

Rate Regulation

Introduction

Concerns over the fairness and equity of insurer rating practices that attempt to charge higher premiums to those with higher actual and expected claims costs have increased as insurers have identified case characteristics that allow them to pinpoint with increasing accuracy those individuals who will incur high costs. While these practices may have the effect of accurately assigning actuarially appropriate premiums to higher risks, they also tend to reduce the pooling of risk between low-cost and high-cost individuals, the core function of insurance.

In response to these concerns, states have developed a number of ways to regulate the characteristics that insurers use to vary premiums charged to different individuals and businesses in the marketplace. In developing rate regulations, policymakers must be aware that any decisions regarding the variation of premiums will create winners and losers in the marketplace. Loose restrictions will be generally favorable to low-cost individuals and businesses, resulting in higher premiums for older, sicker individuals. Tighter restrictions, on the other hand, result in higher premiums for young, healthy individuals and businesses to offset lower premiums for older, sicker individuals and businesses. The desire for equity must also be balanced with the need to avoid the adverse selection that can arise when low-cost individuals decide that the higher premiums they pay are not worthwhile given their expected needs and drop out of the market, resulting in a sicker risk pool and higher premiums.

Types of Rate Regulation

There are four main types of rate regulation in place in the individual and small group markets today:

Actuarial Justification: In markets with actuarially justified rating requirements, insurers must demonstrate a correlation between case characteristics and increased medical claims costs. The NAIC has adopted safe harbors for case characteristics commonly used for setting premiums within which plans may generally vary rates without providing justification. Plans that vary rates in excess of these safe harbors may be required to submit data justifying their use of the characteristics in question.

Rating Bands: Particularly in the small group market, many states have implemented rating bands that limit the variation in premiums attributable to health status and other characteristics. Rating bands are either expressed as a ratio of the highest rating factor to the lowest (*e.g.* 1.5:1) or as the allowable variation above and below an index rate (*e.g.* +/- 30%). Rating bands may also take the form of composite rating bands that place limits on the combined effects of multiple case characteristics (*e.g.*, a composite rating band that allows 4:1 variation based upon health status, age, gender, industry, and group size combined).

Adjusted Community Rating: Adjusted (or modified) community rating laws prohibit the use of health status or claims experience in setting premiums. Other case characteristics, such as age and geography, may be used to vary premiums, though limits may be placed upon these factors as well.

Community Rating: “Pure” community rating laws prohibit the use of any case characteristics besides geography to vary premiums. This form of rate regulation is rarely used.

Commonly Used Case Characteristics

Health status and claims experience: The most direct way for insurers to base premiums on expected costs for an individual or group is to use health status information collected during the underwriting process or claims experience for policies being renewed. Most states that allow health status to be used for rating purposes in the small group market limit it using rating bands that vary from +/-10% to +/-60%. Premium increases due to changes in a business' health status are limited to 15% per year in most states.

Age: Because an individual's health status deteriorates as he or she grows older, leading to increased claims, age has become one of the most commonly employed case characteristics. Under the NAIC safe harbor guidelines, overall variation of 5:1 or less is reasonable in the small group market based upon the expected claims costs of 22-year-olds and 62-year-olds.

Gender: During childbearing years, women can be expected to incur medical costs that are more than 45 percent higher than men, excluding the costs of normal maternity coverage. (Including normal maternity costs, the difference may be as much as 270 percent.) The difference in expected claims narrows with increasing age and by their mid-50s men surpass women. At age 62, men can be expected to have costs that are at least 17 percent higher than women.

Group size: Insurers often charge higher rates to smaller companies for a two main reasons: 1) it is more expensive to issue and service a policy for a very small business than for a larger one; and, 2) small employers purchasing coverage are more likely to have more knowledge of their employees' potential future needs for health care services, creating a greater risk of adverse selection for the insurer. This risk is higher in a guaranteed issue environment where denial of coverage based upon underwriting criteria is prohibited, and businesses with 1-4 employees may be charged as much as 20% than those with 10-24 employees.

