IssueBrief

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States Making Progress On Rate Review

This brief highlights examples of states that are making efforts to improve their rate review processes and discusses how the Affordable Care Act contributes to strengthening rate review.

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Introduction

As health insurance premiums continue to rise at a rapid pace, consumers are finding it more difficult to afford coverage. Through the process of rate review, state insurance departments aim to protect consumers from unreasonable rate hikes by assessing whether or not a proposed increase in premiums is reasonable. However, the power states can exercise over rates varies greatly, ranging from extensive authority to obtain information and approve or reject rate increases, to virtually no authority to review rates.

This issue brief provides examples of states that are making efforts to improve their rate review processes. We reviewed literature and websites in order to select states where these improvements have already had an impact on premiums. We then interviewed insurance departments and consumer advocates from these states to learn more about four areas where they are making progress. In particular, we looked at whether states are doing the following:

- Seeking greater authority to reject unreasonable rate increases
- Providing more public information on rate increases
- Creating opportunities for public input during the rate review process
- Collecting more in-depth information from insurers and analyzing the data more closely

This issue brief also discusses the Affordable Care Act and how it will contribute to the strengthening of state rate review processes. The new law helps states make their rate review processes more consumer-friendly and effective against the skyrocketing costs of premiums in three ways:

1. The Affordable Care Act provides $250 million in grants over a five-year period to bolster states' rate review programs. Cycle I grants of $1 million each were awarded to 42 states, five territories, and the District of Columbia in 2010, and so far, cycle II grants totaling $109 million have been awarded to 28 states and the District of Columbia. The grants that some states received included extra funding to expand their authority to approve, modify, and reject proposed rate changes and for states with large populations and a large number of insurers.[1]
2. The law requires review of all premium rate increases of 10 percent or more in 2011. Starting September 2012, the review threshold will be set on a state-by-state basis. If an increase above the threshold occurs, it must be publicly and prominently disclosed on the websites of the Centers for Medicare and Medicaid Services (CMS), the state insurance department, and the insurer.[2]

3. The law increases the share of premiums collected that insurers must spend on providing health care services (known as the medical loss ratio) to at least 80 percent. The remaining money can be used on administration, marketing, and profits. At the end of the year, if plans do not spend adequate portions on patient care, they must issue refunds to policyholders.

The Affordable Care Act does not alter the authority states already have in the rate review process. Instead, it provides states with financial support to bolster their rate review programs and new federal initiatives to build a comprehensive and transparent review of proposed increases. It's still up to the states themselves to protect consumers from unreasonable rate hikes by continuing to improve their rate review programs.

Finally, this issue brief notes that states are beginning to use rate review as a tool for containing health care costs themselves. We hope that by highlighting the success of key states with rate review work, we can provide valuable lessons for other states looking to improve their review programs.

How Are States Moving Forward?

In light of the recession, consumers are, now more than ever, seeking protection from unreasonable rate hikes. In the following sections we highlight how some states are improving their rate review programs.

Oregon: A Leader in Rate Review

Oregon has a robust rate review program and demonstrates the important role states can play in protecting consumers. By holding the power to reject rate increases before they go into effect, providing the public with easily accessible information, and making efforts to gather input from consumer advocacy groups, Oregon is leading the pack in eliminating unreasonable rate hikes. The state is also working toward using rate review as a tool for health care cost containment. The Oregon Insurance Division works hard to strike a balance between consumer concerns and market stability. Last year alone, Oregon reduced half of the proposed rate increases they received.[3]

Creating An Effective Rate Review Program

Starting September 1, 2011, proposed rate increases above an established threshold, determined as 10 percent or more for this year, must be reviewed by CMS or the state insurance department. If a state is deemed to have an "Effective Rate Review Program," then the state conducts the review. If not, CMS will conduct the review until the state has sufficiently established its review program. These rules apply to individual and small group plans that were established, or that substantially changed, after March 23, 2010. Older plans may be "grandfathered" and thus be exempt from the rules.

For more information about how to tell if a plan is grandfathered, see Grandfathered Plans Under the Patient Protection and Affordable Care Act.

