

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105**

INITIAL STATEMENT OF REASONS

**LOSS RATIO REGULATION FOR
INDIVIDUAL HEALTH INSURANCE POLICIES**

DATE: July 21, 2011

REGULATION FILE: REG-2011-00005

**TITLE 10, CALIFORNIA CODE OF REGULATIONS
CHAPTER 5 SUBCHAPTER 2, ARTICLE 1.9, SECTION 2222.12**

INTRODUCTION

The purpose and intent of these proposed amendments is to implement the mandate of Insurance Code section 10293, which requires that the benefits provided under a policy of individual health insurance must be reasonable in relationship to the premium charged. The proposed amendments would require that health insurers in the individual market in California will have to demonstrate both (1) compliance with the existing 70% lifetime anticipated loss ratio standard prescribed by section 2222.12, so that consumers are assured of receiving reasonable benefit value for their premium dollars on a policy-form basis, as well as (2) compliance with the 80% federal standard on a market-segment basis at the time of the Department's rate review, so that consumers can have the benefit of the federal medical loss ratio from the outset of the rate, rather than having to wait from eight to twenty months for a premium refund.

Background

Summary of Existing Law

Insurance Code section 10293, originally enacted during the 1961 legislative session, requires, among other provisions, that the Insurance Commissioner withdraw approval of individual or mass-marketed policies of disability insurance "if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged."¹ The same Insurance Code section also requires that the Insurance Commissioner promulgate "such reasonable rules and regulations...as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy."² As a result, on November 30, 1962, the Insurance Commissioner ordered that a new Article 1.9, consisting of sections 2222.10 to 2222.19, be added to the California Administrative

Code.³ This article adopted a 50% “loss ratio” as the means to determine whether the benefits provided by a policy were reasonable in relation to the premium charged. A loss ratio is a measure used to evaluate the reasonableness of the benefits provided by a hospital, medical or surgical policy. Here, the “loss ratio” is the ratio of incurred claims to earned premium. In 2006, section 2222.12 was amended to change the loss ratio standard to 70%, and to permit insurers to consider disease management expenses.

Policy Statement Overview

1) Federal Health Reform

The federal Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (Pub. L. 111-152) was enacted on March 30, 2010. Collectively, these two statutes are referred to as the Affordable Care Act (“ACA”). Among the health insurance market reforms of the ACA, section 2718 (42 USCS §300gg-18), entitled “Bringing Down the Cost of Health Care Coverage,” provides that, beginning January 1, 2011, health insurers offering coverage in the individual market must achieve at least an 80% loss ratio. Further, if the insurer does not meet the required minimum loss ratio, it must provide a refund the following calendar year. The Department of Health and Human Services subsequently issued an Interim Final Rule, 45 Code of Federal Regulations Part 158 (Dec. 1, 2010, with technical corrections issued Dec. 30, 2010) which described the factors, scope, and method used in the federal calculation. This Interim Final Rule provides that insurers must report their federal medical loss ratio outcome for a calendar year by June 1 of the following year (45 CFR § 158.110). Thus, for calendar year 2011, the report is not due until June 1, 2012, and premium rebates are not due until August 1, 2012 (45 CFR § 158.241).

The loss ratio calculation method used in the existing California regulation uses a different calculation method than the federal loss ratio. The 70% minimum loss ratio in existing section 2222.12 is a lifetime anticipated loss ratio, which involves projections into the future based on actuarial assumptions regarding factors involved in the ratio, including medical cost inflation, future claims, durational effects, and other factors. The 70% minimum loss ratio is determined at the level of specific policy forms. In contrast, the federal 80% minimum loss ratio involves different factors, is retrospective in nature, and is determined based on an aggregation of the loss ratios for all of the insurer’s individual health insurance forms. Further, the federal 80% minimum loss ratio includes factors, such as premium tax and HIPAA Guaranteed Issue business costs, which are not included in the California 70% loss ratio calculation. This amendment to the regulation conforms the California regulation to the requirements of federal health reform, while preserving the consumer protections of the existing loss ratio standard.

2) Purchasers of individual hospital, medical, or surgical policies lack expertise and market power

One of the most significant factors facing purchasers of individual hospital, medical, or surgical insurance is the disparity in expertise and market power between the purchaser and the insurer. While large purchasers of group health insurance have expertise in judging the level of benefit, and some market power in negotiating benefits, small groups and individuals lack such expertise

and market power. In part as a result of this disparity, the market for individual insurance does not function at full efficiency. In addition, in part because of this disparity, loss ratios for individual health insurance policies are lower compared to the ratios seen in group health insurance.⁴

3) Purchasers of individual hospital, medical, or surgical policies bear an increasing economic burden

