that more detailed information from the insurer or to ask us about it. And we will also have the flexibility to post a comment, which again was a requirement as part of being an effective rate review program.

We are also developing a consumer friendly summary of the rate filings. I don't think you mentioned this Teresa, but you do have that and we've been looking at that, so that rate filings can be very intimidating to look at, so what we want to

do is just have a short explanation for consumers, so they can understand what's in the filing and then if they want to dive deeper into it they'll be able to do that.

So, in short, I mean I think we're very grateful for the Rate Review grant, because it's really helped us learn so much more about our market. And looking at the situation in our state, we've had — I was just going to say in the third quarter, so far of the reports that we have to give to HHS, we've had 11 rate increase filings and we've actually had three companies that have filed decreases during that period of time, so we're just getting started and really looking in depth at the rates, and working with the companies. We have done that already a little bit in our Med Sup and long term care market, and we do, do a lot of discussion with the companies about the size of those increases. So, we're looking forward to using the rate filing process, hopefully to help it be more understandable for consumers and also to identify any problems with rates that we would need to deal with the companies on. Thank you.

LARRY LEVITT: Thanks, Susan, and as Susan said, obviously the competitiveness of the insurance markets in a state may have important implications for the rate review process, it also has implications I think for how exchanges may operate come 2014. And we'll have an analysis out soon

actually that looks at the competiveness of the individual and small group insurance markets state by state to try and provide some context for some of these decisions going forward.

And now from a somewhat different perspective, we have Gary Cohen. I'm pleased to have Gary Cohen here from HHS and HHS is both conducting reviews in states that have not been determined effective, and, uh, also overseeing the process and the disclosure to consumers. Thanks, Gary.

GARY COHEN: Thank you, Larry, and thank you for the invitation to speak today. I'm particular pleased to be here today, because as I'm sure you all know tomorrow is the 18 month anniversary of the passage of the Affordable Care Act. I'm sure you all have your parties planned, and if you don't you better get going on those. It really has been an extraordinary 18 months for health reform and in particularly for rate review, and for federal state cooperation and collaboration, and particularly in rate review. And I think the discussion we've had so far is just an outstanding example of how that has worked and — and what I want to talk with you about today, you know, before the Affordable Care Act was passed we really had a patchwork of provisions across the country with respect to whether and how health insurance rates were reviewed. On one extreme we had states that didn't even require any sort of filing, so an insurance company could just

tell its policy holders, your rates are going up and that was it. And the state didn't even get the basic information that would be needed to review that rate increase. Then we had states that might require a filing, but whether — either because of the laws in the state or because of a lack of recourses in the state insurance department. They really didn't have the staff or the professional expertise to be able to review rates effectively. And I think that Susan really spoke to that quite a bit. In terms of the fact that they didn’t have any actuaries on staff, they didn't have any contract actuaries.

And then you had states, perhaps like Oregon, where they do have robust laws, they did have a robust methodology for reviewing rates, but perhaps there were areas that they can improve as well in terms of letting consumers know what they're doing, in terms of transparency, in terms of having public hearings, and other things to even improved what was already a pretty robust process that they had. So, how does the Affordable Care Act and the regulations that we've adopted under — to implement it, address this situation that we had across the country. And it does it I think really in two direct ways and in one indirect way which is the medical loss ratio that Donna spoke about, but in terms of rate review itself, it does it in two ways. Number one, it sets a federal

floor and it basically tells, it ensures that all health insurance rates for this year of 10 percent or above will be reviewed and will get an expert analysis by actuaries to determine the reasonableness of the increase.

Starting in September of next year, that 10 percent will be decided state by state, so we'll be looking at the information that comes in on filings this year, and we'll be determining a threshold that is particular to a specific market. So, it may be that, you know, in a state like Wisconsin where there is a competitive market, you know, maybe 10 percent isn't the right number, and we'll be working with the states and with the National Association of Insurance Commissioners to come up with a threshold that the purpose of which is to capture as many increases that might be found ultimately to be unreasonable, as we can without capturing too many and subjecting to review too many that ultimately would be determined to be reasonable.

Secondly, it sets a floor by saying, these are the basic things that you need to do in order to be able to review a rate increase for health insurance. There's certain basic information that you need to have and I think Susan laid that out very well, you know, sort of the basic underlying assumptions and, you know, what's happened to medical costs, what's happened to administrative costs, some history there

that enables you to make an evaluation of what that increase is all about and what's driving it.

Secondly, you need to have an analysis of that information by a professional who's able to test those assumptions and determine whether those assumptions are reasonable or not. And third, you need to have a public process of some kind. Now, we don't require that there be a public hearing, but we do require that there at least be notice to the public and an opportunity, whether by email, which is I think what many of the states are doing or by phone, or what have you, so people can provide comment with respect to a proposed rate increase. And if you meet that standard then the state itself is going to be continuing to do those reviews in many cases as it's always done. And as it turns out, ultimately we determine that 43 states and the District of Columbia are going to be doing all of the reviews in their states. There's a couple of states that don't get filings in the small group market, that do get filings in the individual market, so for those states we'll be doing the reviews in the individual market. And then there's six states right now that don't have a process that enables them to do the things that I've described, and so therefore, we at CCIIO will be conducting those reviews.

Actually we've hired an outside actuarial firm that will be doing the reviews and making recommendations to us, as to whether the reviews are quote unreasonable, which is the language of the statute, that we have to make a determination whether the review is unreasonable. We don't have authority to deny a rate increase anywhere, that's not in the Affordable Care Act, so when it comes to the federal government's review, all we'll be doing is reviewing the rates and making a determination as to whether they're unreasonable, making that determination public, and then if the rate goes into effect the insurance company has to post a — what's called a justification, sort of their reason why they believe that they need that rate increase, notwithstanding the fact that, you now, we've determined that we think it's unreasonable and that explanation has to be posted on the insurance companies web site and our web site.

Now the way this process will work is that when rate increases come in they will be disclosed up on healthcare.gov, they're not there yet, but we're just getting started, but very soon it'll be going live and you'll see somewhat along the lines of what Susan and Teresa spoke about, a consumer friendly form that will break that rate increase down, so that people can see what part of that rate increase is due to medical cost, and even broken down further than that. What part of that

increase is due to increase in inpatient hospital costs, what part of the increase is due to outpatient clinical costs, what part of the increase is due to increase in administrative costs, etcetera. And so people will actually be able to see what is it that's causing their insurance company to ask for an increase in their rates. And there will also be a little calculation as to, you know, this rate increase is, you know, for 12 percent, which means on average your premium will go up by a certain dollar amount, so people will be able to sort of make the connection between what that might mean potentially for them.