To qualify as having an Effective Rate Review Program, a state must do the following:

1. Conduct effective and timely review of rate increases
2. Receive sufficient data and documentation for review
3. Examine the following rate factors:
   - Reasonableness of health insurance issuer's data related to past projections and actual experience
   - Medical cost trend changes by major service categories
   - Changes in utilization of services by major service categories
   - Changes in cost-sharing by major service categories
   - Changes in benefits
   - Changes in enrollee risk profile
   - Impact of over or underestimations of medical trends in previous years on the current rate
   - Reserve needs
   - Administrative costs related to programs that improve health care quality
   - Other administrative costs
   - Applicable taxes and licensing or regulatory fees
   - Medical loss ratio
   - The issuer's capital and surplus
4. Have a public disclosure and input process for proposed rate increases above the 10 percent threshold for 2011 or above the state-specific threshold in future years, including the following:
   - Access to rate filings and justification for proposed rate increases on state insurance websites
   - Mechanism for public comment on rate filings subject to review
5. Make a determination of the reasonableness of the rate increase under a standard set forth in state statute or regulations
6. Report results of rate review to CMS for rate increases subject to review

Seeking Greater Authority to Reject Unreasonable Rate Increases

States use one of two approaches to the rate review process: (1) prior approval, or (2) file and use. Having the authority to deny or approve a proposed rate change before it takes effect is an important tool because it can protect consumers from rate increases that are unnecessarily high *before* the new rates go into effect. As of January, insurance departments in 19 states have prior approval authority in all markets, while another 15 have authority over some of their markets.[4] If the insurance department finds that the proposed rates are unreasonable, unjustified, inadequate, or discriminatory, the insurance department can reject them and ask the insurer to revise its proposal. States' prior approval authority may extend to all individual and group insurance policies or to just certain insurers or certain types of policies. With help from their Affordable Care Act grants, more states are now enacting laws to enhance their oversight and authority over unreasonable premium rates.

States without prior approval authority have a system of file and use. In this system, an insurer files its proposed rate change, along with the calculations used to determine the increase, with the state insurance department. The difference between file and use and prior approval authority is that with file and use, the insurer does not need the department's approval to implement the change. Sometimes these states can disapprove rates that are unreasonable, but only after they have gone into effect. By that point, the rates may already have made coverage too expensive for consumers.

In order to review rates, state insurance departments check that proposed rate changes are in accordance with state regulations and meet medical loss ratio requirements. Along with double-checking the insurer's calculations, a department may use assumptions about future medical costs that it believes are reasonable and appropriate to recalculate a rate increase for an insurer. The use of different underlying assumptions by an insurance department and an insurer often leads to a discrepancy in the rates each party believes are justified.[5] A staff member of a state insurance department with prior approval authority said that, although the department would rather work collaboratively with insurers to agree on a rate change, "it's still good to know that we have the authority to disapprove the rate" if the insurer is unwilling to work to lower an unreasonable increase.

Federal rate review grants are also helping states conduct more thorough reviews of proposed rate increases by streamlining the collection of rate filing data, providing resources to draft legislation for states seeking review authority, and helping states implement newly passed prior approval laws.[6]

Rate review authority is already making a difference in New York, North Dakota, and Tennessee, among others.

New York

New authority protects consumers from unreasonable rate hikes.

New York has experienced both prior approval and file and use. Beginning in 1996, the insurance law in New York was revised to allow health insurers to switch from prior approval to file and use. Under file and use, insurers only had to provide an actuarial certification to the New York State Insurance Department stating that they were in compliance with the state's insurance law. They self-certified that their projected claims met the state's medical loss ratio requirements. Insurers were also responsible for reporting if their actual claims did not meet medical loss ratio requirements at the end of the year and for issuing refunds to policyholders if they didn't.

Stripping the department of prior approval authority was detrimental to consumers. "Between 2000 and 2007, insurers self-reported approximately $48 million in refunds. Department investigations, however, revealed improper rate calculations that resulted in over $105 million in [additional] refunds to enrollees. . . ." [7] Unfortunately, under file and use, the department was powerless to take action on behalf of consumers until it was found that insurers had already overcharged consumers. Moreover, consumers had to wait up to 21 months after a rate increase had gone into effect before they received any refund, and they missed out on that refund if they canceled their coverage before the refund was issued.[8]

Losing prior approval authority was extremely harmful to New York. The cost of premiums grew faster; higher premiums resulted in more uninsured people; and those who could no longer afford private coverage enrolled in public programs—costing the state more money.[9] These negative outcomes motivated the passage of prior approval legislation in 2010. The new law grants the insurance department the authority to approve, deny, or modify rate filings for individual, small group, community-rated large group, Healthy New York, and Medigap policies.[10] In October, shortly following its passage in June, the new authority allowed the department to lower rate changes filed by insurers by up to 22 percent.[11]

Currently, New York's federal rate review grant is helping the state implement its new prior approval law, streamline and standardize its rate filing process, regularly post consumer-friendly rate summaries on its website, and obtain consumer input on proposed rate increases.[12]

North Dakota

A commitment to affordability and collaboration with insurers keeps rates lower and more reasonable.

