Project Narrative

New York State Insurance Department

Application for Grants to States for Health Insurance Premium Review- Cycle I

CFDA: 93.511 July 7, 2010

Introductory note: New York requests the maximum available Cycle I funding of $1M under the Grants to States for Health Insurance Premium Review program. For purposes of this grant application, there are three relevant categories of health insurance rate review laws in New York:

1. **"Current Law."** Described in Section A, this is the current state of rate review law in New York at the time this application is submitted (July 7, 2010).
2. **"New York's New Prior Approval Law."** Described briefly immediately below and in greater detail in Section B, the new prior approval law does not go into effect until after September 30, 2010. New York's new prior approval law, under which insurers' proposed health insurance rate (premium) increases must be pre-approved by the Insurance Department before use by the carrier, is a landmark enhancement compared to current rate review laws in New York and nationally. Implementation of New York's new prior approval law is fully funded by State dollars and is not the purpose for which New York seeks federal funds.
3. **Enhanced Health Insurance Rate Review.** Required under the Patient Protection and Affordable Care Act ("PPACA"), these are the rate review enhancements for which New York currently seeks funding in this grant application. Because of overlap in state and federal rate review functions, some enhancements will benefit both the requirements of New York's new prior approval law as well as the requirements of PPACA. As described more fully below, New York only requests federal funding for those enhancements beyond those funded by state dollars.

A) Current Health Insurance Rate Review Capacity and Process

General Health Insurance Rate Regulation Information:

The New York State Insurance Department (the "Insurance Department" or the "Department") licenses and regulates non-profit and for-profit health insurance companies operating in New York State. Health

Maintenance Organizations (HMOs) are regulated by both the Insurance Department and the New York State Department of Health. There are 29 for-profit health insurers licensed in New York, 4 non-profit health insurers, and 19 HMOs. Some of these entities belong to the same holding company structure. The New York State health insurance market consists of the large group market (employer groups consisting of more than 50 eligible employees), the small group market (employer groups of 2-50 eligible employees), and the individual direct pay market. Approximately 61% of New Yorkers are covered through employer sponsored insurance, approximately 40% of whom are covered through self-insured health plans exempt from state regulation. Eighteen insurers offer individual policies; twenty-eight insurers offer small employer policies; and twenty-six offer large employer policies.

New York State has strong consumer protections and, more recently, strong rate review practices compared to other states. Notable consumer protections in New York include statutory requirements for guaranteed issue, pure community rating and open enrollment in most market segments. The small group and individual health insurance markets are community rated, and rates cannot vary by age, sex, health status, or occupation. The large group HMO business is also community rated. The Healthy New York Program (small groups and individuals) and the Standardized Individual Direct Pay Program (offered through HMOs) receive State funded stop-loss subsidies. The large group market (except large group HMO-only coverage) is experience rated. Premium rates for the largest groups are based entirely on their own experience; the premium rates for the remaining groups with more than 50 eligible employees are based on a blend of their own experience and the manual rates with the proportion of the rate that is based on the group's own experience increasing as the group size increases. All experience rating formulas are required to be filed with the New York State Insurance Department and approved before use.

Health Insurance Rate Review and Filing Requirements:

In New York State, health insurance rates are currently filed using one of the following three methods:

(1) File and Use: Under file and use, insurers can increase premiums by simply filing an actuarial certification that the medical loss ratio meets the statutory minimum, with no approval or even review by the

Insurance Department, i.e., the insurers "file" the rate and then "use" it. File and use can only be used for changes to *existing* premium rates (as opposed to *initial* rate filings) for community rated products (small group, individual, large group HMO). Most insurers use file and use to revise their rates. Under file and use, the company's rate application need only include the revised rate tables and an actuarial certification stating that the expected loss ratio meets the statutory minimum (75% for small groups; 80% for individual). The file and use statutes do not require insurers to file any supporting material with the rate application. Upon such a filing, the rate is deemed approved by action of law; the Insurance Department has no authority to prevent implementation of the rate as long as 30 days notice of the change has been provided to the policyholder. For each product where the rates have been filed using this procedure, an annual loss ratio report is required to be submitted following the applicable plan year. Refunds are required if the actual loss ratio for the prior calendar year is below the statutory minimum loss ratio requirement. Policy forms can be combined for such loss ratio testing purposes based on certain criteria. Refunds are issued on a pro-rata basis.