In addition, there will be a — in the cases where we're doing the reviews, we'll be getting really what is a full rate filing, just as the states do today. And that information will be available on our web site as well, so if you really want to get into the details, you'll be able to do that. So, the first way that we've addressed this situation, as I mentioned, where, you know, we have this wide variation in terms of review of rate increases was by establishing this federal floor of sort of the minimum of what states have to do to have an effective review process, and therefore be able to continue doing their own reviews under the Affordable Care Act and our regulations.

The second thing we've done that's provided for in the statute is the grant program. And I think Susan and Teresa

really did a wonderful job actually of capturing the range of activities that have been made possible from these grants. So, we awarded $43 million dollars in grants last year to 42 states and the District of Columbia. We've just this week announced an additional $109 million to spend over three years to 28 states and the District of Columbia. And the range of activity that states have number one used the money for and then proposed to use the additional money for really is a good reflection of kind of where the states were at in terms of their rate review process.

So, in many states where they really did not have the kind of actuarial expertise to be able to do effective reviews, they've hired staff, they've hired actuaries or they've contracted with outside actuaries, and to enable them to do that. A number of states in addition have increased their authority, states either that didn't get filings at a particular market have either issues bulletins or passed legislation to get filings in those markets. And in addition there are several states that did not have the authority to deny insurance rates in the health and insurance market before that now do, Tennessee and North Carolina, and Arkansas are examples of that, where they actually have gotten additional authority that they didn't have before. Many states have been using the funds, as Teresa mentioned, to have a — essentially a

rate review page on their web site, where you can go and learn about rate review generally and then learn about rate review specifically for the company that you're covered by in terms of what it's asked for and what the process is and as we've talked about, making comments and alike.

Just as a few examples, which I think are terrific. I was looking at the information that I have and Teresa, I think between the first round and the second round you're proposing to add eight people to your staff, and Susan, five in Wisconsin I think is the number that I have, that you — and that's pretty typical of other states across the country. Illinois has been able to add 10 staff, California 9, Colorado 8, I mean go down the list. So, so this has had a real direct impact on states ability to handle this work in ways that they, you know, were not able to do previously.

And then the last thing I just wanted to say is there is this connection with medical loss ratio, there's no question about that. I mean, and I think Donna explained very well, if you — we'll talk about the individual market, where the law requires that $0.80 out of every dollar be with certain adjustments be spent on clinical care or on activities that improve healthcare quality — health quality. Obviously if you're going to have to pay back any additional premium dollars that you get when your medical loss ratio falls below that

number, then that creates, you know, a real disincentive to raise your premiums to the point where, you know, the ratio is going to be out of whack and you're going to end up having to pay the money back to consumers anyway. Number one, it doesn't look great and number two it costs money, and there's a real direct cost to having to pay those rebates. So, I think we'll see some mitigation in premium increase certainly for this year, as a result of this new requirement that's gone into effect.

One question that's asked a lot is, well if you haven't got authority to disapprove rates, does having this review and, you know, all this public disclosure really make any difference? And I think that, you know, a review of what's happened in states shows that it really does, that you know, I think that Donna mentioned that often times what happens — the process that happens and I'm familiar from this in California where I was the General Council of the Department of Insurance.

And we saw this last year when one of the major carriers came in with a very large increase, and the first thing that happened is that there was a review of that increase and they found mistakes in the way that the math had been done, so the company quickly corrected that, I mean that was not controversial, it was like, you know, we made some mistakes, you know, but those were mistakes that might not have been

caught if there had not been this independent review, and the second thing is obviously the requirement that you be out in public and explain and justify what you're doing certainly I think has some effect on what it is that companies will ask for and ultimately what they will arrive at.

And then lastly, this negotiation process that goes on and certainly went on when I was in California. Even without the authority to disapprove a rate, companies do want to have a good relationship with their regulator, they have to live with their regulator, there's lots of decisions that they have to come to their regulator for approval of, and so to the extent possible, you know, there's a dialogue and I think it's important to bear in mind that every, you know, the standard that folks put up there which requires that rates be adequate, as well as not excessive is very important, and insurance regulators take it very seriously, because the last thing that nay insurance regulator wants is a situation where a company can't pay the claims that it has that come in, because it doesn't have sufficient capital and surplus to do that. So, you know, it is a balance, it is to some degree an art, as well as a science, and so that sort of — as long the Department of Insurance has the expertise and the resources to be able to really deal on an equal level with the insurance company, I think what will end up happening is these kinds of discussions

and some mitigation in the cost of insurance, even where the state doesn't have the power of approval authority, and I think it's important.

And my last point is in creating this federal floor we did not dictate to the states that they have that authority, we left state law as it is, so whatever the state standard is for reviewing rates remains. If the state has prior approval authority it has it, if it doesn't, it doesn't. But what we did mandate was this floor of a methodology for how rates should be reviewed, and how those results should be made public.

LARRY LEVITT: Terrific. Thanks, Gary. Well, we do have some time for questions before the next panel and we have some microphones going around if you could raise your hands. Right there, and please identify yourself for — yeah.

MIKE MILLER: Thanks, Larry. Mike Miller, I'm a health policy physician here in D.C. And this question may be a little bit on the simple side, but Larry knows that, that's me. It seems to me that if they're going to do rate regulation, if I'm an insurance company, I can sort of dial — in a state that doesn't have a lot of regulation, guaranteed issue, those kinds of things, I can just dial up or dial down my underwriting to dial up or dial down my rate increase each year. So, I understand once we get to 2014 that's going to be a lot

different, but in the current environment can you talk about how the rate review takes that into account? Maybe that's Donna or something else.

DONNA NOVAK: Well, dialing up or down your underwriting would only affect the new individuals coming in. You still have everybody in your block that's in your block, so it's — it really, unless you're growing very rapidly isn't going to have the kind of impact that it sounds like you might be thinking.

SUSAN EZALARAB: But you might say, like for instance if you close a block, I mean that's — maybe that would be a better example.

MIKE MILLER: And then companies that move people over and [inaudible] well we can get you over here, I know you have problems over there [inaudible].

SUSAN EZALARAB: That's just bad. And I think that's one of the things that's going to change with the Affordable Care Act, but certainly that happens now or the company brings out the new product and you have to be underwritten in order to qualify for it and you kind of leave the other folks behind in the other block. We do require as part of our rate filing, that they have to tell us any changes like that, that is a part of the requirement for the actuarial memorandum, so.

GARY COHEN: And just to clarify a little bit. I think it was Susan who said, that sometimes rate filings are — Susan or Teresa, aren't always intuitive or assessable and having read many of these as well, I can certainly vogue for that, but you know, one important thing to look for is this idea of blocks of business or segments of an insurance company's business, and when an insurance company does close a block of business, it means that no new business is coming into that block. And in the current market, healthy people can leave the block and get underwritten coverage either with that insurer or with another insurer, so it means that the people left in that closed block are increasingly sicker and sicker, which is often why when you see these very, very large increase it's due to the fact that it's a closed block of business.