North Dakota's statute gives the insurance commissioner the authority to review and approve rate changes in both the individual and small group market. Most rate changes are approved or denied within 60 days of filing. One insurer, BlueCross BlueShield of North Dakota (BCBS of ND), controls approximately 90 percent of North

Dakota's market.[13] In 2011, the state reduced a proposed increase of 23.7 percent for its individual policies to 14 percent. In 2010, the insurance department also lowered an increase proposed by BCBS of ND for group policies from 19.6 percent to 9.7 percent.[14]

The goal of the North Dakota Insurance Department is to ensure both the affordability of health insurance and adequate revenue for insurers.[15] When it calculates that a proposed rate increase is too high, the department works with insurers to establish a reasonable rate change.

Tennessee

Lowering unreasonable rates and expanding authority to new sectors of the market protects consumers.

Tennessee's insurance commissioner has prior approval authority over its individual insurance market and over long-term care and "dread disease" policies. Until recently, the commissioner had slightly less authority over small group policies. In May, Tennessee gave the insurance commissioner prior approval authority over experience-rated group accident and sickness policies, including some that were previously exempt from review.

In 2010, the commissioner reduced a proposed rate increase of 120 percent for a long-term care policy down to 30 percent, and also reduced a proposed 135 percent increase for a cancer policy down to 15 percent.[16] According to Tennessee's Department of Commerce and Insurance, its success in lowering unreasonable rates is due solely to its strict use of the state's law governing rate filings and its practice of ensuring that proposed rates are correctly calculated.[17]

Until now, rate filing information has not been easily accessible to the public. Generally, people had to physically visit the insurance department's office to view insurers' rate filings. Rate justification documents are even considered proprietary in many states.

The Bottom Line

State laws can give state insurance departments authority to approve or reject proposed rate changes before they go into effect, protecting consumers from unreasonable rate changes. This authority is just one of the necessary tools for building a robust rate review program. A study by the Kaiser Family Foundation found that, in addition to prior approval authority, states with "a process that allows for thorough review of filings and a mechanism for receiving input from consumers are able to extract significant reductions in the rates that insurers file."[18] States that gain new approval authority of their insurance markets are on their way to better protecting consumers, but those without such legislative authority can still pursue the improvements discussed in the remainder of this issue brief.

Providing More Public Information On Rate Increases

Thanks to the Affordable Care Act, this information is becoming easier to obtain. For rate increases over the established threshold (10 percent in 2011), insurers must publicly disclose the following:

- What they expect to spend on medical claims and how much they have spent on claims historically
- The trends they project in the cost and use of medical services
- Information about the plan's benefit changes and the resulting costs
- How much of premium dollars they collect are spent on claims, administration, and profit
- Their history of rate increases over the past three years
- A simple narrative explaining why they are requesting the proposed increase

States are using their rate review grants to expand the availability of public information, and in some cases are providing even more public information than is required under the Affordable Care Act. In general, many states are beginning to post rate filings, justifications, consumer-friendly summaries, and final decisions on their department websites. Providing the public with information about proposed rates and justifications holds insurers accountable to consumers. As a state legislator recently remarked, "The more sunlight we put on rates, the lower they will be."[19]

California, Oregon, and Washington now provide more information about rate increases to the public.

California

Greater transparency helps reduce unreasonable rate hikes.