Industry and occupation: Working conditions and the type and lifestyles of workers may lead to higher claim costs in some industries than in others. The NAIC has adopted a safe harbor of 15 percent for premium variation due to industry in the small group market. Occupation is also often used as a factor in the nongroup market.

Geographic location: The cost of delivering care varies dramatically from one area to another, and insurers often vary their rates by county or by ZIP-code using the employer's business address in the small group market, or the applicant's home address in the individual market. Safe harbors for geography have been set for each state, depending on the variation in medical costs within the state, and range from no variation in the District of Columbia to 1.9:1 in Florida.

Duration of coverage: In medically underwritten, guaranteed-renewable markets, an insurer has the best picture of the health of enrollees on the date that they submit their application. Over time, enrollees' health may deteriorate from what it was at the time of application, leading to higher claims costs. To offset this, insurers in the individual market will often charge higher premiums to individuals who have been enrolled in the same plan for several years. This practice has the perverse incentive of encouraging healthy enrollees who can pass medical underwriting to reapply in order to get the lower, new enrollee rate, exacerbating the very phenomenon it is attempting to fix.

Wellness: In recent years, several states have allowed carriers in the individual to provide premium discounts or other incentives to individuals participating in wellness programs in order to encourage them to adopt healthier lifestyles. In practice, this has been a difficult policy to implement without allowing carriers a back-door way to use health status in setting premiums, and in at least one state where it is allowed no carriers are using it. State flexibility and further study of the best way to use wellness in setting premiums may be warranted.

Pooling of Risk

In applying rating factors, carriers will group policyholders into classes and blocks of business.

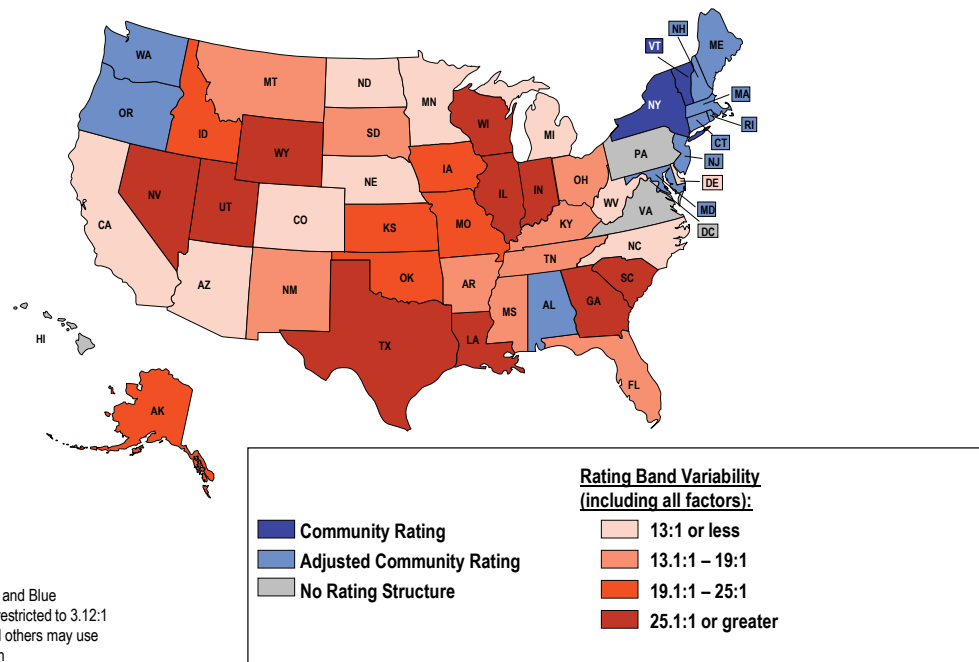
Class of Business: Insurers will maintain different “classes of business” that reflect administrative differences in how policies within them were sold or acquired by the company. For instance, a company may maintain one class of business composed of policies sold by its agents in the regular market, a second class of business may contain policies sold through a purchasing pool, while a third may be made up of policies that were acquired from another insurer. Most states limit both the number of classes that an insurer may maintain and the variation of premiums between classes. Most states with community rating or adjusted community rating disallow the maintenance of separate classes of business. The 1993 NAIC Small Employer Health Insurance Availability Model Act, which is the basis of most states’ small group rate regulation, limits carriers to nine classes of business and limits the index rate for the highest priced class of business to 120% of the index rate for the lowest priced class of business.