(2(a)) Prior Approval (new and amended policy forms and rate changes for other than hospital/ medical coverage): Under prior approval, insurers' proposed rate increases must be approved by the Insurance Department before they can use the new rate, and the Insurance Department is authorized to review, approve, modify or reject the rate increase and the underlying calculations and assumptions prior to the rate going into effect. Prior approval must be used for all initial rate filings and for rate changes that are associated with benefit changes to an existing policy form (e.g. the "six month" coverage changes associated with implementation of federal health reform). The Insurance Department has also maintained prior approval authority for other types of accident and health coverage such as long-term care, disability, fixed payment accident and health insurance. Under prior approval, the Insurance Department reviews the supporting material and either approves, modifies or rejects the rate filing. During this review the expected and historical loss ratio experience are reviewed. If the experience loss ratio has been below the minimum loss ratio standard, a corrective action may be required.

Under current law, New York requires insurers to submit an actuarial certification indicating that the filing is in compliance with the applicable laws and regulations and that the benefits are reasonable in relation to the premium charged. This allows the Insurance Department to rely on the Code of Professional Conduct and

the Standards of Practice that the actuaries must follow. The following criteria are used during the current prior approval review process: (1) premiums are reasonable in comparison to the benefits provided; (2) expected loss ratio meets the required minimum loss ratio standard; (3) claims experience justifies the proposed rate increase; (4) derivation and assumptions used comply with the applicable insurance laws and regulations governing rate development and rate filings; and (5) reviewer's actuarial judgment.

(2(b)) Prior Approval (rate changes for hospital/ medical coverage): Since calendar year 2000, prior approval has been an option that health carriers may use for review of rate increases (although few insurers chose this option for rate adjustments). In the past ten years, "file and use" has been the filing option that carriers have chosen for the overwhelming majority of submissions.

For the 2008 calendar year, 10 companies that used the "file and use" process (described above) failed the statutory minimum loss ratio requirement for some pool(s) of business and provided refunds or premium credits to policyholders. The aggregate amount of such refunds or premium credits to small group and individual policyholders was approximately $20 million, distributed on a pro rata basis.

For rate increase filings submitted under the current prior approval process, the Insurance Department estimates that, in the last 5 years, 30 rate increase applications were reduced or denied for group and individual comprehensive medical insurance, impacting approximately 120,000 consumers. This compares to about 750 rate increases implemented via the file and use methodology over the same time period.

New York's New Prior Approval Law. On June 8, 2010, New York enacted a new prior approval law reinstating the Insurance Department's authority to review and approve, modify or reject health insurance premium rate increases before they go into effect (hereinafter referred to as "New York's new prior approval law" or the "new prior approval law").[1] The new prior approval law represents a significant departure from current law and will apply to rates going into effect after September 30, 2010. This new law is addressed more fully in Section (B) "Proposed rate review enhancements for health insurance."

[1] The text of New York State's new prior approval law is included as an appendix to this grant application.

An Explanation of Current Level of Resources and Capacity for Reviewing Health Insurance Rates: Information Technology (IT) and Systems Capacity

The Insurance Department uses the System for Electronic Rate and Form Filing ("SERFF"), which is a web-based system that allows insurers to upload the documents associated with rate filings for review by the Department. Filing instructions, including links to rating and product checklists, are available to rate filers via SERFF. The links provided take rate filers directly to the checklists and guidance that are publicly available on the Insurance Department website. To date, and even under the new prior approval law, New York's IT capacity for rate review is not sufficient to meet the new and anticipated requirements under PPACA.

An Explanation of Current Resources and Capacity for Reviewing Rates: Budget and Staffing

The Insurance Department's budget is comprised of (a) funding for the direct costs of the Department plus other insurance related initiatives in the state including the regulatory costs of other State agencies, and (b) subsidies for insurance programs (primarily health insurance related). The Department's budget for the fiscal year that ended March 31, 2010 totaled $461,725,000. Of this amount, $138,586,000 was dedicated to funding the activities of the Department's employees. The remainder was sub-allocated for other related purposes.