In 2010, California passed legislation that requires insurers and HMOs to provide 60 days advance notice to policyholders before a rate change goes into effect. It also requires insurers and HMOs to provide a detailed justification for their proposed rates to the California Department of Insurance or the Department of Managed Health Care. For proposed rate increases, the departments will post the following information on their public websites:

- The insurer's justification for a rate change
- The plan's overall assumptions about future medical trends
- The plan's actual and predicted costs for various types of medical services

The California law also requires insurers to give individuals information about why their own premium rates are higher than advertised rates when they purchase a policy. For example, if the insurer charges someone higher premiums because of his or her health status, the insurer needs to explain the reason in clear terms. This will allow consumers to contest any errors in the insurer's assumptions. Insurers must also include information about their maximum rate markups due to health status in their rate filings.[20]

Public outrage at proposed rate increases helped to delay and ultimately reduce double-digit rate increases for many consumers in 2010 and 2011, but it also showed the need for the transparency and oversight that the new law begins to create. In 2010, the California Department of Insurance found major mathematical errors in calculations for rate increases by Anthem Blue Cross and Aetna.[21,22] In response, Anthem Blue Cross lowered its increase from 25 percent to 14 percent, but Aetna kept its rate the same after resubmitting its filing.[23,24] Consumer outrage because of these errors led to California's new transparency law.

In 2011, the insurance commissioner criticized Blue Shield of California, Aetna, Anthem Blue Cross, and Pacificare for proposing large rate increases.[25] After much scrutiny from the public and the commissioner, the four insurers ultimately reduced or withdrew their rate increases. For example, Blue Shield retracted its 6.5 percent increase for individual policies and Anthem Blue Cross reduced its proposed increase of 16.4 percent to 9.1 percent and agreed to post-pone increases to deductibles until 2012.[26,27,28] The Department of Insurance estimates that the rate reductions it negotiated "will save policyholders a total of a least $40 million."[29]

While public review has helped consumers, the Department of Insurance and the Department of Managed Health Care note that prior approval authority, which California lacks, would further protect consumers. For example, when the Department of Managed Health Care determined a rate change to be unreasonable, the insurer implemented it nonetheless.[30, 31] The lack of prior approval authority for rate increases, as the Insurance Commissioner puts it, means "Health insurers still hold all the cards and consumers remain at their mercy."[32]

Oregon

Oregon is farthest along in posting public information about rate filings.

Since 2007, the state has posted entire rate filings on the web for public inspection (see www.oregonhealthrates.org). In addition, the public can view correspondence between the insurance company and the Insurance Division regarding proposed rates. Though insurers sometimes argue that information should be withheld as a trade secret, Oregon notes that sharing the entire rate filing with the public has *not* resulted in any adverse consequences to the insurance market.[33] Consumers and the public are given a 30-day comment period, during which the website allows users to comment directly on proposed rates. Visitors to the site can also read others' comments and view Oregon's decisions on rate increases and its rationale. Information about past decisions can be helpful to consumer groups commenting on other rate increases.[34]

Washington

New legislation allows consumers to comment on rate filings and see where their premium dollars are going.

In July 2011, a new law went into effect that mandates that individual and small group plans disclose rate filing information before a rate increase is approved or denied. Insurers must disclose the rate information for all rate changes, not just those that exceed the federal rate threshold as specified by the Affordable Care Act.[35]

The department is now posting information on pending rate filings to its website and will also begin allowing the public to comment on pending rate increases or sign up for email updates when insurers propose a rate increase. In addition to posting information from the company's detailed filing, Washington posts a consumer-friendly summary that includes a breakdown of how premium dollars will be spent on medical claims, salaries, marketing, and other administrative costs, along with the history of the company's rate increases. The state's rate review grant is also helping it to build a consumer website called "Consumer Care," which will soon provide more information and education on health care coverage. These changes aim to inform consumers about the rate review process and publicly disclose how insurers are calculating their rate increases.

The Bottom Line

Without public disclosure of rate filing information, consumers are left in the dark about where their money is going. Health care costs are among the highest expenses a household incurs, and consumers should be aware of the reasons for premium increases. Public disclosure is also important because it holds insurers accountable to policyholders for their spending. The availability of rate filing information gives consumers and advocates the necessary information to double-check insurers' justifications for rate increases.

Creating Opportunities for Public Input During Review of Rate Increases

Public input is important to rate review because it provides an outside perspective on proposed rate increases. Methods for gathering public input include formal hearings, town halls, and having consumers send in written comments. Input from consumers and advocates can help the insurance departments catch errors and potential problems they might otherwise miss during their review. However, prior to this year, only a handful of states had established public input mechanisms. In 2010, only 14 states reported allowing consumers to provide input in the rate review process, and just six of those states reported holding public hearings on proposed rates.[36]

The Affordable Care Act encourages more states to develop mechanisms for public comment on proposed premium increases before they go into effect. If states want to qualify as having an Effective Rate Review Program, they must include a mechanism for public input before rates go into effect. Many states are using their rate review grants to strengthen or establish public input mechanisms.