SUSAN EZALARAB: I know of at least one case where a regulator said, no, we see what you're doing and you're not going to be able to do it, so — in states where they have the authority they try to stop them.

CAROLINE POPLIN: Here.

GARY COHEN: Oh, okay, sorry.

CAROLINE POPLIN: I'm Dr. Caroline Poplin, I'm a physician and an attorney, and I guess my question is sort of the same. Susan talked about competitive markets and I know everyone competes for the young healthy people and the small

groups with the young healthy people, but the competition is different, I would assume for customers who are less attractive, and I wonder how you determine competition in a situation where all customers are not the same.

LARRY LEVITT: Maybe if I take the prerogative of the moderator to add on to that question a little bit, which is how do any of you see this changing or the competitiveness of the market changing as — as the provisions of the Affordable Care Act come on in 2014?

TERESA MILLER: So, I don't want to take this in a direction that you didn't necessarily intend, but I think one issue that I know, since Larry, you mentioned that Kaiser Family Foundation is going to be looking at this. One point I didn't make that I think is worth at least thinking about, as we talk about competitive health insurance markets, and I actually — it was even in my notes to say this and I didn't say it, Oregon has a competitive health insurance market as well, and our market is very unique when you look at — I think it's similar to Wisconsin's is my understanding.

We have seven domestic carriers that's not counting your uniteds, but we have seven domestic carriers that compete for our individual and small group business, so we do have a competitive market. But — and Oregon's geography may be part of this as well, but what we find, you know, a lot of — there's

been a lot of discussion about the need for more competition, the Oregon though, one of the things that we found, as I look at trends in Oregon and compare them with trends in other states where there's really just kind of one dominant carrier, one thing that I don't know that has been brought into the discussion is the relationship between the insurer and the provider is different I think in a competitive market, than it is in a market that's not competitive.

And I know that the negotiations that happen in Oregon between insurance companies and providers are very, very different than the negotiations that happen in a state with really one carrier, where the carrier walks in and says, hospital, here's what I'm going to pay you. In Oregon we have knock down drag out discussions between insurers and hospitals especially, particularly when you've got, you know, kind of an isolated, you know, one hospital in the area where that hospital can basically say, here's what we need, we need a 50 percent increase, and the carrier says, no, we don't want that, and the hospital says, okay, well, you know, I've got six other carriers I can choose from, so you know, that — and that's actually something when I talked about us looking at ways we can get at those underlying costs, I think there may be ways, especially in a state like Oregon that does have that competitive market where we can try to put insurers on a more

even playing field when they go into those negotiations. And again I hope I didn't take that in a totally different direction, but I think it's worth — as we talk about competition in these markets, I think it's worth thinking about that there's other issues that it creates.

DONNA NOVAK: That's actually a really good point, it's not just competition of the insurers, but it's the underlying providers, which is the underlying costs. I just wanted to just very briefly answer Larry's question and that is there are a lot of mechanisms in the new law that are intended to solve some of the problems that you're pointing to. One of them is risk adjustment and I promise not to talk actuary, so I won't try to explain this, except that if an insurer attracts less healthy individuals they will be paid more in the future and that's not true today. Those mechanisms don't always work 100 percent, but they are intended to solve that problem.

GARY COHEN: One other point to make in response to your question, Susan, I think you said in the individual market in Wisconsin, the average age is 35, so the folks that you're talking about are not getting covered in the individual market today, they're just not, I mean so that's one thing that will change as a result of the Affordable Care Act, those folks will be able to get covered, because we'll have a guaranteed issue. And then the other thing I would say is that unlike Wisconsin's

and Oregon, the insurance market — the health insurance market in most states is highly concentrated, and so in most states there is a dominant carrier that has 65, 70 percent or higher of the market, there may be one or two additional carriers that have seven, eight, ten percent of the market, and then there may be many other carriers, but they each have one percent or left. So, we don't have those competitive forces operating in most states.

LARRY LEVITT: In the back there.

BERNADETTE FERNADEZ: Bernadette Fernandez with the Congressional Research Service. I have a question specifically about rate review, but I actually have a comment first. I think the comparison of MLR requirements and rate review, at least with respect to PPACA are a bit strained. I see them as looking at a slightly different unit of analysis, and to me there's a big — there's a lot that can happen between a proposed rate increase versus what you see in the MLR or sorry in the — right, MLRs that are going to calculate it based on actual premium revenue, and claims costs, so I'm just throwing that out there, not necessarily to — for reply, although I am curious as to what your thoughts are on that.

So, my real question actually is about the rate review process, and Gary, I really appreciated the fact that you brought up the instance in California, because obviously that

got a lot of national press, and to me, I mean our take away is that it happened not only because California has a certain amount of authority, but clearly you were able to do an actual audit, and a real thorough review of the methodology, and I think that, that — my question then becomes, given that so many states currently do not have the authority or, you know, they have what we look at as kind of surface authority file in use, how confident are folks that the rate review requirements under PPACA will actually lead to states eventually complying not just in kind of the letter of the law, but also in the spirit.

GARY COHEN: Well, I mean obviously I can't speak to what states are going to do, but what I do think though is that there has been through the Affordable Care Act, through incidents like the one that we've talked about that happened in California. There's been a tremendous amount of attention directed to rate review generally, and I think we've seen a lot of activity in the states, as a result of states having to make a choice, quite frankly, you know, do we want the federal government reviewing health insurance rates in our state or do we want to be reviewing health insurance rates in our state. You know, as we've seen, the states by in large would much rather do it themselves than have us do it, let's be frank about that, and that's fine, that's what we'd rather have too, and so my own view is that once you get — and I'd certainly be

interested in Susan and Teresa's view of this. Once you get dedicated professionals, you know, in the Department of Insurance across the country engaged in this activity with the resources that they need to be able to do it effectively. They will do a good job.

SUSAN EZALARAB: Yes, as part of our cycle to rate review grant requests we actually put in there one of our objectives is to actually do some audits, and to hire some actuary firms to do some audits out in the field. I think that the difference with California, I believe they actually had a specific loss ratio requirement for the product, so when the carrier didn't meet that, that was pretty significant. Not all states have that, and that's that discussion again about sometimes it's medical loss ratio related to a product that the law has, but the one that's for the Affordable Care Act is talking about the product line, so it is a little bit confusing there, but our — the commissioners of insurance have very broad authority to ask a licensee for any information to conduct an examination or an audit at any time, so I'm really not concerned about that.

