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Consumer Advocate Input on New Jersey's Premium Rate Review and Reporting Process

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Table of Contents

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Executive Summary

The New Jersey Department of Banking and Insurance (DOBI) received funding from the U.S. Department of Health and Human Services to redesign and standardize its system of reviewing health insurance premium rates and reporting information to the federal government and the public. As part of this initiative, DOBI asked the Rutgers Center for State Health Policy (CSHP) to collect input from consumer advocates representing people with disabilities or chronic medical or mental health conditions from around the state on New Jersey's health insurance premium rate review and reporting process in an effort to tailor this process to meet consumer needs. Seven consumer advocates chose to participate in this study, and their input is summarized in this report. The following highlights areas of agreement among advocates.

- Participants had almost no prior knowledge of DOBI's premium rate review process.
- Consumers would like to see how insurers derive premiums and how premium dollars were spent in the previous year.
- DOBI should collect and review proprietary information including but not limited to cost trajectory assumptions, profit margins, and investment income used to determine premiums from health insurers.
- Consumers would benefit from a tool that shows how changes in specific benefits would impact their premium.
- Participants reported that consumers would prefer a large number of plan choices so that they could find the best plan to meet their needs.
- Insurers should be required to report and make public the added cost of each individual benefit mandate. The cost of each benefit mandate should not assume worst case adverse selection, but should be priced similarly to other benefits.
- Premiums should not be controlled by restricting specialist or hospital networks.
- Premiums could be controlled using tiered co-payment structures for prescription drugs.
- Consumers supported using profits from health insurance plans designed to attract healthier enrollees to subsidize the cost of plans that attract sicker enrollees.

- Information about insurance plans should be made available on the internet, in print, and through in person presentations.

Consumer advocates representing people with disabilities or chronic medical or mental health conditions disagreed in a few key areas. Some felt that broker and agent fees should be built into health insurance premiums, while others felt that they should be added on a case-by-case basis. The consumer advocates had no particular opinion on whether premium rate fluctuations should be averaged across years or whether more profitable health insurance markets (large group and Medicare) should subsidize less profitable markets (small group and individual).

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Introduction

The Patient Protection and Affordable Care Act (ACA) of 2010 included new state requirements for collecting and reviewing information on health insurance premium rates issued by private health insurance carriers. The U.S. Department of Health and Human Services (HHS) has stipulated specific information that states must collect and review on the pricing of health insurance plans. The ACA also offers states funding to improve their systems for collecting and reviewing premium rate information. System improvements should allow states to better report the required premium information to HHS. HHS also hopes that improved rate review processes could become more automated and efficient and offer consumers protections against unreasonable rate increases.[1]

New Jersey has more experience than some other states with premium rate review. However, New Jersey's system for reviewing premium rates has been largely manual. Staff of the New Jersey Department of Banking and Insurance (DOBI) has been responsible for collecting premium rate information, and managing data files. A credentialed actuary at DOBI reviews individual premium rate filings to determine whether submitted information meets regulatory guidelines. DOBI does not have the authority to approve or disapprove premium rates, but does review rate filing information submitted by insurers for compliance with state guidelines. Premium rate filing requirements vary by health insurance market. New Jersey does not require a standardized format for rate filing. Rate filings are evaluated for completeness, compliance with state laws, including rating bands and minimum loss ratios, consistency across similar plans, and reasonableness of projected medical care cost assumptions. DOBI does not currently review health insurers' investment income, federal income taxes, profits on other lines of business, or executive compensation. The individual and small group markets have minimum loss ratio requirements. Rates in these markets are reviewed retrospectively, and rates are adjusted and refunds issued if loss ratio requirements are not met.

[1] Department of Health and Human Services. "Grants to States for Health Insurance Premium Review-Cycle I: Initial Announcement, Invitation to Apply FY 2010." CFDA 93.511. June 7, 2010.