We looked at how three states (Connecticut, Maine, and Oregon) are improving their public input mechanisms. These states were chosen because they have already established public input outlets. In two of these states, Oregon and Maine, we found that the insurance departments contracted with a consumer advocate group to provide independent, consumer-focused evaluations of proposed rates. These reviews provided the evidence for both states' insurance departments to reduce big rate hikes. In Connecticut, although the state's insurance laws do not require consumer input, the Attorney General and the Office of the Healthcare Advocate have called for rate hearings and have testified on behalf of consumers. In all three of these states, public input has had a major impact.

Connecticut

Input from the public, the Office of the Healthcare Advocate, and the Attorney General prevents a rate hike and improves the rate review process.

Connecticut has no law requiring hearings or public input on proposed rates. However, when the insurance commissioner approved an average rate hike of 19 percent (as high as 30-40 percent for some policyholders) for certain plans sold by Anthem in September 2010, policyholders were angry; the lack of public input and transparency in the rate review process brought the Connecticut Insurance Department under fire.[37]

Political and consumer outrage from the September case prompted the Insurance Department to hold a hearing on an increase proposed by Anthem for different insurance policies later that year. Both the Attorney General and the state's Office of the Healthcare Advocate (OHA) participated in the rate review process. The Connecticut OHA was created in 1999 and is charged with assisting consumers who have health insurance provided by a managed care organization. Together, the Attorney General and the OHA hired a health care economist to examine the filing, pointed out insufficiencies, and raised a series of questions about the possibility of an unaffordable rate increase causing consumers to switch or drop coverage. Twelve members of the public provided testimony and many more submitted written documents with public comments.[38]

Broad and extensive input from the public and the two agencies led the Insurance Department to rule that Anthem's proposed rate increase of 19.9 percent was excessive and to deny the entire rate increase. In 2011, the Insurance Department continued to crack down on excessive rate increases and rejected a proposed average increase of 35 percent by American Republic for its individual plans and average rate increases of 20 percent or more for individual HMOs and major medical plans offered through ConnectiCare Inc.[39]

The Anthem case in Connecticut shows that four sets of eyes are better than one. Having the public, the OHA, the Attorney General's office, and the Insurance Department review a proposed rate increase resulted in greater scrutiny and the rejection of excessive rates. According to Vicki Veltri, the OHA's Healthcare Advocate, "We're able to go more deeply into rate filings from an objective standpoint and help assist the department in their decision."[40] More importantly, thanks to such input, the state is forced to examine whether the rate increases are justifiably imposed on consumers. Starting this year, the OHA will be able to convene up to four hearings for proposed rate hikes of 15 percent or more for individual and small group HMO policies. While this arrangement will help obtain public input on some proposed increases in the immediate future, Connecticut still does not have a law that would secure the public's right to participate in all rate reviews in the years to come.

Oregon

Input from consumer advocacy group holds insurers accountable.

This year, Oregon strengthened its rate review program by using portions of its federal rate review grant to contract with the Oregon State Public Interest Research Group (OSPIRG) Foundation to provide regular comments on proposed rate increases.

Input from OSPIRG is helping to push the insurance division to look at the affordability of premiums as a factor of market stability, question assumptions insurers are using to calculate proposed rates, request more information from insurers, and ultimately lower rate hikes. For example, this past spring, Regence BlueCross BlueShield of Oregon proposed a 22.1 percent rate hike for individual policies, which would have affected around 59,000 individuals and families. Among the concerns raised by OSPIRG were the following:

- A big rate increase would cause enrollment to drop. Healthier enrollees would go elsewhere, and that would drive up future costs and premiums for remaining enrollees.
- The company's leaner benefit offerings were also causing people to look elsewhere for coverage.
- The company had not adequately justified its assumptions about future medical costs.
- The company was requesting 1.1 percent profit but already had higher-than-required surplus.[41]