I think it's more — there's kind of a presumption in the way you spoke that somehow insurers aren't doing a good job and aren't providing the proper information in rate funds. We kind of take the opposite view. We work very closely with our

insurers and our expectation is that when they're submitting a request for a rate increase they have a basis for it. We're certainly going to look at that, but we're not assuming that every, every filing will somehow need to be reduced. We really have to look at all the elements that are in it, and I think Donna went over some of those elements in her presentation.

LARRY LEVITT: We have time for a couple more questions before the next panel. Right here.

RYAN LYNCH: Hi, Ryan Lynch, Health Policy Analyst. I have a question about the thresholds. If the threshold is say 10 percent, is there an incentive for insurance companies to come in each year just below that, and so rather than three percent one year and 12 percent the next year, it's going to be nine or 9.9 percent each year. And also if they do know that they're going to hit threshold is there an incentive then, instead of submitting a request of an increase of 11 percent to say instead it's going to 15 or 20 percent, knowing that it will be examined?

GARY COHEN: So, I would say that on a whole, insurance companies are going to ask for what they think they need, you know, that's going to be the main drivers. What — what's the rate that they think they need based on their projections, as far as where their costs are going to go and so forth. The — I mean we'll see whether there's a lot of filings that are coming

in at, you know, nine and half or 9.9, I think that it's a complicated. If you want to game it or you know, be strategic or something, it's a little bit complicated, because you don't know what the threshold is going to be next year, it might be lower.

So, if you're asking for an increase now that maybe is a little bit less than you think you need, because you want to stay under 10 percent, you know, you may have a difficulty sort of making up for that next year if it turns out that in a particular state that you're doing business in the threshold is actually even lower, so you know, I think that's a difficult, you know, sort of calculation to make.

LARRY LEVITT: Let's make it back to the perception of how competitive this market is or not, as well, which people can obviously differ and it differs from state to state. I think we have time for one more before — right here. There's a microphone right to your —

SARAH HANSFORD: Oh, I'm sorry, sorry. Sarah Hansford [misspelled?] with BNA. Miss Miller, I wanted to ask you, you were talking about you thought you might be able to get some tools to help insurers control the costs, like what kinds of tools could you bring to bear on that?

TERESA MILLER: So — and I don't want to pretend like I'm an expert on this. The reason we're doing a study is

because I really want to look at what options might be out there, but I'll give you an example of something that actually the carriers, my carriers had talked to me about a couple years ago. I think it's become more common place now, but they had a lot of difficulty, at least a few years ago, when they were trying to negotiate with providers, in particular hospitals, getting provisions in the contract like I probably call it the wrong thing, but a never events clause.

Some of you in this room may know what that is, so if something happens at a hospital, the wrong arm is amputated, something — a sponge is left in after surgery in the person or something that I think — and I understand Medicare uses a list that maybe they go by a different name, but there's experts that have come together and said, we can all just agree that these things should never happen in a hospital. When those happen, part of the question I'm interested in is who pays for that, so do policy holders pay for that, because hospitals then pass those costs on to the consumer, so then when you do have to amputate the other arm they end up paying for both type of thing.

And insurers in my market at least have been trying to get those provisions in their contracts with insurers, so that — or with providers, so that their policy holders didn't pay for that, but they were having difficult again, maybe just in

my market because it is competitive, they were having difficulty getting hospitals to agree to that, because again, hospitals would just say, I won't sign that contract if it has that provision in it. Again, I think this is becoming more common place, but those are the types of things, particularly since I do have this competitive market and providers can just say, I won't sign that.

I'm interested in trying to figure out are there provisions and contracts like that, that might help reduce costs ultimately for the policy holder that we could look at basically putting everybody on an equal footing, and saying, okay, insurers, we're going to say we're not going to approve your rates unless you have this clause in your contracts.

SARAH HANSORD: So, I guess my question would be, what do you make the hospitals sign?

TERESA MILLER: Well, I can say that any insurer who does business in Oregon has to have that clause in their contract, so where's a hospital going to go at that point?

LARRY LEVITT: Well, thanks. Please join me in thanking this terrific panel [applause]. Don't go anywhere, we're going to do a very quick change and turn it over to my colleague, Gary Claxton for the next discussion. Thank you very much.

GARY CLAXTON: I think we would like to start the second panel now as people sort of get their coffee and get seated. I think we had a good discussion in the first panel, so we're going to try to get some reaction in the second panel. We have again, we're blessed by having two people with a lot of experience, both former insurance commissioners. We have Kim Holland, who's the Executive Director of State Affairs for the Blue Cross and Blue Shield Association, and she was the former elected Insurance Commissioner of Oklahoma, is that correct? And Mila Kofman, who's a Research Professor at Georgetown University, and right before that was the Insurance Commissioner in the State of Main. And we're going to start with Mila. Go right ahead.

MILA KOFMAN: Thank you very much. Thank you Kaiser Family Foundation for having me, inviting me to be part of this great event and very timely event, so Larry and Gary asked me to give you a perspective for a consumer perspective on rate review and federal reforms and what rate review really means for consumers, and I'm going to give you that, but I'm also going to give you some sense of what it was like to be a state insurance regulator looking at rates. So, I'll wear my former hat, as well as a consumer hat.

Okay, so in Maine, the rate review standard is very similar to what most states have and that is that rates cannot

be excessive, inadequate or unfairly discriminatory, and you heard Sue from Wisconsin talk about that.

Unlike Oregon, most states have this type of standard, which is not very detailed and there's a lot of discretion given to the state insurance regulator to figure out what it really means. In Maine we also use to have a prior approval requirement in the individual market, which means that before an insurance company could increase rates or even set a new rate for a new product the insurance company had to get that rate improved. And there were two ways of doing that, one was through rate hearings, which are very formal hearings, almost like a court hearing, where you have a set of administrative standards that apply, and whoever participates, and usually the attorney general participated, in some cases consumers groups participated.

There were very formal rules and things had to be done in a certain way and there was always a court reporter in those situations. Also, there was an informal process to get rates approved, and in Maine there were hundreds of rate filings that were filed each year, but there weren't hundreds of hearings for good reason, you just don't have resources to hold hundreds of hearings. But when I was state insurance regulator I really felt that it was important to hold hearings for a number of different reasons.

One was to allow consumers, employers and individuals, and family insured to really be part of the process, to provide feedback to government, and to enable consumers to see how the process worked. Many consumers and this is one lesson I learned through holding those hearings is that many consumers really believed that government wasn't there for them, and that somehow state insurance regulators were in bed with industry. And many consumers didn't have a sense of what a rate process is, what evidence regulators look at to figure out whether the rates are fair and are evidence based.

