Actuaries Club of Hartford &
Springfield Annual Meeting
November 17, 2011

Health Care Reform/ Legislative Update

Mary Ellen Breault
Director, Life and Health Division
Connecticut Insurance Department

Revisions to Rate Filings

- Bulletin HC-81-2 Guidelines for Rate filings effective May 31, 2011 revised Bulletin HC-81 to add requirement to file capital and surplus data to comply with effective rate review process
- CT has prior approval authority over individual rates and group rates for Health Care Centers (HMO)
- Bulletin HC-81 required indemnity small group rates to be filed (not just those over 10%), but rates are not subject to prior approval
- CID hired an actuarial consultant to help review small group filings as part of CT's rate review grant

Association Business

- Bulletin HC-88 modifies treatment of Associations for rate and form filings
- CT historically treated association plans as group since there was a master policy and certificates issued to members
- HHS recently provided guidance on rate filings for associations
  - Associations of individuals subject to rate review as individual coverage
  - Associations of small groups subject to rate review as small group coverage
- For consistency, CT will now treat associations of individuals as individual subject to all statutory requirements of individual plans
  - Filing requirements of individual plans
  - Prior approval for rates
- Associations of small groups continue to be subject to small group requirements including Bulletins HC-46 and HC-81-2
- Bulletin applies to all health products sold through associations

Rates Increases

- Governor vetoed a bill that required public hearings for rate increases
- Insurance Commissioner and Health Care Advocate agreed to hearings:
  - when requested by the Health Care Advocate;
  - in accordance with the Uniform Administrative Procedure Act (Chapter 54 of the General Statutes);
  - for rate increases of at least 15 percent or more;
  - on individual medical insurance plans, whether offered by an insurance company or an HMO and small group health insurance (groups with 50 or fewer employees) offered by an HMO
  - up to four hearings per calendar year
- Effective 9/1 any rate increase in the individual or small group market over 10% must be reviewed for reasonableness
- 10% measured over entire year so if a quarter exceeds 10% it does not necessarily trigger an unreasonable rate review
- CT has an effective rate review process, so will complete these reviews
- As part of Cycle I Rate Review Grant, CT has purchased the Milliman Pricing Model and will incorporate its use into our rate review process
- Since 9/1, no filing has met this threshold

Minimum Loss Ratio

- Individual and small group plans must meet MLR of 80%
- Large group plans must meet MLR of 85%
- Filings are due May 31, 2012 for 2011
- Issue of premium holidays raised to avoid rebates
- CT will not approve premium holidays
  - Appearance of circumventing PPACA
  - Potential violation of CT's rebate laws
  - May not impact all appropriate policyholders
- NAIC Health Actuarial Task Force will review MLR formula to incorporate risk adjustment
- Adjustment for commissions may resurface, but will require federal statutory change

Impact of Federal Mental Health Parity

- Bulletin HC-87 clarified allowable copays for mental health services to comply with federal parity
  - CT mandates mental health coverage and has full mental health parity in individual, small and large group markets
  - Federal regulation provided 2 tests to determine maximum cost sharing level
    - Substantially all-cost sharing applied to at least 2/3 of all services in classification
    - Predominant-cost sharing level that applies to more than ½ services in classification (can combine levels to meet 50%, but lower amount prevails)
  - Initial guidance from HHS regarding regulation was that mental health office visit copay could not be higher than copay for primary care physician regardless of substantially all/predominant tests
  - HHS later revised guidance to allow use of the tests to determine if a higher specialist copay could apply
  - If plan has higher copay for specialists, actuary must certify and provide a demonstration that substantially all and predominant tests are met as part of form filing
  - After initial approval, must file demonstration annually

Mandated Benefits

Bulletin HC-70-11 provides notice of newly required coverages for health:

- Cost sharing prohibited for early intervention services in Birth to 3 program
- Annual limits for Birth to 3 for Children with autism increase to $50,000/year
- Enacted compliance with PPACA
  - Coverage for dependent children to age 26 revised to remove residency and non-married status
  - No pre-ex limitation for children under 19
  - Prohibits lifetime limit on essential benefits; set minimum $1 million on non-essential
- Policies with dental coverage must disclose that non-par dentist may balance bill
- Expands coverage for mammography to include MRI

Mandated Benefits continued

- Cost-sharing prohibited for any additional colonoscopy ordered in a policy year
- Coverage for expenses of testing for bone marrow donor match
- Prohibits plans with prescription coverage from requiring use of alternative brand name or over-the-counter drugs
- Expands coverage of routine costs of cancer clinical trial to include clinical trials for disabling or life-threatening chronic diseases
- Coverage for treatment of prostate cancer

Changes to Utilization Review, Internal and External Appeals processes

- UR expanded to include retrospective reviews
- Internal and external appeals processes amended to follow NAIC model in accordance with PPACA requirements
- Public Act 11-58 made changes effective July 1 in anticipation of original federal requirements
- Carriers were required to file forms as of July 1 certifying compliance, but were allowed to use them prior to approval so business could continue
- CID will review and require changes if non-compliant
- CID published several Bulletins as guidance
    - HC-82 Form Filing Guidelines
    - HC-83 Process and Timelines
    - HC-84 Revisions Licensing Requirements eff. July 1
    - HC-86 Renewal Licensing Requirements

Exchange Planning and Implementation

- CT plans to operate a state exchange
- Planning run out of Office of Policy and Management
- Enabling legislation has been passed
- Exchange is set up as a quasi-public agency overseen by Board
- Exchange Board members appointed (14 members/11 voting)
- Insurance Department is non-voting member
- Insurance Department will regulate entities that participate in the exchange
    - Licensing companies
    - Financial reviews
    - Form and rate filing reviews
    - Market conduct
- Stakeholder meetings held
- CT received planning grant ($1million)
- Public forums held
- Consultant hired as part of planning grant

Exchange Planning and Implementation continued

- Completed survey of carriers regarding existing business
- Consultant report due in December
- CT received $6.7 million Level I grant for further planning and development and to hire executive staff
- CT was not an early innovator state, but is participating with New England States Consortium Systems Organization
- Search for CEO for Exchange
- RFP posted for development of business operations, IT functions and consumer assistance (Responses due November 16)
- CT will have to develop a temporary reinsurance mechanism
- CT will have to decide if state will seek alternative risk adjustment mechanism or implement federal program
- General concerns regarding timeline and state flexibility
- HHS has developed a partnership model if states are not able or willing to develop state exchange

Other Health Care Reform Activities

- Multipayer Data Initiative
  - A working group has been convened to develop and implement a statewide multipayer database
  - Database will be used to increase efficiency, enhance outcomes and understand health expenditures in public and private sectors
- Sustinet Health Care Cabinet
  - 28 member cabinet within the office of the Lt. Governor
  - Task is to advise the Governor and Ofice of Health Reform and Innovation on the development of an integrated health care system in CT
- COOPS will be subject to insurance regulatory requirements
  - Must be licensed
  - Must file forms and rates

QUESTIONS

RESOURCES

All bulletins can be found on the Connecticut Insurance Department website:

www.ct.gov/cid

Contact information:

Maryellen.breault@ct.gov

860-297-3857