New Jersey has chosen to take advantage of funding available through the ACA to improve its premium rate review process. Under this grant, DOBI will develop standardized formats for rate filings, electronic filing and capture systems, and tools for analyzing and reporting the information. The new system will allow New Jersey to produce reports for HHS as well as for state entities.

In addition, DOBI is considering ways that the rate filing process might be made useful and available to consumers. DOBI contracted with the Rutgers Center for State Health Policy to collect input from consumer groups around the state on what they feel should be included in the premium rate review process and what information would be most helpful to their constituents. Following guidance provided by US DHHS, New Jersey has asked that Rutgers include in this study consumer groups that serve those with chronic illnesses and disabilities, including mental illness. Methods used to invite consumer input and lessons learned from these discussions are presented in this report.

Methods

In the winter 2010-2011, Rutgers Center for State Health Policy (CSHP) worked with DOBI to assemble a comprehensive list of consumer advocacy organizations that serve the needs of disabled and chronically ill state residents who are typically insured through New Jersey's private state-regulated health insurance markets, namely the non-group and small group markets. These organizations represent vulnerable populations who may benefit the most from enhanced premium rate review and reporting procedures. Consumer groups representing those typically insured by Medicaid, NJ FamilyCare, or Medicare were not included since modifications to the premium rate review and reporting process only affect the private state-regulated insurance markets. The final list consisted of nineteen organizations, including four representing disabled residents, eleven representing residents with various chronic health conditions, and four representing those with mental or addiction problems. This list is provided in Appendix A.

CSHP planned to hold three discussion groups and invite a representative from each organization to participate in the group most convenient to them. CSHP mailed letters out three weeks prior to the groups and followed up with phone calls to each organization. Seven organizations chose to participate (indicated in Appendix A). However, due to inclement weather and various scheduling difficulties, CSHP conducted an in-person discussion with one participant, five phone interviews, and one participant chose to email her responses. Participants included one organization representing the disabled, three representing those with chronic physical illness, and three representing those with mental illness and addiction.

CSHP used a discussion guide that was developed in consultation with DOBI. The discussion guide began with questions designed to ascertain the participant's understanding of

DOBI's current role in premium rate review, followed by questions about premium rate information that might be helpful to consumers and regulatory ideas to reduce premiums. The discussion guide is provided in Appendix B of this report. All documents and procedures for this project were reviewed and approved by the Rutgers University Institutional Review Board; and all participants received the approved informed consent document and were read an oral consent script before beginning the guided discussion.

Findings

Input gleaned from our interviews with seven consumer advocates representing people with disabilities or chronic medical or mental health conditions was summarized and is provided in detail in Appendix C of this report. Highlights of those findings are described here. To start, participants had limited understanding of DOBI's current role in reviewing health insurance premium rates. Five admitted having no knowledge of DOBI's premium rate review process. One believed that DOBI reviews rates for accuracy. Another thought that the public is currently given the opportunity to weigh in on premium rate increases.

All seven participants agreed that information about how an insurer spent premium dollars in the previous year would be helpful for the public. However, two participants felt that consumers would never be able to understand how premium rates are arrived at because the calculations are too complicated. All seven participants felt that it would be helpful for the public to view information about how a premium rate was derived. Participants also felt that DOBI should review proprietary information including cost experience that underlies rates, profit margins, cost trajectory assumptions, investment income, and presumed payments to agents and brokers, among other factors, that insurers use to calculate premium rates. However, only a small number felt that DOBI should have the power to approve this information, or that it should be made public. Participants felt that the process of DOBI reviewing this information would keep these assumptions reasonable. A few suggested DOBI publicize their assessment of how appropriate these proprietary charges are, without releasing detailed information.

Participants agreed that it would be helpful to see how changes to specific benefits might increase or decrease the premium rate. Most participants favored having a large number of plan choices because this would allow the consumers they represent to find the best plan to meet their needs. Most participants also felt that it was important to communicate plan information in a variety of ways so that consumers with differing disabilities could access information in whatever way works best for them. In particular, information should be available on the internet, in print, and through in-person presentations.