So, I thought holding public hearings around the state was really, really critical, and I did that in the evenings and I went all around the state to enable consumers to participate, and in fact with some of those hearings we had people who drove three hours to make it to the hearing, just to get five minutes worth of testimony in. So, I thought public hearings were really critical. And I do want to digress for one minute and to thank the federal government that gave Maine at the time a million dollars to review their rate review process. That grant, part of the funding went to a consumer advocacy group to enable the consumer advocacy group to participate in the rate review process in a very formal way, so the advocacy group was able to hire their own actuary to actually review the filing,

to review all the data, as well as to participate in the rate proceeding.

And the actual rate hearing, by the way, if any of you have gone to one, you know, it's really a battle of the actuaries. You get four or five actuaries in the room and they battle it out, in a very nice way, it's not like lawyers cross examining witnesses, the actuaries are actually very nice to each other, but it really is, the whole proceeding is really based on looking at a lot of data, a lot of evidence. Most of the review is actually — is very much data driven. There's some parts of the review that are, I would say policy calls, but most of it is evidence based, and allowing consumers to be a part of that process and to see that it really is not made up stuff that happens, but there is evidence you look at to figure out whether rates are fair. And by the way, I wish I could — I wish I was wrong on this, but I have to say, regulators are not magicians, okay?

And lots of consumers, although they were happy that they had input into the proceeding still were unfortunately forced to lose their coverage, because they couldn't afford any kind of rate increase what so ever. And so regulators can do a whole lot, they can make sure that rates are fair, they're supported by evidence, but they're not magicians, and so there's very little that they can do to actually tackle the

cost drivers, which is the cost of care and the utilization, so I just think it's really important to remember that.

The other aspect of the rate review proceeding that I thought was important was it gave regulators an opportunity to find violations of the law, both intentional and unintentional, in fact in what rate proceeding we discovered that a company wasn't meeting its — the required medical loss ratio of 65 percent back then in Maine, and in fact it was only paying out like $0.40 on the dollar, so the company agreed to do refunds, premium refunds to the tune of $5.6 million plus interest to the consumers who were overcharged, plus they paid a $1 million fine.

It's also an opportunity to make sure the administrative aspect of the rate is legitimate, especially when you have companies that do business in many states, not just one state, you could have one function like claims processing being performed in California, even though the consumer lives in Maine, and you know, the mail being sent to the consumer from Connecticut, and so you want to make sure that the administrative charges associated with the Maine premium rate is actually legitimate, so through the rate review process regulators have an opportunity to make sure that the administrative costs are being allocated correctly.

Okay, so in Maine, rate review what it did for consumers, and I'll just tell you the last couple of years. When I was there, for example in October of 2010, Anthem, which is the largest company enter in the market in Maine wanted a 23.1 percent increase, and I approved 14.1 earlier this year. Anthem filed a 9.7 percent increase, and I'm sure it has nothing to do with the 10 percent threshold that HHS set, and — and I approved 5.2, so it really does make a difference when you look at this chart, what the request is and what ultimately got approved. And certainly my predecessors were just as comprehensive in their review of the Maine rates as you can see what was filed was not actually approved.

I'm going to jump to the small group market, because in Maine there was no prior approval authority, so essentially whatever the rate carriers filed, that was the rate that they were able to use, so as you can see there really was not review of the rate to figure out if it was based on proper calculations and data.

There's this myth out there that when you have comprehensive rate review companies can't make money, and I'm just going to give you one example in Maine, where Maine has had prior approval for many years, and for the most part, the company on the entire market was able to make a profit and that

shows the dividends at Anthem of Maine was able to transfer it to its parent company, WellPoint.

A couple of words about federal reform and what I think of it. In terms of the authority that HHS has, I was one of a few regulators who endorsed a bill in Congress that would have given HHS, what I call real authority over rates, meaning if a state didn't have authority to review rates, then HHS could come in and review rates, so I think that bill is still pending, and I do hope that eventually it will make it into law, because I do think reviewing rates is critical for consumers.

As we go into 2014 and employers have to provide coverage, consumers have to buy coverage, and the government is putting a lot of money on the table to subsidize private coverage, all of us will want to make sure that the rates are being charged are fair, that consumers are not being ripped off, that the rates are evidence based and that they're legit, right? That's really important to make sure that someone is watching over what insurance companies are doing and charging in terms of rates, as well as, I think it's important in terms of the use of federal tax subsidies and tax dollars that will subsidize the private market. So, I think absent that I want to just say that the states that haven't had a comprehensive review authority over — over rates are — and I agree with what

was said earlier, they are using the current jurisdiction they have to be more aggressive, to be more comprehensive, to make sure that the rates are fair, even before 2014. Did I run out of time?

GARY CLAXTON: You just did.

MILA KOFMAN: Okay, thank you.

GARY CLAXTON: Next we'll hear from Kim Holland, Blue Cross Blue Shield Association. Thanks, Mila. Good job.

KIM HOLLAND: Well, good morning. I'm delighted to join you here, and I bet you're all anticipating a rebuttal, but you're not going to get one, and I really appreciate my colleagues bringing up, what we have Anthem, we had Regence, the whole Blue Cross system [laughter], priming me, right? But I want you to know first and foremost a little bit about me, because you've heard that I was a regulator, I'm now with the Blue Cross Blue Shield Association, I've spent my entire life in some way, shape or form dealing with America's healthcare system. I was an insurance broker and consultant, so I worked with little tiny businesses and individuals trying to negotiate with insurance companies. Certainly serving them and trying to help them wade through myriad of issues that you deal with, with changing life events that go about dealing with individuals throughout their lives, and most importantly and I think this is true, I'm not only — my colleagues and myself

here as a regulator, but certainly true of the company I now serve, and my personal perspective of an insurance consultant. Most importantly I worked hard to build the trust of individuals who literally I dealt with at the most profound and some often times difficult times in their lives, certainly the most dramatic times in their lives, an illness, a birth, a death, all of those things, so that trust is sacred.

I went on to my regulatory environment which was a very interesting perspective. I bought insurance for my small business and now here I am with an insurance company. So, I think I've been all along the block on this deal, and it has been fascinating to me to recognize that from any vantage point how much there is to know. This is a very, very complex world, and each and every one of us, whether you're a regulator, whether you're a buyer, or whether you're an insurance company or whether you're the government, are dealing with the complexities of this particular issue, and not — not in small measure, the complexity's due to the diversity of this great nation.

I mean the fact of the matter is every one of us comes from an environment that is very different. Teresa's regulatory environment is very, very different from Oklahoma's, as is Maine. You know, we are a no government state in Oklahoma, so the things that Teresa embraces and her citizen's

embrace would actually be frowned upon in Oklahoma and are regularly.

