



Individual and Small-Group Market Health Insurance Rate Review and Disclosure:

State and Federal Roles After PPACA

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OVERVIEW — Oversight of private insurance, including health insurance, is primarily a state responsibility. Each state establishes its own laws and regulations regarding insurer activities, including premium increases for the insurance products within its purview. The authority that state regulators have to review and deny requests for premium changes varies from state to state, as do the amount of resources available to state insurance departments for reviewing premium changes. In some markets where insurers have proposed or implemented steep increases, such changes have received considerable attention from the press, state regulators, and policymakers. The Patient Protection and Affordable Care Act (PPACA) requires annual review of premium increases and disclosure of those increases determined unreasonable beginning in September 2011. Under PPACA, each state will conduct these reviews for individual and small-group health insurance unless the federal government concludes they do not have an effective review program and assumes review responsibility. As they did prior to PPACA, state laws govern whether rates go into effect and establish the parameters of regulators' authority. This issue brief outlines specific state and federal roles in the rate review process and changes to rate review processes since PPACA was enacted.

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Individual and small-group coverage is typically purchased from insurers, which are regulated by the states, while most (though not all) large-group coverage is purchased from self-funded employers, which are not subject to state regulation.¹ Nationally, about 14 million² people were covered by individual (also called non-group) insurance and about 22 million³ workers and dependents were covered by a small-group employer policy in 2010. Enrollees or employers on behalf of their employees pay a premium in exchange for a pre-determined set of health benefits under their health insurance. Insurers calculate premiums (or rates) using “actuarial estimates of the cost of providing coverage over a period of time to policyholders and enrollees in a health plan.”⁴ Policyholders may face premium changes each year that reflect actuarial analysis of the changes in the underlying costs of insurance—price and utilization of services, administrative costs, profit, and other factors.⁵ According to the Kaiser/HRET survey of employer-sponsored health benefits, premiums for family coverage have increased between 2001 and 2011 at an average annual rate of 7.3 percent for firms with 3 to 199 workers and 8.1 percent for firms with 200 or more workers.⁶ Data on premiums and premium trends for people with individual health insurance are scant, but one nationally representative survey of people with individual health insurance in 2010 found that 77 percent faced a premium increase at their last renewal, with annual increases averaging 20 percent among those experiencing increases.⁷

A number of steep premium increases for individual and small-group policies, as well as instances of insurer miscalculations, have called attention to the increasing cost of coverage, the lack of information about what drives premium increases, and states’ authority and resources to oversee insurer conduct. Anthem Blue Cross of California’s request in February 2010 for a 39 percent increase in health insurance premiums in the individual market received national attention. After delaying implementation of the new rates, an independent

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actuary hired by the state to review Anthem's filings discovered errors in its calculations, resulting in Anthem withdrawing its request and seeking a lower average increase of 14 percent and a maximum of 20 percent.⁸ Certainly, rate increases are not always the result of errors, but this case highlights the potential benefit to enrollees when insurers' calculations are reviewed independently.

STATE AUTHORITY TO REVIEW AND APPROVE RATES

Regulation and licensure of health insurance is primarily a state responsibility.⁹ Requirements for insurance carriers are generally enforced by a state department of insurance and the state insurance commissioner. Each state establishes its own laws and regulations for aspects of insurers' activities, such as financial standards, market conduct, contracts, consumer complaints, and premium rates for the health insurance products it regulates. States may have different requirements for different market segments—individual, small-, or large-group policies—or for different product types such as HMOs, PPOs, or indemnity plans. States may define market segments differently, but most define a small employer as having 2 or more but not more than 50 employees and a large employer as having at least 51 employees.¹⁰

One way that states exercise their regulatory authority is by requiring insurers to file information about rates and, in some cases, requests to increase rates, prior to implementing them.¹¹ Rates are typically "filed as a formula that describes how to calculate a premium for each person or family covered, based on information such as geographic location, underwriting class, coverage and co-payments, age, gender, and number of dependents."¹² Oversight requirements for insurers' rates "are used to help ensure that premium rates are adequate, not excessive, reasonable in relation to the benefits provided, and not unfairly discriminatory."¹³ As with other regulated aspects of insurer conduct, states vary in their requirements for notifying state regulators of rate changes and providing information to justify those changes. State regulators' authority to review and deny requests for rate changes also varies, as does the amount of resources available to state insurance departments for reviewing rates and the information required. Most states require rates and supporting information to be filed with the state, though some require it only for HMOs or BlueCross BlueShield plans, or if there is a rate increase proposed. As of December 2010, ten states did not require such rate filings and instead require actuarial certification that the rates comply with state laws.¹⁴