Participants disagreed on whether broker and agent fees should be built into all health insurance premiums or added on to the premiums of those who use their services. Those who

felt it should be included in all premiums indicated that these services are important to the consumers they represent, who may have limited ability to understand and compare plan benefits and determine which plans would best meet their health care needs. Others felt that consumers should have the ability to shop for a more affordable broker or not use one at all.

Ideas for stabilizing health insurance premiums were posed to participants. These ideas included averaging premium rate fluctuations across years, using profits from plans that attract healthy enrollees to subsidize plans that attract less healthy enrollees, and subsidizing higher cost health insurance markets with profits from more profitable markets. Participants had mixed feelings about these strategies. Only the idea of using profits from plans that attract healthy enrollees to subsidize plans that attract less healthy enrollees garnered any interest from participants.

Participants largely agreed that insurers should be required to report and make public the added cost of each benefit mandate and justify how they calculated the cost. Most participants felt that benefit mandates should not be priced assuming worst case adverse selection. A few strategies for pricing benefit mandates were raised, including using average expected cost or retrospective cost experience. One participant suggested that DOBI provide a standardized model for how insurers should price benefit mandates.

A few methods for controlling health insurance premiums were raised with consumer advocates to assess their desirability among chronically ill health care consumers. Participants did not support restricting specialist and hospital networks to control premiums. However, most felt that the tiered co-payment structure for prescription drugs is a reasonable method for controlling costs. But, two participants felt that this method limited access to needed treatments for consumers with multiple health conditions. Those with multiple health conditions may need a very specialized treatment regimen that may not fit into traditional prescribing patterns.

Participants disagreed on whether co-payments or co-insurance should vary based on the proven efficacy of a treatment. Some felt that this was reasonable. Others felt that consumers should have equal access to all health care so that their treatments could be tailored to meet their particular health care needs. One participant felt that information on the efficacy of different treatments should be more readily available to physicians so they can discuss the information with their patients when deciding on a course of treatment. Another suggested that reducing reimbursements to physicians for less effective treatments would be more effective. One participant felt that it was acceptable for less effective treatments to cost more as long as the costs are not out of line with other treatment options. For some with severe or multiple disabilities, treatments that work for the general population may not work for them, so access to other options should be maintained, even if at a somewhat higher cost. Participants also suggested that prior authorization procedures are an administrative burden

and not a good use of time and money. Case management might be a more effective way of managing cost and a better use of premium spending.

Discussion

The New Jersey Department of Banking and Insurance is working to improve and standardize its system of reviewing health insurance premium rate filings and reporting information to the public, as is required under federal health reform. DOBI asked CSHP to seek input from consumer groups representing patients with typically complex conditions around the state to inform this process. CSHP conducted interviews and collected information from seven consumer representatives representing those with disabilities and chronic medical or mental health conditions. Their opinions may not represent the views of other public interest groups. The information gathered in this project is intended to inform ongoing efforts by DOBI to review and refine its rate review procedures.

Findings indicate that consumer advocates have limited knowledge of DOBI's role in reviewing premium rates and insuring that they are reasonable and appropriate for consumers. In general, consumer groups were eager for more information on how premium rates were arrived at, how premiums were spent in the prior year, and most importantly, DOBI's assessment of whether rates are reasonable. Views on strategies to control cost were mixed, although there were some areas of consensus. Specifically, the advocates expressed concern about limiting specialty or hospital networks, they agreed that broad risk pooling across plans is important, and that better information and transparency is valuable. There was less agreement on tiered cost sharing based on evidence about medical effectiveness and cost sharing across health insurance markets.