So, one of the things I can tell you from the Blue Cross Blue Shield Association is we embrace the state based regulatory system, because we recognize that state regulators are best capable of addressing the needs of their particular markets and are closest to the people that they serve. I mean they do recognize the cultural diversity and differences that distinguish Oregon from Maine, and from Oklahoma, so we very much support that and work very closely with our regulators in that regard.

A little bit about the Blues for those of you that don't know, the Blue Cross Blue Shield Association is really a federation of 39 different Blue Cross Blue Shield Plans, that are all independent community-based organizations. We literally insure or have — offer coverage in every zip code in America. We ensure almost one in three Americans. And what I'm going to tell you, we didn't get there by beating people up, by having really high rates, by treating our customers badly or because they — we crammed the product down their throat. I mean the fact of the matter is we have a free market system in America for the purposes of health insurance, and we may all agree that it doesn't work as well as it should, and hopefully the Patient Protection Act is going to close some of

those gaps. But it's important to recognize that most insurers, first good quality insurance companies want a good quality regulator, yeah. They expect to be held accountable, expect to deliver a value proposition to their customers, and I can tell you from this organization that is critical to us. The role of a state regulator and the role of insurance companies, first and foremost, above all other consumer protections is to preserve the solvency of that company.

I mean the fact of the matter is the most important thing we do is make sure we exist to pay claims not tomorrow, right, but down the future. So, we look very carefully in terms of our rate review process at that solvency picture. The majority of our companies are not for profit, they are mutual companies that are owned by the policy holders that we have, and as such, we don't offer stock or can't issue a stock offering to raise capital, that has to come out of the rate making process, right? So, we're very, very sensitive to the ability to have adequate capital and surplus, to be able to anticipate the needs of our members and the future, to actually adjust to the changing dynamics of a healthcare environment that isn't necessarily predictable, as we all know.

I mean we're watching healthcare costs go up, we have tremendous advancement in medical technology in this country that is not inexpensive, and all of those things as a financing

tool, insurance has to be prepared to address all of those things, plus the unknown, and really is the risk, and we can't predict in any one day with real certainty just what the expense — what our healthcare expenditures are going to be in a given year. So, the process and assurance of solvency, rate adequacy is just as critical as measuring the excessiveness of rates, and one of the things I can tell you, as a large — a large organization with many of our companies are the largest in the market. We do care very much of the application of standards applied universally across all insurance companies. We do want to make sure that if there is a standard set, solvency measurements, consideration of all the factors, that those are applied uniformly, regardless of the size of the insurance company, because in the absence of that you do create an unlevel playing field and have the potential of disrupting a market or certainly disrupting a company's business. You know, one of the — the question — there was somebody that asked a question about insurance companies that might use underwriting, for instance, as a way to stop writing business or for individuals that are older and having difficulty getting insurance, you know, one of the challenges that I always saw as a regulator, and still we're struggling with it, I think will be remedied by the Patient Protection Act, if indeed the mandate is upheld, is the reality that in a free market,

basically what competition does in driving rates down is it creates an environment where people are excluded from the market, because the only tool an insurance company has then to decrease rates is to try to eliminate risk, right? Which means those individuals that are most in need frequently are not able to buy, and I witnessed that over and over again in Oklahoma, that's why many states have now addressed some of that by having high risk pools, and certainly the Patient Protection Act improved that, but still at the end of the day it's expensive.

And the fact is, the number one reason why people don't buy insurance is because of cost, okay. So, one of the things that the mandate will do is ensure that everybody has the opportunity through — will be required to buy to eliminate the adverse selection, because if you're not required to buy and we have the insurance reforms that guarantee your access to it, who's going to sign up first, all the sick people, right? And then what's going to happen with rates, so we have to balance the healthy with the not so healthy, the young with the more — the aging, to ensure that we have a market that risk can be spread universally, and that is the elegance in many respects, the Patient Protection Act taking into consideration all of those things and certainly taking why the mandate is so critical.

In the absence of that mandate, we're right back where we are — where we started from, really. Although you might — the insurance reforms might allow individuals access without pre-existing condition limitations, it's not going to do anything to hold down costs, because the situation that was described earlier of only the sick people coming to the table, or only people buying only when they need it will create the dynamic of increasing costs. So, we have to have all of those things to ensure that we do ultimately have that competitive market that we're looking for. I wanted to talk a little bit and just — I'm going to keep my remarks brief, because I really am interested in the conversation here, but Teresa touched on something that is kind of near and dear to my heart, not only now, but it has been for some time, and that is the question of politic and rate making, and while I would offer up to you with my experience with each of the people, the regulators you've heard from or former regulators you've heard from today. I would certainly — certainly say that, that would not be the case in their environments, but we are not immune to that, we are simply not immune to that. In the rate making process, as was certainly conveyed here earlier, it is a numbers process.

It is generally, should be a reasonably objective process were insurers are required to demonstrate through actuarial sound processes, how they derived, how they came up

with a rate. Most insurance departments or many have actuaries on site that actually that go through and review, and certify that, that rate is indeed justified by other actuaries, right? Working with lots of actuaries, I know it won't shock you that actuaries have differing opinions and can approach things from different angles, but generally, I mean in many respects, and in most instances, insurants or actuarial justification is required, it should be required, and it should be — it is substantiated by the department. But I have witnessed circumstances where regulators ignored that for political reasons, because it was attractive to consumers for any number of political reasons to support or deny a rate increase or reduce a rate increase for political purposes, for popularity purposes versus what was actuarially sound. It doesn't happen all the time, in fact the good news is it doesn't happen regularly, but I would just offer up to you, that for most insurance companies, at least again quality insurance companies excessive rates are regular either.

I mean that even — even Gary acknowledged the fact that most insurance companies want what they think they need, and we could — we can debate that on the margins, but generally they're not there to gage a consumers, because at the end of the day we just want to sell — we just want a product people will buy, going back to my original statement. I mean we are

in business to serve our consumers. And the only way that we're going to be able to do that is by bringing value to the people that purchase our products. And we can't do that by pricing excessively or not providing necessary services, so all of these dynamics work together. I absolutely in our organization embraces the transparency that's offered through the medical loss ratio, I mean I think what that is going to do, if it does nothing else is going to make it abundantly clear, the point that was made earlier, that the majority of dollars are spent on medical care, okay?

And that's the big nut we've got to crack next. I mean the fact of the matter, every — there's all these players, everybody's got to come to the table, as insurance commissioner, that was what I hoped to accomplish, get providers, get your — whether they're doctors, hospitals, and all the ancillary folks, with your insurance folks, with consumers, get them all at the table to appreciate the give and take. That's one of the things that the Patient Protection Act has attempted to do. You've got to have all of these people at the table in order to make reasonable, rational and equitable decisions on this issue. So, it is time to focus on healthcare expenses and recognize that we are not going to control premiums, unless we can control the rising cost of medical care expenses, okay? This will help through transparency and other

things, but it is not going to control it at the end of the day.