States' rate review authority falls largely into two categories: "file and use" and "prior approval." In states with file and use authority, rates once filed with the state can go into effect on a specified date without state approval. In states with prior approval authority, state regulators may review rate filings and approve or disapprove rates based on their analysis of insurers' assumptions and calculations before they go into effect. In some states with prior approval authority, the rates are deemed approved if the state does not take action within a specified period, typically 30 or 60 days. Thirty-four states and the District of Columbia have prior approval authority over the individual or small-group markets.¹⁵ In 13 of those states, that authority is limited to the individual market, the small-group market, or certain product types.

As noted in a December 2010 report that looked in-depth at the review authority and practices in 10 states, a state's statutory authority to review rate increases does not provide detail about the rigor of the rate review process, nor does a state insurance department's prior approval authority over rates necessarily preclude large rate increases from taking effect. How reviews are conducted and what actions are taken "can vary widely from state to state, depending on motivation, resources, and staff capacity."¹⁶ A July 2011 U.S. Government Accountability Office (GAO) report observed such variation in states' authorities, but also found that "not all variation in states' practices was consistent with differences in state insurance departments' authorities to review and approve or disapprove rate filings."¹⁷ The report examined states' oversight of private health insurance premium rates and reported the results of a state survey of insurance commissioners. It found variation in state authority to review rate filings and variation in practices such as the timing of reviews, the type of information considered, and opportunities for consumer input. The survey also found variation in the comprehensiveness of states' reviews, for example:

Survey respondents from Texas reported that for all filings reviewed, all assumptions, including the experience underlying the assumptions, were reviewed by department actuaries for reasonableness, while respondents from Pennsylvania and Missouri reported that they did not always perform a detailed review of information provided in rate filings. Respondents from Pennsylvania reported that while they compared data submitted by carriers in rate filings to the carriers' previous rate filings, the state's department of insurance did not have adequate capacity to perform a detailed review of all rate filings received from carriers. Respondents from Missouri reported that they looked through the information provided by carriers in rate filings in 2010, but that they did not have the authority to do a more comprehensive review.¹⁸

REVIEW AND DISCLOSURE OF UNREASONABLE PREMIUM INCREASES

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), passed on March 23, 2010, and amended by the Health Care Education Reconciliation Act (P.L. 111-152), requires the Secretary of the Department of Health and Human Services (HHS), in conjunction with the states, to establish and carry out a process for the annual review and disclosure of unreasonable health insurance premium increases.¹⁹ The final rule implementing the annual review and disclosure provision establishes standards and processes for

Characteristics of an Effective State Rate Review System

The Center for Consumer Information and Insurance Oversight (CCIIO), a division of the Centers for Medicare & Medicaid Services (CMS), determines a state's rate review system to be effective if it :

- Receives sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases.
- Considers several factors as they apply to the review:
 - Medical cost trend changes by major service categories
 - Changes in utilization of services (i.e., hospital care, pharmaceuticals, office visits) by major service categories
 - Cost-sharing changes by major service categories
 - Changes in benefits
 - Changes in enrollee risk profile
 - Impact of over- or underestimate of medical trend 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.
- Makes a determination of the reasonableness of the rate increase under a standard set forth in state statute or regulation.
- Posts either rate filings under review or preliminary justifications on their websites, or posts a link to the preliminary justifications that appear on the CMS website.
- Provides a mechanism for receiving public comments on proposed rate increases.
- Reports results of rate reviews to CMS for rate increases subject to review.

Source: "Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses," Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services, fact sheet, available at http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

determining whether a premium increase is unreasonable and requirements for public notification of unreasonableness; it is effective for rate changes scheduled on or after September 1, 2011.²⁰ Insurers are required to submit justification for rates that meet or exceed the minimum threshold for review—10 percent in 2011—and either the state or CMS will determine whether the increase is unreasonable. In states deemed to have effective rate review programs, CMS will adopt the states' assessments of the reasonableness of a submitted rate; in states without effective programs, the federal government will assess reasonableness. State laws and regulations regarding rate review and approval authority still apply to insurers in the state, and rates deemed unreasonable under the federal process may still go into effect depending on state law. Requirements for disclosure and review of unreasonable premium increases apply to individual and small-group health insurance plans, but do not apply to large-group plans, grandfathered²¹ plans, or insurance coverage that meets the definition of "excepted benefits" (for example, limited scope dental and vision).