Appendix A

NEW JERSEY CONSUMER ADVOCACY ORGANIZATIONS
INVITATION LIST FOR PREMIUM RATE REVIEW DISCUSSIONS

Note: Participant organizations are indicated in bold with an asterisk. *

Disability Advocates

Alliance for the Betterment of Citizens with Disabilities
Community Options, Inc.
Disability Rights NJ *
The Arc of New Jersey

Chronic Health Condition Advocates

Brain Injury Association of New Jersey
National Multiple Sclerosis Society – New Jersey Metro Chapter
Hemophilia Association of New Jersey *
Cerebral Palsy of New Jersey
The Spina Bifida Resource Network
Autism New Jersey *
The Hyacinth Foundation
American Diabetes Association – New Jersey
Diabetes Foundation, Inc.
Cancer Hope Network
Women's Heart Foundation *

Mental Health Advocates

Coalition of Mental Health Consumer Organizations
Mental Health Association in NJ *
National Alliance for the Mentally Ill – NJ *
NJ Association of Mental Health & Addiction Agencies, Inc. *

Appendix B

HEALTH INSURANCE PREMIUM RATE REVIEW DISCUSSION GUIDE

Broad Introductory Discussion

As a means of introducing the conversation, I would like to start by explaining that federal health reform, otherwise known as the Patient Protection and Affordable Care Act, gives states the opportunity to enhance their health insurance premium rate review and reporting methods. The New Jersey Department of Banking and Insurance, which I will refer to as DOBI from here on, regulates and reviews rates for fully insured health insurance products including those sold in the individual and small group markets, and to medium sized employers. Many large employers self-insure their enrollees and are subject only to federal regulation. DOBI also does not regulate traditional Medicare, although it regulates Medicare supplement insurance. DOBI is responsible for reviewing premium rates to ensure that they are appropriate given regulatory guidelines. These are the areas that we will be discussing today.

1. What is your understanding of the current DOBI rate review process? Is this process consistent with what you think it should be? If your expectations are not being met, what changes do you think are needed?

2. I think everyone here would agree that they think premium rates are too high. Are there ways that you think DOBI's rate review and reporting practices could be useful for reducing rates for your constituents or helping your constituents understand whether premium rates are justified? What information do you think would help? What actions do you think DOBI could take in reviewing this information?

Premium Information

3. Would it be helpful to see how insurers spent premium dollars in the previous year? (If needed) For example, would you like to see detailed breakdowns of types of administrative expenditures and spending on particular types of health services?

4. Would it be helpful to your organization to have access to more detailed explanations of how an insurance premium rate is calculated or derived?

a. In order to make premium rate calculations totally transparent, insurers would have to disclose information that is currently proprietary including releasing cost experience that underlies rates, profit margins, cost trajectory assumptions, investment income, presumed payments to agents and brokers, and other factors. Insurers contend that it is important that this information remain confidential as it helps them compete in the market and offer more competitive products.
    i. Do you think that this information should be reviewed by DOBI? How important is this?
    ii. Do you think that this information should be approved by DOBI? How important is this?
    iii. How much of this information should be publicly available? Is there an alternative to full transparency that would meet your needs?
    iv. Why?

5. Would it be helpful to see how changes to specific benefits might increase or decrease the premium rate, e.g., changes in co-payment levels, tiered benefit structures, or number of allowed visits, or admissions?

6. When shopping for health insurance would your constituents prefer to have a large number of plan choices, or only a few choices that are simpler and can be compared more easily in terms of benefits and cost? Why? Is there a way that your organization would prefer to have material presented (on the web, printed material, or in-person presentation)?

7. Brokers and Agents often assist group customers, and may assist individual customers in understanding choices and prices in the health insurance market and dealing with carriers. Brokers and agents may also perform some administrative duties, such as taking enrollment information, which would otherwise be performed by the carrier. Currently, insurers set aside a certain percentage of premiums in the individual and small employer markets to pay insurance brokers and agents. Applicants may also be able to learn about insurance products by contacting insurers directly or by shopping insurance plans online. Do you think that a set broker fee should be included in every insurance product, or should broker fees be added on separately to premiums so that consumers can shop around for a lower priced broker or not use a broker at all as a way of reducing premium cost?