So, I will close with that, and just look forward to your questions.

GARY CLAXTON: Thank you. Are there any — I think we have microphones. Are there any questions? There's two over here, so.

CHERYL FISH-PARCHAM: I'm Cheryl Fish-Parcham from Families USA, and I have a question for Kim Holland. I just wanted to go back to something you said at the beginning about the cultural differences in Oklahoma, and ask you, as your — wearing your former regulator hat, you know, what kind of public process would be regarded as good in reviewing rates in Oklahoma.

KIM HOLLAND: Well, I don't think our consumers are any different that any others in that they want to know somebody is reviewing the reviewing rates, okay, and — or at least looking out after their best interest, whatever that process might entail. In terms of when I — and speaking of the public in terms of their — their willingness to drive legislation to encourage more government engagement in that process. That just didn't play out in Oklahoma. There wasn't — these was — there has not been a ground swell of that, there has been generally the premise that the market will drive costs whether

that, and we had a use in file system in Oklahoma for — still do, and so it's much more free market principals. We actually did a way, the only thing that we had public hearings on were workers compensation, and actually eliminated that a few years ago, so there hasn't been public hearings in Oklahoma for quite some time.

GARY CLAXTON: [Inaudible].

CHERYL FISH-PACHAM: — HHS in Maine, in the individual market, premiums are quite low, but the deductibles are quite high, how do you think the consumers will react to changes for 2014, when the premiums are obviously going to have to go up, and deductibles will have to come down?

MILA KOFMAN: Well, I — I or many consumers, premiums are high, even the consumers who choose the higher deductible options, the premiums are just too high. And even with comprehensive rate review there's only so much you can do year to year, you know, in a five year period, you can see your premiums triple. With the Affordable Care Act, one of the best features I think is the help that will be available through tax credits and other subsidies to help people afford coverage. The other great feature I think is the fact that coverage will be meaningful.

It will work when you're sick and when you're healthy, there won't be the days of $30,000 annual family deductibles

anymore, that will all disappear. So, people will have access to more affordable coverage they'll be tax help to support the premium cost, and other out of pocket expenses, people who need to see a doctor when they're sick, they're going to be able to do that without worrying that they can't go to the doctor, because they have a $10,000 or $30,000 annual deductible. I'll give you and example, in one of the hearings I held in Maine, there was a lobster man, who came to testify. he had a condition which made him pass out. And so when he had to go out in his boat to work, he had to take his wife with him in case he passed out, because of course if he passed out he'd drown, so she couldn't really work, because she had to help him work, and his annual deductible was over $10,000, and he couldn't afford to go see a doctor for his condition, he was insured, but he really wasn't in a meaningful way. So, the Affordable Care Act will change all of that, it will give people meaningful coverage, and affordable coverage, and secure coverage. And the private market I think will work in a way it's really intended to work, where carriers get to compete on efficiency, not who is good at avoiding risk.

KIM HOLLAND: Can I had something to that, if I may, you know, I think Mila points out a very important part of the Patient Protection Act in terms of consumer affordability and that is the importance of those subsidies, but at the end of

the day that isn't dealing with the cost of coverage, I mean it's still — we're going to have more people in the system, and hopefully a lot of those people will be the young.

In Oklahoma, I can tell you that 50 percent of the people that are uninsured are between the ages of 19 and 32, and that's not that far off from what it is in America. So, we know that there's a lot of young folks out there that aren't buying coverage that are going to improve the pool, but there's a lot of senior — more senior people too that have serious health conditions and haven't been able to get coverage in the market. Those two will be in the pool, so it still, it does require us again to go back and recognize that we're going to have to do something about healthcare costs, now one of the things that the Patient Protection Act does is it requires insurers, as part of that claim expense, they also can include quality or care expense, and in some regard, some of those expenses are insuring that people get the right care, the right place, the right setting, um, providing better continuity true to the continuum of care that one might need for any type of illness.

But there's still much more that we'll need to do and we're all — we all, whether you're a payer, or whether you're a provider or a consumer of health services, we're all going to have to work closely together to really control the fact or get

control over our health care costs which are the highest in the world.

GARY CLAXTON: I would just point out in Maine now, the coverage is guarantee issue, so part of the reason the premiums are expensive is that the market place is relatively sick, so premiums had actually come down with tax credits and a broader risk pool is suppose to go up. Are there any other questions?

CAROLINE POPLIN: Hi, I'm Dr. Caroline Poplin, and I'm a physician and an attorney. And I have a question actually for you both. For Kim, she said and I've often heard that it there are no underwriting standards or no mandate, people won't buy health insurance until they need it and they're sick. I'm 64, that hasn't been my experience.

My experience is that people buy health insurance if they can afford it, and the people who don't, don't buy it, because they're healthy, it's because they're poor, and that leads me to a question for Mila, we are talking about the ACA, and 2014, and significant subsidies. Looking at congress today, it doesn't look like they're going to be significant subsidies for anything and certainly not for Obama care, is the policy community thinking about what to do in the event that they're — the subsidies are much smaller than anticipated, that means if there's a mandate still, that a lot of people will fall into that category of too poor to buy health insurance,

but too rich to get subsidies, and what do we do in that situation, that's the situation in Massachusetts. There is a group of people like that.

KIM HOLLAND: Well, let me — since you asked or phrased my first, let me respond to that and just to be clear, first and foremost I would agree with you today that most people who don't buy coverage don't buy, because they can't afford it. Now, we do have that young group, largely under 25 that would prefer a cell phone, and that's just fine, that's what we would expect of them, but now good parents can keep their college, six, seven, and eight year college — your children on their plans for a long time, so we're all reveled about that, all of us that have older children, so — but what I was referring to was under the current patient protection act, which does require insurance companies to guarantee issue coverage does require them to eliminate any preexisting condition limitation. In the absence of a mandate there, under that circumstance, the reality is people are always going to protect their best interest, it's just human nature, and if they could enroll for coverage when they walked in the hospital door, get the coverage they needed and drop it when they left, they would do that, I mean that's just human nature. I'm not saying all people would do that, but there would be a large enough number that it could — it would create an adverse selection situation,

so my comment was only relative to the Patient Protection Act and that it is important that we balance the insurance reform requirements with a requirement that everybody do their part and be responsible and purchase coverage, since it will be more affordable with the subsidies that are available.