CMS: Most State's Rate Review Programs Effective

To determine readiness to assist with the PPACA-mandated rate review and disclosure provisions, CMS evaluated each state's current review process and determined whether it has an effective rate review program for individual and small-group market products. (See text box for characteristics of an effective rate review system.) Based on its review and evaluation, CMS announced that, as of August 22, 2011:

- 42 states, the District of Columbia, and the U.S. Virgin Islands have effective review for all insurance markets and issuers;
- 2 states (Pennsylvania and Virginia) have effective rate review for the individual market and the federal government will review small-group rates;
- 6 states (Alabama, Arizona, Louisiana, Missouri, Montana, and Wyoming) and four U.S. territories (American Samoa, Guam, Northern Mariana Islands, and Puerto Rico) were found not to have effective rate review programs, and the federal government will review rates to determine reasonableness.

PPACA required the Secretary to award grants to states during the five-year period beginning with fiscal year 2010 to help states carry

out premium reviews and provide information to the Secretary.²² The law appropriated \$250 million to be available for spending under the grants program. On August 16, 2010, HHS announced the first round of grants to states who applied for awards; each of the 45 states that applied plus the District of Columbia were awarded \$1 million to enhance their current processes for reviewing health insurance premium increases. Five states—Alaska, Georgia, Iowa, Minnesota, and Wyoming—did not apply for the first round of grant funding. In their applications, states outlined their intended use of grant funds for pursuing additional legislative authority (18 states and DC), expanding the scope of their current health insurance review process (21 states and DC), implementing a more extensive and detailed review process (46 states), making more information available to the public (42 states and DC), and upgrading necessary technology (all grant recipients).²³ Twenty-one states addressed changes to premium rate review in their 2011 legislative session and, as of July 21, 2011, nine states—Hawaii, Maine, New Mexico, New York, North Dakota, Tennessee, Utah, Vermont, and Washington—passed laws to change their rate review processes.²⁴ A second round of grants to states was announced in February 2011.²⁵ Those grants, totaling \$109 million, were awarded to 28 states and the District of Columbia on September 20, 2011. States receiving the second-round grants have proposed to use the funding to introduce legislation to strengthen authority to review or publish rate increases, expand the scope of their review, bolster the information required from insurers, enhance consumer access to information about rate review, hire new staff, and improve information technology.²⁶

Defining and Determining “Unreasonable” Rate Increases

According to the regulation, the first step to determining whether rate increases are unreasonable is for CMS or the state to review rate increases that meet or exceed specified thresholds. In the first year of the review process, an increase in the rate²⁷ in the individual or small-group market is subject to review if it is at least 10 percent more than the previous year’s rate. After the first year, state-specific thresholds will apply.²⁸ State-specific thresholds will be published no later than June 1 of each year and will be effective September 1 of that year.

For states determined to have effective rate review programs, CMS will adopt the states’ assessments of unreasonableness of a submitted

rate. A state's final determination must include an explanation of its analysis and be provided to CMS within ten business days following its determination. For states lacking effective rate review programs, CMS will review submitted rate increases. It will use three tests to determine whether a rate increase is excessive, unjustified, or unfairly discriminatory and therefore unreasonable. An increase will be determined²⁹:

- **excessive** if it causes the premium to be unreasonably high relative to the benefits of the policy. CMS will consider “whether (1) the rate increase would result in a projected medical loss ratio below the applicable federal standard; (2) one or more of the assumptions is not supported by substantial evidence; and (3) the choice of assumptions is unreasonable.”
- **unjustified** “if the issuer provides data or documentation that is incomplete, inadequate, or otherwise does not provide a basis to determine whether the increase is unreasonable.”
- **unfairly discriminatory** “if it results in premium differences between insured people with similar risks that are not permitted under State law or, if there is no applicable State law, does not reasonably correspond to expected differences in costs.”

Justification for Rate Increases Subject to Review

The PPACA rule establishes requirements for health insurers to submit a preliminary justification to CMS and applicable states for all rate increases subject to review. The health insurance issuer must send CMS and the state the preliminary justification (i) prior to the implementation of the rate increase, in states that do not require a proposed rate increase to be filed prior to implementation of the increase, or (ii) on the date the issuer submits the proposed increase to the state, in states that require a proposed rate increase to be filed with the state prior to implementation.

The preliminary justification has three parts. Part I, the “rate increase summary,” must include:

- historical and projected claims experience,
- trend projections related to utilization and service or unit cost,
- claims assumptions related to benefit changes,

- allocation of the overall rate increase to claims and non-claims costs,
- per-enrollee per-month allocation of current and projected premium, and
- three year history of rate increases for the product associated with the rate increase.