Block of Business: Insurers will also group business by the form of the policy, creating a block of business. In the individual market, carriers will also create “rating blocks” based upon initial health status classification. For instance, a carrier may group all new business that is charged a 25 percent health adjustment into a single block and then apply experience adjustments to the entire block, rather than reunderwriting each renewed policy every year. When carriers stop actively selling a block of business, the result is a closed block, which can experience rate spirals as those who can pass medical underwriting purchase other coverage, leaving a pool of risk that becomes progressively sicker. In the small group market, limitations on the use of rating factors apply across all blocks of business.

Small Group Market

In the small group market, nearly all states have enacted some form of rate regulation. Rating bands are the most prevalent form of regulation in this market, with most states basing their statutes on the NAIC’s 1993 Small Employer Health Insurance Availability Model Act. Nine states (AL, CT, MA, MD, ME, NH, NJ, OR, WA) utilize adjusted community rating, while two states (NY, VT) employ community rating. Three states (HI, PA, VA) plus the District of Columbia have not enacted legislation regulating premium variation in the small group market.

Small Group Premium Variation



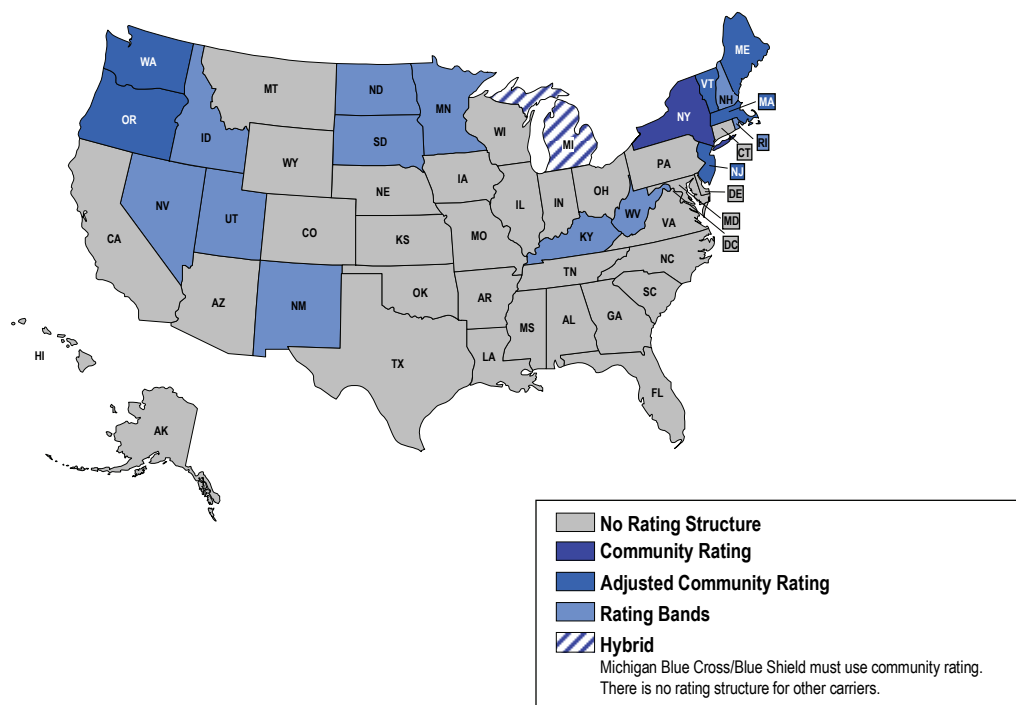
Nearly every state requires all risk within a class of business to be pooled together, and limits the variation between different classes of business, effectively tying together the premiums of every small business covered by every carrier.