Concerns from the division prompted them to hold the first public rate hearing in 20 years. Extensive public outreach by OSPIRG Foundation and other consumer groups led hundreds of consumers to attend the hearing and testify. During the hearing, OSPIRG Foundation called on Regence to reveal the underlying assumptions and calculations it had used to derive its 22.1 percent rate hike, do more to reduce costs while improving quality, and work to stabilize plunging enrollment by limiting rate increases.[42] In July 2011, the division ultimately found Regence's proposed increase to be unreasonable and cut it in half, allowing the company to raise its rates by only 12.8 percent.[43] This case contributed to the division's decision to begin holding regular rate hearings on most future individual and small group rate requests.[44]

As for the division's relationship with OSPIRG Foundation, it says that "[OSPIRG Foundation has] pushed for greater detail . . . [and] their focus on holding companies to complying with the letter of the law with regard to filing requirements reinforced the division's practice of establishing public transparency."[45]

Maine

Input from consumer advocacy groups, the Attorney General, and the public helps reduce rate hikes.

Maine's Bureau of Insurance has prior approval authority over its individual and small group market. For the past three years, the bureau has also held hearings for rates proposed by the largest insurers in the state. In 2010, Anthem proposed a 23 percent increase for individual policies. This increase would have affected nearly 11,000 policyholders.[46] The Attorney General, who can act as an intervening party in rate hearings, demanded that Anthem disclose more information on how they were calculating such a large rate hike and opposed the profit margin Anthem had built into its calculations. According to a consumer group in Maine, "because the Department held public comment sessions outside of Augusta [the Capital of Maine], the public had unprecedented access . . . increasing public access and participation eight to nine times what it had been in the past." [47] In this particular case, approximately 100 consumers attended the hearing.[48] The public also submitted more than 300 written comments on the proposed rate increase.[49] Scrutiny from the Attorney General and strong input from the public on how this rate hike would negatively affect Mainers, on top of an in-depth review by the bureau, led to a reduction in the rate increase from 23.1 percent to 14.1 percent. [50]

In January of 2011, Anthem filed for a 9.7 percent increase to its individual policies. This time, in addition to the Attorney General intervening, federal funding from the bureau's rate review grant provided Consumers for Affordable Health Care (CAHC) with the resources to conduct an in-depth review of Anthem's filing. Both the Attorney General and CAHC cross-examined Anthem's data, made several requests for more information, and provided expert testimony during the rate hearing.[51] The superintendent, based on her review and input from the two contributing groups, approved a lower rate of 5.2 percent after finding that Anthem's projected administrative costs and profit margin were excessive.[52] The Bureau's decision saved consumers nearly $3 million in premiums—half of which would have gone toward profits for Anthem.[53,54]

The Bottom Line

Input from the public, consumer advocacy groups, and agencies like the Attorney General's office provides a second look at rate filings. This can flag errors that the insurance department might have missed. State insurance departments are tasked with balancing the financial needs of health insurance companies and the affordability of coverage to consumers. Clearly, if insurers cannot stay in business, then consumers are left without insurance. But, if coverage is unaffordable, people may never be able to purchase it in the first place. Insurers have the resources to make a strong case for the necessity of rate increases. Allowing for public input gives consumers a voice and ensures the fairness of the rate review process.

Collecting More In-Depth Information And Better Analyzing Data

States are standardizing and expanding the data and information that they receive from insurers and improving their methods for using these data to review rates. These improvements are desperately needed. In the past year, 20 states reported that they did not independently verify rate filing information submitted by an insurer.[55] Collecting more in-depth information and thoroughly double-checking insurers' calculations of rate increases will help save consumers from paying higher premiums to cover administrative expenses or profits rather than better quality of health care.

The Affordable Care Act ensures that either CMS or state insurance departments collect and examine a number of factors that make up a proposed rate increase above an established threshold. These factors are listed in detail on page 3. Maryland and New Jersey are taking steps to analyze additional factors more efficiently.

Maryland

Changes to data collection and disclosure forms will make rate review more effective.

In January 2011, a consultant recommended that the Maryland Insurance Administration enhance its review and oversight of insurance by standardizing all rate filings—not just those above the threshold specified under the Affordable Care Act—and requiring insurers to submit complete and detailed data. The consultant's report also urged Maryland to gather more state-specific data about medical trends and insurers' capital and surplus.[56,57] A public hearing was held in June to discuss the consultant's recommendations, and the public, insurers, and provider groups generally expressed support for these recommendations. In a letter to the Insurance Administration, the Maryland Hospital Association, for example, wrote "[the Maryland Hospital Association] has questioned the apparent inconsistency between declining, low-single-digit rates of increase in total Maryland hospital costs, and steadily climbing, double-digit health insurance premium increases. Unveiling the reasons for this inconsistency requires information that is not currently readily available."[58] Providing more public information on rate filings and improving data collection may help keep rising insurance premiums in check.