Part II, the “written description justifying the rate,” is a “simple and brief narrative describing the data and assumptions used to develop the rate increase, the most significant factors causing the increase, and a brief description of the policies’ overall experience.” Part III is the “rate filing documentation,” which must be provided to CMS when it is reviewing the rate increase; for states with effective review processes CMS will accept a copy of a rate filing submitted to a state that included each of these elements. Part III must include:

- a description of the type of policy, benefits, renewability, general marketing method, and issue age limits;
- scope and reason for the rate increase;
- average annual premium per policy, before and after the rate increase;
- past experience and any other alternative or additional data used;
- a description of how the rate increase was determined, including the general description and source of each assumption used;
- the cumulative loss ratio and a description of how it was calculated;
- the projected future loss ratio and a description of how it was calculated;
- the projected lifetime loss ratio that combines cumulative and future experience and a description of how it was calculated;
- the federal medical loss ratio standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under federal law; and
- if the projected future loss ratio is less than the applicable federal medical loss ratio, a justification for this outcome.

The information on Parts I and II will be available for review through the HealthCare.gov website. Information not deemed confidential in Part III will be on CCIIO’s website.

Public Release of Review Outcomes and Unreasonable Rate Increase Findings

The final determination of whether a rate increase is unreasonable will be posted on the CMS website and the insurer's website. If CMS has reviewed the increase, its determination and a brief explanation of its analysis will be posted within five business days. CMS will also provide this information to the health insurance issuer in cases when the increase is determined to be unreasonable. As mentioned above, CMS will adopt the state's final determination in states deemed to have an effective review process. In states where the state determines that the rate increase is unreasonable, but the insurer is permitted to implement the increase under state law, CMS will provide the state's final determination and explanation to the insurance issuer within five business days of CMS receiving the information from the state.

Health insurers that implement unreasonable rate increases must provide CMS with a "final justification" responding to CMS's or the state's determination within ten days of implementing the increase or receiving the final determination. Health insurers must also prominently post on their website: (i) the portions of the preliminary justification posted on the CMS website; (ii) CMS's or the state's final determination; and (iii) the issuer's final justification. This information must be made available on the issuer's website for at least three years. In addition, CMS will make an issuer's final justification available on HealthCare.gov for three years. HHS released a preview of the publicly available rate review tool for consumers on September 1, 2011.³⁰

CONCLUSION

The PPACA provisions requiring rate review and disclosure maintain state responsibility for regulation of insurance and do not prohibit insurers from implementing rate increases deemed excessive under the federal definition for non-grandfathered individual and small-group health insurance plans where states do not have authority to disapprove rates. Rather, the law requires disclosure of information about premium increases and their basis to regulators. Regulators expect that this scrutiny, in combination with the subsequent public disclosure about rates deemed excessive and other policy changes such as minimum medical loss ratio requirements for health insurers, will help to moderate premiums for consumers

purchasing individual or small-group insurance policies. The effectiveness of the rate review and disclosure process to moderate unreasonable premium increases depends on adequate capacity in the states and in the federal government to manage the review process and consumer access to information, which will likely be enhanced by grant funding. The authority that states have to disapprove unreasonable rates, which is not directly affected by the PPACA requirements, will also still play an important role in the moderation of premium increases. Although the process will not prohibit a justifiably steep rate increase from going into effect, the information required on the justification forms will provide valuable insight into the extent to which different drivers of premiums, such as price and use of medical services, the risk profile of covered populations, and administrative costs, change from year to year and contribute to premium increases.