While there is a risk of adverse selection resulting from rating restrictions in the small group market, it is mitigated somewhat by the fact that businesses are rated based upon the averaged characteristics of all their covered employees and by the fact that employers often pay a large percentage of the premium, making it unlikely that young, healthy employees will find better deals by shopping on their own for coverage.

Individual Market

Rate regulation in the individual market is far less prevalent than in the small group market. One state (NY) has enacted community rating, six (MA, ME, NJ, OR, WA, VT) have adjusted community rating, and eleven have implemented rating bands (ID, KY, MN, ND, NH, NM, NV, RI, SD, UT, WV). The remaining 32 states, plus the District of Columbia have not enacted rating restrictions in the individual market. These states rely upon actuarially justified rating. Rating restrictions are particularly challenging to implement in the nongroup market due to the increased risk of adverse selection that results from a voluntary market in which every individual is rated on his or her own characteristics and is paying the full cost of coverage.

Individual Market Rating Rules



Below are the details of individual market rating rules in selected states:

Actuarial Justification (31 states and DC): No limitations set in law
Alaska, Arizona, California, Montana, Wyoming, Colorado, Texas, Nebraska, Kansas, Oklahoma, Iowa, Missouri, Arkansas, Louisiana, Wisconsin, Illinois, Tennessee, Mississippi,

Indiana, Ohio, Alabama, Georgia, Florida, Pennsylvania, Maryland, Delaware, Virginia, North Carolina, South Carolina, Connecticut, Hawaii, DC.

Rating Bands (11 states): Health status may be used, but within limits

- **Kentucky:** Rate band on health: 2.08:1. Composite rate band for age, gender, industry and occupation: 5:1.
- **Nevada:** Variation due to health status may not exceed 1.75:1. Age, sex, occupation, geography and family composition may also be used.
- **New Hampshire:** The use of health status is limited to 1.5:1. The use of age is limited to 4:1. The use of tobacco use is limited to 1.5:1. Rating for health status may not be changed after issuance of policy
- **New Mexico:** Within any age group, health status may be used to set premiums within a 250% composite rate band that also includes a maximum variation of 20% due to gender.
- **Rhode Island:** Rhode Island has one carrier in the non-group market, which may use health status, age, and gender to vary premiums. Limits on these factors are negotiated between the carrier and the Health Insurance Commissioner.
- **Utah:** Premiums may not be increased from the index rate by more than 30% due to health status. There is no restriction on reductions from the index rate due to health status. Any adjustment for health status at renewal may not exceed 15% applied to an entire class of business.

Others are **Idaho, North Dakota, South Dakota, West Virginia, and Minnesota.**

Adjusted Community Rate (6 states): No health status rating – other factors allowed

- **Maine:** Premiums may vary by age and geography. All premiums must be within 20% of the community rate, meaning the limit on variation is 1½ :1. Legislation was enacted to allow age-based discounts up to a maximum 2½:1 variation, effective 7/1/2009, but was never implemented because the discounts were to be supported by a reinsurance pool and the funding mechanism for the reinsurance pool was repealed.
- **Massachusetts:** Non-group market has been merged with small group market. Composite rate band of 2:1 for age and geography. Additional adjustment of .95:1.10 for group size. Adjustments for smoking and wellness program participation are allowed, but are not used by any carriers.
- **Washington:** No health status allowed. Age, geography, tenure discounts, and wellness activity discounts may be used to set rates. Age is restricted to 3.75:1.

Others are **Oregon, Vermont, and New Jersey.**

Community Rate (2 states): No variation besides geography

- **New York**
- **Michigan:** Blues Plan only, other carriers may use rating factors