Consumers who purchase individual hospital, medical, or surgical insurance policies face a growing economic burden, as both premium costs and out-of-pocket expenses have significantly increased. This economic burden is consistent with larger trends in health care costs. In the past decades, health care spending in the United States has outpaced the general rate of inflation.⁵ Nationally, the amount spent per person on health care increased 74 percent between 1994 and 2004.⁶ In addition to the increase in health care costs, the nature of the expenses has changed over the past 20 years, shifting to areas for which the individual hospital, medical, or surgical insurance policyholder often must pay a significant portion of the expense. For example, between 1984 and 2004, the amounts paid for prescription drugs, as a percentage of national health expenditures, increased from 4.9% to 10.0%.⁷ From 2001 through 2004, the average annual growth rate in national health care expenditures was 8.4 percent.⁸ In the California individual hospital, medical, or surgical insurance market, premiums rose almost 40 percent between 1997 and 2002, in contrast to an approximately 12 percent rise in the prices of other goods and services, as measured by the Consumer Price Index, over the same period.⁹ Since section 2222.12 was last amended in 2006, the disparity between the rate of increase of health insurance premiums and the overall rate of inflation has become even more dramatic: while cumulative overall inflation between 2006 and 2010 was 12%, the cumulative rate of premium increases for individual and group insurance over the same five years was 48%, four times the rate of overall inflation.¹⁰ Moreover, in the individual market recent increases have been more extreme. In 2010, the Kaiser Family Foundation reported that the most recent premium increases imposed by insurers in the individual market averaged 20%.¹¹

4) Purchasers of individual hospital, medical, or surgical policies are a vulnerable population

While this environment of rising costs poses challenges for purchasers of individual hospital, medical, or surgical insurance, additional factors make these purchasers particularly vulnerable.¹² First, the individual hospital, medical, or surgical insurance market is the last resort for many; California has a higher rate of persons without insurance and lower rates of employer-sponsored coverage than does the nation as a whole.¹³ In addition, the need for individual hospital, medical, or surgical insurance has been increasing due to corporate downsizing.¹⁴ Those who are not fortunate enough to receive insurance through their workplace and are not eligible for public programs must attempt to obtain coverage in the individual market. Once covered by individual insurance, many consumers rely on maintaining that coverage for years. In California, the individual insurance market is an important source of long-term hospital, medical, or surgical insurance coverage for a sizable fraction of those who purchase it.¹⁵

A second factor that confronts purchasers of individual hospital, medical, or surgical insurance

policies is the fact that products in the individual market are difficult to qualify for because they are carefully underwritten to manage risk. A third factor is the rapidly increasing cost of individual insurance. High premiums and the low incomes of many of the potential purchasers of individual insurance make affordability a particular concern.¹⁶ The increasing expense of individual hospital, medical, or surgical insurance reduces affordability, which in turn reduces availability for consumers who might otherwise be forced to go without vital hospital, medical, or surgical insurance coverage. Also, inadequate benefits in individual insurance coverage can be a major source of underinsurance, which affects 13-20 percent of the privately insured.¹⁷ On average, coverage in the individual hospital, medical, or surgical insurance market is less complete than coverage in the group market.¹⁸ Thus, purchasers of individual hospital, medical, or surgical insurance are faced with rapidly increasing health care costs in general, as well as even more rapidly increasing premiums for individual coverage. Because they have no realistic alternative to individual coverage, such persons are at risk of being priced out of the individual insurance market, and joining the large number of uninsured Californians.

SPECIFIC PURPOSE AND REASONABLE NECESSITY OF PROPOSED REGULATIONS

The specific purpose of each adoption and the rationale for the determination that each adoption is reasonably necessary to carry out the purpose for which it is proposed are set forth below.

Proposed Amendments To:

Title 10, California Code Of Regulations

Chapter 5 Subchapter 2, Article 1.9, Section 2222.12, “Standards For Determining Whether Benefits Of An Individual Hospital, Medical Or Surgical Policy Are Unreasonable In Relation To The Premium Charged Pursuant To Subdivision (C) Of Section 10293”

Pursuant to the authority granted by Insurance Code section 10293, which provides that the Insurance Commissioner (“Commissioner”) may promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary to establish the standard or standards by which to determine whether the benefits provided under the policy are unreasonable in relation to the premium charged, the Commissioner has determined that amending the existing regulation to incorporate the federal loss ratio requirements necessary to establish standards for determining the reasonableness of the premium in relation to the premium charged for individual health insurance policies, so that the adverse impact of increasing health insurance premiums for vulnerable consumers in the individual market can be moderated through implementation of both the existing state, and new federal, medical loss ratio standards.

In addition to the above reasons, further specific reasons for the amendments made to each section are as follows:

AMEND SECTION 222.12. "STANDARDS OF REASONABILITY"

The authority of the commissioner under Insurance Code Section 10293 being to withdraw approval of policy forms the benefits of which are not reasonable in relation to the premium charged, whether the approval of any form of an insurer should be withdrawn pursuant to said section shall be determined by an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop. Some of such factors which will be considered by the commissioner are hereinafter in this article set forth, but their listing does not preclude an-insurer from urging any other factors which it considers relevant to the issue involved.