ENDNOTES

1. U.S. Government Accountability Office (GAO), "Private Health Insurance: State Oversight of Premium Rates," GAO-11-701, July 2011, p. 5, available at www.gao.gov/new.items/d11701.pdf.
2. Henry J. Kaiser Family Foundation (KFF), "Survey of People Who Purchase Their Own Insurance," June 2010, p. 6, available at www.kff.org/kaiserpolls/upload/8077-R.pdf.
3. Estimate of the number of persons covered by a policy through a small employer (<50 employees) is from Stacey McMorro, Linda J. Blumberg, and Matthew Buettgens, "The Effects of Health Reform on Small Businesses and Their Workers," June 2011, p. 6, available at www.rwjf.org/files/research/72530quickstrike201106.pdf.
4. GAO, "Private Health Insurance: State Oversight of Premium Rates," p. 5.
5. For an extensive discussion of the factors that drive premium increases, see Mark Newsom and Bernadette Fernandez, "Private Health Insurance Premiums and Rate Reviews," Congressional Research Service, Order Number R41588, pp. 4–13, January 11, 2011.
6. Average annual rate of growth is author's calculation using data from the Henry J. Kaiser Family Foundation, Health Research and Educational Trust (Kaiser/HRET), *Employer Health Benefits 2011: Annual Survey* (Menlo Park, CA:Kaiser Family Foundation, 2010), p. 23, available at <http://ehbs.kff.org/pdf/2011/8225.pdf>.
7. KFF, "Survey of People Who Purchase Their Own Insurance," p. 6.
8. Duke Helfand, "A mathematical David stuns a healthcare Goliath," *LA Times*, July 15, 2010, available at <http://articles.latimes.com/print/2010/jul/15/business/1a-fi-anthem-20100716>.

9. For a summary of federal vs. state regulation of health insurance see, Kaiser Family Foundation, "How Private Health Insurance Works: A Primer, 2008 Update," April 2008, pp. 8–20, available at www.kff.org/insurance/upload/7766.pdf.
10. "PPACA redefined a small employer as an employer with an average of 1 to 100 employees, and a large employer as an employer with an average of at least 101 employees. For plan years beginning before January 1, 2016, a state has the option to define small employers as having employed an average of 1 to 50 employees during the preceding calendar year and to define large employers as having employed an average of at least 51 employees during the preceding calendar year." GAO, "Private Health Insurance: State Oversight of Premium Rates," p. 5, note 13.
11. Newsom and Fernandez, "Private Health Insurance Premiums and Rate Reviews," p. 15.
12. GAO, "Private Health Insurance: State Oversight of Premium Rates," p. 5.
13. GAO, "Private Health Insurance: State Oversight of Premium Rates," p. 5.
14. Sabrina Corlette and Janet Lundy, "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," Henry J. Kaiser Family Foundation, December 2010, Appendix A, available at www.kff.org/healthreform/8122.cfm.
15. Corlette and Lundy, "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," Appendix A.
16. Corlette and Lundy, "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," p. 9.
17. GAO, "Private Health Insurance: State Oversight of Premium Rates," p. 11.
18. GAO, "Private Health Insurance: State Oversight of Premium Rates," p. 13.
19. P.L. 111-148, sections 1003, 10101(i), 124 Stat. 119, 139, 891 [adding and amending Public Health Service Act (PHSA) section 2794].
20. On December 23, 2010, the Center for Consumer Information and Insurance Oversight (CCIO) in Center for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (HHS) issued a notice of proposed rulemaking implementing rules for health insurance issuers regarding the disclosure and review of unreasonable premium increases. The final rule with comment implementing requirements for disclosure and review of unreasonable premium increases was released on May 23, 2011. See U.S. Department of Health and Human Services (HHS), "Rate Increase Disclosure and Review," Federal Register, vol. 76, no. 99, May 23, 2011, available at www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf.
21. Grandfathered plans are plans that existed on March 23, 2010; see HealthReform.gov, "Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and 'Grandfathered' Health Plans," available at www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.
22. P.L. 111-148 section 1003, 124 Stat. 139, 140, 891 [adding and amending PHSA section 2794(a)(1) and (c)].

23. HealthCare.gov, "Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities," available at www.healthcare.gov/news/factsheets/rateschart.html.
24. NCSL, "State Approval of Health Insurance Rate Increases," updated September 1, 2011, available at <http://www.ncsl.org/?tabid=19787>.
25. HHS, "News Release: States Can Apply for Nearly \$200 Million to Help Fight Health Premium Increases," February 24, 2011, available at www.hhs.gov/news/press/2011pres/02/20110224a.html.
26. HHS, "Over \$100 Million to Help States Crack Down on Unreasonable Health Insurance Rate Hikes," September 20, 2011, available at www.healthcare.gov/news/factsheets/2011/09/rate-review09202011a.html.
27. To calculate whether the threshold is met or exceeded, the weighted average (the average increase over all policies weighted by the premium volume) increase for all enrollees subject to the rate increase will be used. Rate increases during the 12-month period that precedes the date on which a rate increase is effective are aggregated to determine whether the specified threshold is met or exceeded.
28. CMS is working with the National Association of Insurance Commissioners to develop methods for determining state-specific thresholds.
29. HHS, "Rate Increase Disclosure and Review," p. 29968.
30. See www.healthcare.gov/ratereview09012011a.html.