In the current budget, approximately $1,038,947 (annualized) is devoted to rate review for health insurance coverage. To take account of requirements for the new prior approval law that New York passed on June 8, 2010, and which go into effect October 2010, additional funds of $932,958 (annualized) will be added.

The actuarial unit that currently reviews the prior approval rate filings for new policy/ amended policy forms consists of four actuaries who report to the Deputy Chief Actuary who is a Fellow of the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA). Two of these actuaries are FSAs and two are Associates of the Society of Actuaries (ASA). File and use filings are reviewed by three individuals who report to the Deputy Chief Actuary. Each of these individuals has passed at least one of the examinations sponsored by the Society of Actuaries.

The Department receives approximately 1,650 rate filings annually. In 2009, a typical year illustrative of the current rate review scheme, approximately 70 were prior approval medical rate increase filings and 150 were

file and use medical rate increase filings. The average amount of time for completing a current prior approval rate review is about three months which includes time waiting for insurers to respond to questions from the Insurance Department regarding the submissions.

Consumer Protections:

The Insurance Department receives hundreds of consumer complaints annually regarding the size of health insurance premium rate increases. Currently, insurers are required to give 30 days advance notice to policyholders in writing of rate changes. There is, however, currently no required format for such notice. Under the current file and use system, there is no requirement for a public hearing and no comment period because submitted rates become effective by action of law. Under the current prior approval alternative, public hearings are required for HMO and non-profit health plans but only one such public hearing has been held since 2000. The new prior approval law does not require public hearings, but requires 60 days advance notice to consumers of a rate change and requires a 30 day period in which consumers can submit written comments on a rate filing to the Insurance Department.

Premium rates for the Standardized Individual Direct Pay Program and for the Healthy New York Program are posted on the Insurance Department's website. The website shows, by county, the participating insurance companies and contact information, and the current premium rates for the plan design options within each of these two programs. Rate tables for all other products are not posted on the Department website, but are available to the public under the Freedom of Information Law (FOIL) either in person or by mail. Premium rate increases are not posted on the Insurance Department's website. The actuarial justification and supporting documentation included rate filings are generally not made publicly available because insurers maintain that this information is proprietary and therefore exempt from applicable FOIL requirements.

Examination and Oversight:

Under the current file and use process, the rate increases submitted by insurers are deemed approved by action of law. As mentioned previously, refunds under the file and use process for the 2008 experience year

were about $20 million to small group and individual policyholders. Separately, in 2008 and 2009, the Insurance Department executed stipulations with three insurers, which included penalties for failure to send proper or timely notice to approximately 11,000 enrollees before implementing a file and use rate increase. On May 18, 2009, the Insurance Department held the only rate hearing in the past two years at which the Department considered the application of a health insurer for a rate increase.

B) Proposed Rate Review Enhancements for Health Insurance

Over the entire grant period, the New York State Insurance Department will significantly enhance its rate review and approval functions to effectively implement both New York's new prior approval law and the PPACA. As mentioned previously, the Insurance Department's newly increased rate review authority flows from two sources: (1) New York's new prior approval law, enacted June 8, 2010 and effective October 2010; and (2) the heightened rate review obligations under the federal PPACA.

Expanding the Scope of Current Review and Approval Activities

New York's new prior approval law will not only increase the scope of the Insurance Department's authority to review rate increase applications, but will also increase the volume of rate applications filed under the prior approval mechanism (all applications currently filed under file and use will now be filed under prior approval). The new prior approval law authorizes the Insurance Department to reject or modify a rate application if it finds that the rate is unreasonable, excessive, inadequate or unfairly discriminatory. The Insurance Department's determination must be supported by sound actuarial assumptions and methods. Compared to file and use rate applications, prior approval rate applications will include more detail to allow the Insurance Department to make these determinations. Because there is a relatively short time between enactment of the new prior approval law -- June 8, 2010 -- and when issuers will begin to file rate applications under the new prior approval process -- July and August 2010 for rates to go into effect January 1, 2011 -- the Insurance

Department will phase in some enhancements this year and continue to implement enhancements in ensuing years. For instance, with current staffing levels, the Insurance Department will triage applications to focus on potentially problematic applications, such as those including abnormally high rate increases or medical loss ratios below the statutory minimum requirement, and submissions that the Secretary of Health and Human Services ("Secretary") has determined constitute "unreasonable increases."