Moving forward, Maryland is improving the information it provides to consumers by doing things like spelling out the key drivers of premium increases. The insurance administration is also creating opportunities for public comment during the rate review process.[59]

New Jersey

Standardization of data collection will streamline the review process.

New Jersey is a file and use state—in the individual and small group markets, insurers must submit a rate filing with the New Jersey Department of Banking and Insurance (DOBI) prior to using a rate. However, an insurer is not required to wait for the approval of DOBI before implementing a proposed rate change. Rates can be disapproved before or after they go into effect. According to law, disapproval can be for any of the following reasons:

1. The filing is incomplete
2. The filing does not comply with the law, including requirements that
   - rates are set so that at least 80 percent of premiums collected will be spent on medical claims (the "medical loss ratio")
   - differences in premium rates are based only on age and, in some cases, gender and location, and
   - the difference between the highest and lowest premium rates fall within established limits
3. The rates are inadequate
4. The rates are unfairly discriminatory[60, 61]

While there are regulations on what insurers must submit in a filing, insurers do not have to submit the information in a particular format.[62] In order to improve efficiency and accuracy, DOBI is using its rate review grant to work with consultants to develop a standard format for automated filing and review. An insurer has the right to a hearing to contest a finding that rates are not in compliance with the law. Unfortunately, consumers do not have the right to call hearings when they believe rates are discriminatory or will negatively affect them.

The Bottom Line

The Affordable Care Act requires insurers to submit standardized information for all proposed rate increases of 10 percent or more. It also creates a uniform process for disclosing that information to the public. This standardization will streamline the rate review process, enabling states to analyze rate hikes faster and making it easier for the public to understand what they are paying for.

As in Maryland and New Jersey, the Affordable Care Act has started to standardize the collection and review of all proposed rate changes—not just those above the 10 percent threshold. Standardization would ultimately better protect consumers by cutting the time it takes to review rates.

Using Rate Review as a Tool for Cost Containment

The growth of health insurance premiums correlates to the rising costs of medical care, which continue to outpace the growth of earnings and inflation.[63] States with a robust rate review program can protect consumers from unreasonable rate increases and hold plans accountable by ensuring that the majority of premium dollars are spent on the medical needs of policyholders. Unfortunately, rate review is not currently structured to address the ultimate problem of rising health care costs.

Moving forward however, states such as Massachusetts, Oregon, and Rhode Island are beginning to look at rate review as a potential mechanism to clamp down on the exponential growth of medical costs.

Massachusetts

Agencies and new legislation work to bend the health care cost curve.

Currently, the Massachusetts Division of Insurance requires all insurers to include detailed explanations of the bases for all rate requests, including explanations of what carriers are doing to contain costs when they file a rate change.[64] The division is also focused on examining variations in payments to providers and promoting care coordination. Additionally, the division is pursuing new ways to educate consumers about choosing providers, reducing medical costs by making healthier lifestyle choices, and seeking medical homes. Overall, the division is pursuing cost containment by using rate review, focusing on preventive care, and promoting healthier lifestyles as ways to bend the cost curve.[65]

In 2008, Massachusetts passed "An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care."[66] One of the many things the law did was create a Special Commission on Health Payment Reform "to investigate restructuring the current payment system to provide incentives for efficient and effective care." The commission's unanimous recommendations included moving health payers to global payments and emphasized the need for preventive care and greater care coordination.

The law also authorized the Division of Health Care Finance and Policy and the Attorney General to review the underlying growth of medical care costs and to hold annual public hearings with health care providers and insurers on the matter. In the Attorney General's 2010 reports, she found that the prices insurers paid to hospitals and provider groups in the same geographical areas varied greatly, and that these variations were based

on market leverage of hospitals and provider groups, rather than on differences in quality of care provided. Moreover, the report found that the recent increases in health care costs in Massachusetts were due to price increases and not to an increase in the use of services.[67]

These findings led to the passage of legislation in 2010 that requires providers and hospitals to report, in a standardized format, their total medical expenditures and quality of performance. It also established tiered and limited network health insurance plans that lower the cost of premiums. At the behest of the governor, Massachusetts is now currently contemplating legislation that would encourage the formation of accountable care organizations, make reforms to the payment system, and allow the Division of Insurance to consider projected reimbursement rates for providers when reviewing an insurer's rate filing.[68]

Oregon

A new study looks at ways to use rate review for cost containment.