Specific Regulatory Ideas

8. Many ideas exist about how to change the way that premium costs are charged. Here are a few. Please tell me what you think about these and whether there are any others that are of interest to you.
    a. Rate Stability – This approach averages premium fluctuations from year to year. So, rather than having a 2% rate increase in a year when costs did not rise much and a 15% rate increase the next year when costs rose more steeply, insurers might be required to charge an 8% increase in both years. Is this a good idea?
    b. Plan Cross Subsidization – Insurers tend to price insurance plans based on who they expect to enroll in the plan. So, more comprehensive plans tend to be costlier because they expect sicker people to choose them, while high-deductible plans that tend to attract healthier enrollees are priced more competitively. Should premiums be increased somewhat in the plans designed to attract healthier individuals to subsidize some of the cost of the sicker enrollees in more comprehensive or lower cost-sharing plans?
    c. Market Cross Subsidization – Should profits that insurers make in one insurance market, i.e. Medicare policies, or large group policies, be used to subsidize costs in other markets like the individual and small group markets?
    d. Any other ideas?

9. The impact of mandated benefits on premiums is not currently transparent. Insurers report premiums in aggregate so the marginal cost of each benefit mandate is not known. Opponents of mandated benefits claim that mandates add significant cost to health insurance premiums, while others believe that the costs are not great.
    a. Should insurers be required to report the added cost of each benefit mandate and justify how they calculated that cost?
    b. Publicizing the cost of each mandate may show that mandates are not as costly as was thought. On the other hand, publicizing the cost of individual mandates may make some mandates vulnerable to repeal. Do you think that these costs should be publicized individually?
    c. When insurers are required to offer specific benefits, they may price these benefits assuming worst case adverse selection. Do you think that this is an appropriate approach to pricing these benefits? Do you have any other suggestions for how mandated benefits ought to be priced?

10. What do you think about the way that plan benefits are structured?
    a. For example, most insurance plans have a two or three tiered structure for prescription drugs where copayments for certain more costly name brand drugs are higher than for lower-cost generic drugs or brand name drugs that are on a selected list or formulary. Is this benefit structure a good way of controlling premiums? Or, is there a better approach?
    b. Another benefit design that might control costs is to base copayment or coinsurance rates on the proven efficacy of each treatment option, so that treatments scientifically proven to be more effective would cost less than treatments that are less effective. Do you think this benefit structure is a good way of controlling premiums or improving outcomes?
    c. Are there any other specific benefit designs that may control costs, such as using restrictive networks of specialists and hospitals, which may not work well for your constituents? Are there other cost management strategies that you would suggest that help keep premiums down without creating barriers for your constituents?

11. Is there anything else that you would like to share about premium rate review and reporting in New Jersey?

Appendix C

SUMMARY OF CONSUMER ADVOCATE INPUT ON NEW JERSEY'S PREMIUM RATE REVIEW AND REPORTING PRACTICES

1. Understanding of DOBI's role in premium rate review
   - No knowledge of DOBI's rate review process (5)
   - Reviews for accuracy (1)
   - DOBI should be able to compel insurers to fully justify the premium rate (1)
   - DOBI should have broader oversight of other markets, including self-insured (1)
   - Believes that the public is currently offered the opportunity to weigh in on rate increases (1)

2. Ways that DOBI's rate review process might reduce premiums or justify premium rates
   - Full disclosure of information that goes into rates (1)
   - More information about plan options (1)
   - Consumers should be made aware of DOBI's website, which has a lot of information that would be useful to them (1)
   - Consumers can not understand how premiums are calculated, too confusing (2)
   - Problem with high premiums is providers practicing defensive medicine (1)
   - Use Minimum Loss Ratios to control premiums (1)

3. Would it be helpful to see how premiums were spent in the previous year
   - Yes (7)

4. Would it be helpful to see information on how premium rates were derived?
   - Yes (7)
   - Proprietary information should be reviewed by DOBI (7)
   - Proprietary information should be approved by DOBI (2)
   - Proprietary information should be made public (3)
   - DOBI should publicize their assessment of how appropriate those proprietary charges are without releasing the proprietary information (3)