PPACA further imposes both substantive and procedural requirements beyond those specified under New York's new prior approval law. For instance, substantively, the Department's actuaries will have to review issuers' rate filings to ensure premiums accurately reflect PPACA requirements that become effective September 23, 2010 such as those related to annual limits and extended coverage for dependents. Also, PPACA imposes a minimum medical loss ratio requirement on large groups whereas New York does not; the Insurance Department will have to implement filing and review procedures as they are developed by the Secretary. Procedurally, the Insurance Department will oversee PPACA's reporting requirements to the Secretary as well as other requirements under PPACA. As with the new prior approval law, the Insurance Department will phase in some enhancements related to PPACA this year and continue to implement other enhancements as other provisions of PPACA become effective.

As more fully described below, the Insurance Department will focus Cycle I funding on improving filing requirements, enhancing staffing and enhancing IT capacity. Because there will be some overlap in the Insurance Department functions in reviewing rate applications under both state and federal law, certain enhancements will help the Department meet the requirements of both the new prior approval law and the PPACA, but the Insurance Department will coordinate funding from both the state and federal government to ensure there is no overlap in funding. For instance, additional actuarial staff is needed to meet the increased workload associated with New York's new prior approval law and the PPACA reforms. New York's recent budget appropriation funds New York's prior approval activities. New York's budget crisis does not, however, provide additional funding to comply with the heightened rate review requirements under PPACA. New York seeks this rate review enhancement grant funding to support those rate review functions required by PPACA that are beyond the scope of New York law.

Improving Rate Filing Requirements

Standardization: Under the current file and use procedure, no supporting information, other than an actuarial certification, is required to be submitted with rate filings. As issuers are required to submit more detailed applications under the new prior approval law and PPACA, the Insurance Department will standardize and streamline those filings and, to the extent possible, integrate them with the reporting requirements of the PPACA.

Checklist: The Department will develop a new, enhanced checklist of material to be submitted in connection with future renewal rate filings. The checklist will include the required contents of the actuarial memorandum to be submitted to support and to justify the requested rate increase, and will be the basis of a standard format for the filing that will be developed as a template for all rate filers. This checklist and standard application format will be fully developed by December 2010 and posted on the Department's website thereafter. Insurance Department actuaries also will conduct training for the lower level actuaries on the new procedures.

Market Segment Reporting: The financial examiners will develop specifications for more detailed market segment reporting of financial data from the NY quarterly and annual supplements (such as, data by large group v. small group v. individual and by broad product type) and implement associated review procedures for insurers and HMOs. The Department’s goal is to implement such enhancements with the March 2011 quarterly financial statements.

Claims: The Department will develop a more standardized structure for reporting claims experience and other supporting information and revise the checklist described above accordingly with the goal of completing and posting these updated requirements on the Department’s website by July 2011 for use with renewal rate filings to be effective about January 2012.

Enhancing Rate Review Process – Staffing ($476,064 for Cycle I)

The Insurance Department requires additional actuarial staff and resources to meet the increased rate review workload. A new actuarial unit will be created under the new prior approval law to review renewal rate filings. The head of this new unit will be a Fellow of the Society of Actuaries (FSA), but at a minimum, an Associate of the Society of Actuaries (ASA), and will report to the Assistant Chief Actuary who is an FSA and a Member of the Academy of Actuaries (MAAA).

Using Cycle I funding, two additional actuaries, not provided for as part of the state's prior approval budget, would be hired to report to the new unit leader. The ideal qualification of these actuaries will be a credential of ASA or higher, however, the Department will consider candidates who have already passed some actuarial examinations but have not yet achieved ASA status. Because the Department has historically had difficulty attracting credentialed actuaries, it may be necessary to hire recent college graduates who are interested in becoming actuaries and who are interested in and dedicated to passing the Society of Actuary examinations to achieve ASA or higher status.

Using Cycle I funding, one insurance examiner with an accounting background will also be hired to support this new unit and to develop and review the non-actuarial information (e.g. market segment financial analysis and overall solvency considerations) submitted with rate filings and insurers' financial statements.