(a) Benefits provided by a hospital, medical or surgical policy shall be deemed to be reasonable in relation to premiums ~~if either~~ if both of the criteria in subdivisions (1) and (2), below, are satisfied:

(1) (A) the lifetime anticipated loss ratio is not less than 70%, and ~~(2) (B)~~ in the case of a rate revision, the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage is also not less than 70%, or, if the insurer chooses to include disease management expenses in determining compliance with these standards, ~~(3) (C)~~ the sum of the lifetime anticipated loss ratio and the lifetime anticipated disease management ratio is not less than 70%, and ~~(4) (D)~~ in the case of a rate revision, the sum of the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage and the anticipated disease management ratio over the future period for which revised rates are computed to provide coverage is also not less than 70%. ~~and;~~

(2) the insurer's projected medical loss ratios in the individual market, calculated using the method described in the interim final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. §§ 158.220-158.232, 75 Fed. Reg. 74927-74928, (December 1, 2010)) and incorporated herein by reference, are not less than 80%.

(b) Benefits provided by a hospital, medical, or surgical policy delivered or issued for delivery to any person in this State prior to July 1, 2007 and not subject to any rate revision effective on or after July 1, 2007 shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(c) Benefits provided by supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(d) Benefits provided by a hospital, medical or surgical policy designed to supplement Medicare, as defined in subdivision (l) of Insurance Code section 10192.4, must meet the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code.

NOTE: Authority cited: Insurance Code section 10293.

Reference: Insurance Code section 10293(a).

The Commissioner has determined that the current 70% lifetime anticipated loss ratio standard, evaluated on a policy-form basis, protects California consumers by assuring that each policy form will return at least 70 cents of benefit for each premium dollar. The proposed amendments will provide further protection to California consumers by conforming the California regulation to the requirements of federal health care reform while providing consumers with immediate access to the additional benefit of the federal 80% standard, on a market segment basis. This regulation applies the 80% standard to consumers' premium dollars from the outset, without the insured having to wait for up to twenty months for a premium refund. Under federal law, a consumer who pays a premium in excess of that justified under the federal loss ratio requirement would have to wait until August of the following year for a refund. This presents the consumer with an inflated premium for the entire year of coverage; for individuals and families in difficult economic circumstances, such a front-end excess premium can create a barrier to access to health coverage, making the coverage effectively unavailable. Applying both the California and Federal standards in a complementary fashion through this amendment achieves the mandate of Insurance Code section 10293, that benefits under a policy be reasonable in relation to the premium charged, while also removing a barrier to access to coverage, therefore making this vital coverage more available to Californians.

July 21, 2011

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¹Insurance Code section 10293(a)

² Insurance Code section 10293(a)

³ California Department of Insurance Ruling 127, file number RH-89, November 30, 1962, "In the Matter of the Proposed Adoption of Rules and Regulations of the Insurance Commissioner relating to Standards by which the Insurance Commissioner shall withdraw Approval of any Individual Medical, Hospital, or Surgical Policy the Benefits of which are Unreasonable in Relation to the Premium Charge."

⁴ see, "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance

Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).

⁵ As of 2004, the growth rate in national health expenditures was 7.9%, compared with an annual growth rate in the Consumer Price Index of 2.7 percent. Per-capita national health care expenditure in 2004 was 17.6 times the level in 1970, while consumer prices, as measured by the CPI were 4.9 times 1970 levels. *Snapshot: Health Care Costs 101, 2006 edition*, pp.1, 15, 16, California Health Care Foundation, www.chcf.org.

⁶ *Snapshot: Health Care Costs 101, 2006 edition*, p.4, California Health Care Foundation, www.chcf.org.

⁷ *Snapshot: Health Care Costs 101, 2006 edition*, p.6, California Health Care Foundation, www.chcf.org.

⁸ *Snapshot: Health Care Costs 101, 2006 edition*, p.14, California Health Care Foundation, www.chcf.org.

⁹ Buntin, *supra* at W3-456.

¹⁰ *California Health Care Almanac: California Health Plans and Insurers*, October 2010, California HealthCare Foundation, www.chcf.org

¹¹ *Recent Premium Increases Imposed by Insurers Averaged 20% for People Who Buy Their Own Health Insurance, Kaiser Survey Finds Facing Such Increases, Some Enrollees Switched To Lower-Cost Coverage People With Pre-Existing Conditions Much More Likely To Report Problems*, Kaiser Family Foundation, <http://www.kff.org/kaiserpolls/posr062110nr.cfm?RenderForPrint=1>.

¹² *Snapshot: Health Care Costs 101, 2006 edition*, p.1, California Health Care Foundation, www.chcf.org.

¹³ Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, 227, May 2, 2006, www.healthaffairs.org.

¹⁴ Testimony of Mr. Roupen Berberian, Health Net Life Ins. Co., December 1, 2005 California Department of Insurance Investigatory Hearing Regarding Profitability of Health Insurance Companies, (file number IH05049314) RT 64:16-18.

¹⁵ Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, 228, May 2, 2006, www.healthaffairs.org.

¹⁶ Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, May 2, 2006, www.healthaffairs.org.

¹⁷ Buntin, et. al., *Trends and Variability in Individual Insurance Products in California*, Health Affairs, W3-449, Sept. 23, 2003, www.healthaffairs.org.

¹⁸ Buntin, *supra* at W3-457