The Oregon Insurance Division reviews and approves individual, small group, and portability plans, but has found that, despite having a robust rate review system and ensuring that a high portion of premiums are being spent on health care, costs to consumers are continuing to rise.[69] That's due to the continuing growth of medical claims costs, which are the primary driver of rate increases.[70] Therefore, Oregon is researching whether or not the division can influence medical claims costs through the rate review process. Examples that might be considered include requiring insurers to spend more on primary care, rejecting rate increases if provider costs go up by more than a set percentage, or rejecting rate increases if an insurer's contract with a provider covers serious medical errors caused by the provider.[71]

The division's study on using rate review in conjunction with potential cost containment measures will wrap up by the fall of 2011.

Rhode Island

State's Standards of Affordability work to slow the growth of medical costs.

The Office of the Health Insurance Commissioner (OHIC) was established by the Rhode Island Health Care Reform Act of 2004 to oversee health insurance. Its objectives are 1) protecting consumers, 2) encouraging fair treatment of medical service providers, 3) ensuring financial success for health insurers, and 4) improving the health care system's quality, accessibility, and affordability.[72]

OHIC started efforts to address premium costs to consumers in 2008 by requiring insurers to list steps they were taking to make coverage more affordable.[73] In 2009, OHIC, the Health Insurance Advisory Council (composed of consumers, businesses, and medical providers), and

insurers developed the Standards of Affordability. They include investing in primary care infrastructure, expanding adoption of the chronic care model medical home, standardizing electronic medical record incentives, and working toward comprehensive payment reform across the health care delivery system.[74] (For more on Rhode Island's Standards of Affordability, see www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_Affordability%20Report.php.)

OHIC and insurers agreed that, in order to slow the growth of health care costs, health insurance plans will "increase the portion of medical spending on primary care by five percentage points (from 5.9 percent to 10.9 percent) over five years, without increasing total medical expenditures."[75] The goal is to create a strong primary care infrastructure for Rhode Islanders, which will keep health care costs down in the long run.[76]

Insurers have generally been supportive of and engaged in the implementation of the Standards of Affordability. The process also involved a great deal of public input, and now that the standards have been created, OHIC continues to educate the public on the issue.

Currently, OHIC is wrapping up the second year of implementation. It's too early for detailed statistics, but OHIC believes that the standards and other efforts to make coverage more affordable will reduce the growth of health care costs over time.[77] Rate increases requested by two of the three largest insurers in Rhode Island have been declining for three years now.[78]

Rhode Island is also using its rate review grant to fund a study on the costs of inpatient and outpatient care with Medicare, Medicaid, and commercial plans. They completed a study last year about the difference in costs for hospital care among different types of coverage. The study found that hospitals affiliated with a system of providers receive higher payments from plans than unaffiliated hospitals.[79]

The Bottom Line

Increasing medical claims costs often motivate insurers to request a big rate hike. However, work in states like Massachusetts, Oregon, and Rhode Island shows that rising costs may be addressed by better coordinating care for patients, ensuring that consumer dollars are spent on high-quality care, and educating consumers on lifestyle changes that can reduce health care costs.

Conclusion

Rate review is an important consumer protection tool, and grants from the Affordable Care Act are helping all states—regardless of their current level of authority—to make improvements to their programs. As we have seen throughout this issue brief, states are making innovative changes to better protect consumers from excessive rate increases. They are pursuing more authority over their health insurance markets, providing the public with more information, creating opportunities for public input, collecting more in-depth information from insurers, and better analyzing these data. To address rapidly growing costs to consumers, some states are now also attempting to use rate review to control health care costs.

Improvements to the rate review process are making a difference in the lives of consumers who are struggling to afford coverage as premiums continue to rise. Although rate review is just one tool in an arsenal of consumer protections, it is arguably the key element keeping the costs of premiums from skyrocketing out of control. When used effectively, rate review holds insurance plans accountable to the people they serve. However, states must continue to make progress in order to adequately protect consumers from the rising costs of insurance premiums.

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