The new staffing for this new unit will be completed during the Cycle I funding period. Please see the attached Organizational Chart for additional detail on the composition of the rate review staff units. Additionally, the contracting services for the IT enhancements (explained below) may utilize additional staff.

Enhancing Rate Review Process - IT Capacity ($474,436 for Cycle I)

IT capacity is perhaps the most significant area in which PPACA requires rate review enhancements beyond the requirement of New York's new prior approval law. Since there was no budget allocation for IT improvements under the new prior approval law, using Cycle I funds, the Insurance Department will enhance its current IT capacity including infrastructure and staffing to streamline, standardize and modernize its systems in

order to meet the requirements of prior approval, enhance its internal capacity to analyze data and documents obtained from rate filings, and fulfill the Department's reporting requirements to HHS.

The Insurance Department will evaluate current IT capacity and improve the following areas:

- The Department's in-house capacity to analyze data/ documents received from issuers in rate filings;
- The type and accessibility of data that the Insurance Department requires to report to HHS and meet its obligations under the prior approval law;
- The extent to which external resources, including contractors or consultants, will be needed to assist the Department in reaching its goals.

As part of this process, the Insurance Department will consider, among other options, plans to develop and implement the following IT enhancements to support its rate review functions:

- Enhancement of the current health document management system to allow for the capture of the additional data elements from the rate filings;
- Enhance reporting capabilities by including additional reports and modifying existing ones;
- Interface upgrade that will include ability to perform easier data entry and data manipulation using browser based interface;
- Current workflow enhancement to perform automated rules validation based on the new laws and business rules for all data that is captured, to the extent such automation is practicable;
- A remote capture mechanism enabled to allow companies to submit filings using web submission. The remote capture interface could be integrated with the Department's web-based portal and provide a constant method for issuers to submit information into the system;
- Integration with the Department's web-based portal to provide ability to review available documents related to the rate review filings;
- Integrate data entry screens into the Department's portal to allow specific filings-related comments.

The Insurance Department envisions that the process of standardization and modernization of its systems will occur in multiple phases. The following is a detailed, estimated description of the proposed enhancements including the budgeted amount and expected timeline:

IT Phase I of Grant Cycle I: $168,808

The Insurance Department plans to contract with NAIC to enhance SERFF to address data collection and reporting requirements as defined in Section V on pages 16-17 of the grant announcement. The SERFF enhancements incorporating HHS reporting requirements will be implemented in a phased approach with the first release to occur within 3 months of the receipt of the HHS uniform template for reporting. NAIC estimates the cost to New York for these enhancements is $18,808 (to be paid from Cycle I grant funds). NAIC expects that the last enhancements of SERFF would be completed approximately 8 months after receipt of the HHS reporting template.

In conjunction with SERFF enhancements, the current document management system for rate filings in New York State will be modified to include the data fields added to SERFF. The Department's Oracle database, which stores the data collected from rate filings, also will be expanded to capture this newly generated data and reporting functionality will be expanded.

The Department's estimated hardware budget for Cycle I is $50,000. For Cycle I, the Department's main hardware goal is to increase its data storage capability. This added capacity will allow the Department to capture, store and manipulate the data that is needed to meet mandated requirements. The Department will likely need additional hardware in future grant cycles based on future needs.

Phase I's start date is contingent upon receipt of Cycle I grant funds and the release of the HHS uniform reporting template for data reporting under the rate review grant. Phase I, which includes hardware costs ($50,000), the expected payment to NAIC for SERFF enhancements ($18,808), and $100,000 for contract services, is expected to cost $168,808. Much of the work in this phase will be completed by August 2011.

IT Phase II of Grant Cycle I: $152,814

As part of planned enhancements to increase transparency in the rate filing process, the Department will begin to update its website to provide plain language, consumer-friendly information about rate filings. This will be a significant enhancement beyond the minimal information of this nature currently available.

The Insurance Department plans to expand its analysis of financial data reported by issuers in the New York Supplement to their annual reports. These plans include the data mining of financial data by extracting previously submitted data from existing data sources and the updating of the Department's database to capture newly filed data in separate fields that allow for the running of reports.

The Department anticipates that this phase of the work will begin as soon as an external contractor is identified and retained. The anticipated start date of an outside contractor would be April 1, 2011; however, the State's procurement process may delay this process. The budgeted cost for this grant cycle is $152,814.