MILA KOFMAN: I guess I'm more optimistic than you are, I do think that if the Affordable Care Act is fully implemented we will fundamentally change the way we do things. Our system is really irrational now. For instance, if you can't afford to go get preventative services done or to get diagnosed early, or even for instance if you have diabetes, if you can't afford the test strips and to get your blood test done every quarter, you get sick. And by the time you're in the medical treatment system, you're really, really sick and we're spending a whole lot of money on you, when it would have been a lot cheaper to prevent you from getting sick or control your chronic illness, so right now we do things in a very irrational and very expensive way.

In fact we let people die, preventable deaths each year, because our system of financing medical care is just so irrational. So, one of the things that I believe ACA will do is it will give us a more rational way of doing things, just with, you know, the current requirement that's already in effect, the preventative benefits, that ultimately will save

lives and make treating illnesses I think less expensive, because we'll be able to detect conditions early and allow people to go to the doctor when they should be going to see their doctors.

GARY CLAXTON: [Inaudible].

MILA KOFMAN: Okay, well I think we want to take a few more questions, but I'm happy to chat with you after the event to share more of why I think it will succeed in changing the way we finance our medical care.

GARY CLAXTON: We have a couple more — time for a couple more questions, over there.

AMY ZETTEL: Thank you. Hi, Amy Zettel [misspelled?] from Potomac Research Group. I have a question for you, Kim, if you don't mind. In the last panel a lot was talked about of how rate review may play into the exchanges and I'm wondering from an insurers perspective how — if there's any — if it will change the competitive nature of the insurance exchanges and if we're anticipating rate review to look differently under the exchanges versus outside of the exchanges.

KIM HOLLAND: Well, I'm sure you're aware that states have a lot of flexibility in terms of how they establish their exchange. Some will approach it where the exchange assumes more of a regulatory posture and may make decisions about what products are available in the market, to those states that will

not do that, that the exchange will be more of a market place with all of the required elements under the Patient Protection Act, but in terms of availability of products and so forth that will be open to those plans that can be deemed qualified to participate. So, I think depending on which way it's approached, rate review certainly can have an impact, much as it does in a market today. If you have — if you're only letting one or two carriers participate in the exchange, it may be a natural consequence to assert more authority over the rate making process.

I can tell you from the Blue Cross Blue Shield Association, we feel very strongly about consumers having the opportunity to buy products that are best suited to them, and that they have the option of choosing from an array of qualified health plans, so certainly our preference is that exchange model that allows all qualified plans to participate, but you know, that's at the state, that's the states prerogative, and again different environments and different cultures will dictate how that's approached.

GARY CLAXTON: I guess before we conclude I'd like to ask one question myself and this is mostly for Kim. I think we heard you say, I think several times, that you can't really use rate review to deal with underlying healthcare cost, cause that's the drivers, but in the system we have we sort of rely

on insurers to mediate between consumers and providers and so if we — if the rate review process can't ask anything about how insurers are doing that, what is it about our system that would help us or what is it that insurers should be held accountable for in terms of being able to address the — what they have put themselves and advocate to put themselves in a position to do, which is to be that mediator.

KIM HOLLAND: Well, and I think that's a great question, Gary. A couple of things just in terms of the environment, I would say to you that most insurance regulators don't have control over provider contracting, okay, you recognize that, that's not true universally, but in terms of network, the relationship between an insurer and the providers that they contract with in a non-HMO environment is generally something that is not a regulated component. So, there's certain dynamics and Teresa alluded to this in her comments. One I would recommend to you a recent health affairs article that suggests that actually the concentration of medical facilities, hospitals, and physicians actually has a greater impact on the cost of healthcare then insurance and the competitiveness of the insurance market.

So, you know, I think that there are certainly things insurance can do, there to your point, we buy insurance to manage care, now we don't really like it when they do, because

if an insurer says no, generally somebody's mad, right? I mean they'll go to the legislature, they're go to our regulator, I mean if it's a legitimate thing, and I can tell you from a quality insurance, from a quality insurer standpoint, not just the Blue's, but most quality insurers, they look at the quality based on what — to the extent they can based on outcomes, but also just on understanding that the circumstances and the environment, physicians are vulnerable and they want to say yes to a patient and I've interceded many times prior to being a regulator where a physician was recommending a treatment modality that wasn't appropriate and wasn't even indicated by the situation or actually could even be dangerous because the individual wanted it.

So, there's a lot of those kinds of dynamics that can be controlled through managed care, more evidence, more — the connection between claims data and clinical care data that really paints a whole picture for people as they move in and out of the system, you know, people are not tangent, so they don't go to the same doctor all the time, and certainly we're going to be expanding the availability of coverage to a population or new Medicaid expansion of individuals who could go from private sector back to Medicaid and back, we've got to connect all of those different systems, so physicians actually have what they need to properly treat a patient by having their

entire history and really have a clear understanding of what they're dealing with when a patient presents themselves.

All of those things in the insurance companies investments in making that possible actually working and supporting evidence based approaches, their own investment in quality tools are going to help the process, but it's, you know, it's a long way in coming, Gary, you know, it's an evolving process and again it's going to be one of those things that they're not going to be able to do that in a vacuum, and so I think the extent to which we can collaborate and that's one thing that insurers can do hopefully is get people to — get their providers to collaborate and work with them to produce better outcomes for what we all want and that's better patient outcomes, better treatment for our patients.

MILA KOFMAN: I'm just going to add a few words to that, when I was a regulator I saw a huge difference in what some insurance companies did, some really heavily invested in their clinical management care, into their IT systems, into their personnel, to really try to keep the insured person healthy, and when the person wasn't healthy to try to enable the person to access the kind of medical services that the person needed. So, there was a huge investment by some into actually managing care, others were a completely polar opposite of that, because

they knew that they can recover whatever their expenses are in rates.

So, there was this huge disparity in the market place and I think one of the things that will happen with 2014 and Affordable Care Act is that there will be more pressure on the entire industry to actually invest more into quality, into actually managing their insured population, because the competition that's currently in the marketplace that's based on underwriting and finding the healthiest of the healthy to insure, that's no longer going to be the norm, and the norm is going to be competition based on efficiency and quality, and so I think the carriers that are not investing now will ultimately have to do that to compete effectively for business.

KIM HOLLAND: I agree with that. I agree.

GARY CLAXTON: Well, with that I think we'll wrap up. I want to thank everyone for coming. I think two — over two hours talking about rate review is very laudatory for you all to want to be part of it. I think we learned a few things. The Affordable Care Act, even though it only requires that insurers justify rates that are unreasonable seems to have had a much bigger effect than what it looks like it did on paper. And there's been a lot of attention, both at the federal level and at the state level to how this is done, and a lot more transparency, and we're going to learn a lot more through that,

so thanks everyone for coming. And we appreciate it

[applause].

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.