5. Would it be helpful to see how changes to specific benefits might increase or decrease the premium rate?
   - Yes (7)

6. Large number of plan choices OR fewer choices that can be more easily compared?
   - Large number (4) – More choices allows consumers to find the best plan to meet their needs.
   - Small number (2) – Too many choices can be confusing.
   - Not too many, not too few (1)

   How plan information should be presented, web, print, in-person presentation?
   - Web (6)
   - Print (6)
   - In-Person Presentations (5)

7. Broker and Agent fees included in premiums?
   - Should be included in all premiums (2)
   - Should only be included in the premiums of those who chose to use an agent or broker (3)
   - Don't know (2)

8. A. Rate Stability – Averaging rate fluctuations across years.
   - Yes (2)
   - No (1)
   - Don't know (4)

   B. Plan Cross Subsidization – Subsidizing comprehensive plan premiums with profits from plans designed to attract healthy enrollees
   - Yes (4)
   - No (1)
   - Don't know (2)

   C. Market Cross Subsidization – Subsidizing more costly markets (small group and individual) with profits from more profitable markets (large group, Medicare)
   - Yes (2)
   - No (3)
   - Don't know (2)

   D. Other Thoughts
   - Perhaps there could be a system where people could contribute a small amount from their pay checks throughout their lives into some kind of savings account or membership plan that would then allow them to have access to more affordable premiums when they are older and would otherwise face higher premiums.

- Insurance rates in the individual market are extremely high and increase every year by the full amount allowed by regulation. This may be done in an effort to deter individuals with chronic illness from enrolling. This discriminatory practice targets our most vulnerable populations.
- Associations should be brought together for individuals and small employers so they can get rates like large groups.
- Prior Authorization is a waste of time and money. It is not effective at controlling costs. Just an administrative hassle. Case management is an effective way of managing cost and a good use of premium spending.

9. A. Should insurers be required to report the added cost of each benefit mandate and justify how they calculated the cost?
   - Yes (6)
   - Don't know (1)

   B. Should the costs of individual mandates be publicized?
   - Yes (6)
   - Don't know (1)

   C. Should benefit mandates be priced assuming worst case adverse selection or a different method?
   - No (6)
   - Don't know (1)
   - Should use average cost (3)
   - DOBI should provide a standardized model for how insurers should price benefit mandates (1)
   - Costs should be based on retrospective experience not a prediction of what costs might be in the future (2)

10. A. Tiered co-payment structure for prescription drugs
   - Good way of controlling premiums (4)
   - Bad way of controlling premiums (2)
   - Don't know (1)

   B. Basing co-payments or co-insurance on the proven efficacy of a treatment
   - Good way of controlling premiums (3)
   - Bad way of controlling premiums (3)
   - Don't know (1)

   C. Restrictive specialist and hospital networks
   - Bad way of controlling premiums (5)

- Don't know (2)

D. Other ideas for controlling premiums without creating barriers for consumers

- Consumers should have open access to the health care system. Co-pays should be the same regardless of the drug, efficacy of the treatment, or whether the provider is in a network. Different drugs, treatments, or providers might be best for different kinds of patients, especially those with multiple health issues and they should have equal access to all of their options so that they can get the best care. (2)
- Using medical homes and acute care organizations to manage care for consumers is a better method for controlling cost without creating barriers to care. (1)
- Eliminate insurance fraud. (1)
- Information on which treatments are most effective should be more accessible to providers so that they can discuss this information with their patients when deciding on a course of treatment. Sometimes more expensive treatments are chosen when research shows that there are cheaper and more effective options. But providers want to do the more expensive procedures. (1)
- Maybe reducing reimbursements to physicians for less effective treatments would be a better way of controlling cost. (1)
- Okay for less effective treatments to cost more, as long as the costs are not out of line with other treatment options. For some with multiple or severe disabilities, things that work for the general population may not work for them so they should still have access to other treatment options, even if at a somewhat higher cost. (1)

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