IT Phase III of Grant Cycle I: $152,814

As part of the modernization of the rate review process, the Insurance Department will create a web based platform that would allow issuers to efficiently provide data directly to the Insurance Department.

Updating the Insurance Department's website will continue in Phase III. During this phase, such updating may include creating a consumer web page with a web-based tutorial and other interactive features.

Phase III work will be performed by an external contactor with computer programming expertise and additional contractors as needed. It is likely that the Insurance Department will need funding in future grant cycles to complete these activities. In Grant Cycle I, Phase III enhancements are budgeted for $152,814.

The total budget amount for enhancing the Department's IT capacity for Grant Cycle I is $474,436.

Enhancing Consumer Protection Standards

As mentioned above, New York's new prior approval law requires insurers to provide notice of proposed rate increases to affected policyholders to allow those policyholders to submit comments to either the issuer or the Insurance Department. The law further requires the Department to post all relevant comments on

its website to provide a public forum for comments on the rate increases. The Insurance Department will increase its capacity to meet this posting requirement by the end of 2010.

In addition, the Department will update its website to provide general information about the rate filing process to the public in a user-friendly format. The Department anticipates that this information will be crucial to consumers understanding of the public disclosure of unreasonable, unjustified and/or excessive rate increases required under PPACA by both HHS and the required posting of the information on issuers' respective websites.

C) Reporting to the Secretary on Rate Increase Patterns

The Insurance Department will develop and implement procedural and systems enhancements to comply with the data reporting requirements in the grant as outlined in the forthcoming HHS-provided data template. The Department acknowledges that Section 2794 of PPACA requires grant participants to provide data to the Secretary on health insurance rate trends in premium rating areas over which the Insurance Superintendent has jurisdiction. Please see the IT enhancements described above for details on the anticipated process the Department will use. The Department awaits further guidance regarding the uniform reporting template and takes note of the required data listed in the funding opportunity announcement.

D) Optional Data Center Funding: Amount Requested: $49,500

FAIR Health, Inc. is an independent, not-for-profit[2] organization created in October 2009 to serve as an objective and transparent source of healthcare reimbursement data for consumers and other stakeholders. FAIR Health was created in response to New York State Attorney General Andrew Cuomo's investigation of insurance industry's methods for determining reimbursement rates for services provided by out-of-network providers. FAIR Health's activities are being supported in part through funds derived from the settlement reached with all of the major insurers in New York State.

[2] Note that FAIR Health's application for 501c(3) not-for-profit designation is currently pending.

FAIR Health is in the process of acquiring a large, national database of millions of de-identified healthcare claims from Ingenix, Inc., a subsidiary of United Healthcare. FAIR Health anticipates assuming ownership of this database by Fall 2010 and will expand its claims database by collecting data from payors and other contributors. FAIR Health's first product offerings will include a free consumer website that allows consumers to view variations in charges for specific medical procedures by geographic area. FAIR Health will also license a series of products targeted to payors that are intended to assist in the establishment of reimbursement rates for out-of-network services.

FAIR Health has contracted with a consortium of academic research institutions to upgrade and refine the design of the methodologies used to derive the rate benchmark information that will ground its consumer website and its payor products. FAIR Health will publish its research methods and make them widely available to the users of its database.

Given its not-for-profit status, its academic ties, its database of healthcare claims data, the technology it is developing for publicly reporting healthcare cost data, and its commitment to transparency in health information, FAIR Health is a suitable partner for the Insurance Department as it works to identify claims cost drivers and differences throughout the State, and to enhance its rate review process.

The Department seeks $49,500 to support the NYSID-FAIR Health partnership. These funds will cover staff time and expenses for a one-year planning process through 2011 that achieves the following objectives:

- Establish how FAIR Health's data and technologies can be used to support the Insurance Department's efforts to review health plan rates. This planning effort will include identification of the specific analytic methods FAIR Health will apply to its data for the NYSID, as well as exploration of how FAIR Health might expand its database to include allowed charge data rather than just actual charge data.

- Establish the content of the data reports that FAIR Health will provide the NYSID and the formats of data submission. This will include details on how FAIR Health's data and research findings will be made available to payors, providers, researchers, policymakers, and the general public.