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Health Policy Brief

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'Unreasonable' Insurance Rate Increases. The Affordable Care Act requires states and the federal government to review premium increases that appear excessive.

WHAT'S THE ISSUE?

The Affordable Care Act of 2010 requires the federal government to work with the states to develop a process for reviewing "unreasonable" increases in premiums for certain categories of health insurance. The Department of Health and Human Services (HHS) recently issued a proposed rule defining the meaning of "unreasonable" and describing how states and the federal government would review insurance company proposals to increase premiums. The goal is to discourage insurers from inappropriately raising premiums and to make the health insurance market more consumer-friendly and transparent.

This brief describes what is in the law and the proposed federal regulation, and summarizes criticisms coming from insurers on the one hand and consumer groups on the other.

WHAT'S THE BACKGROUND?

Health insurance premiums have risen steadily during the past decade and have grown much more rapidly than general inflation or wages (Exhibit 1). Many factors contribute to rising premiums. These include increases in outlays on health care, such as spending on hospital and physician services; changes in the benefits covered by health insurance policies; changes in the demographics of insured people, such as age; and rising insurer profits and administrative costs.

As health insurance becomes less affordable, more people are likely to become uninsured. The number of uninsured Americans younger than age 65 rose to 50 million in 2009, the latest year for which federal Census Bureau data are available (Exhibit 2).

VARIATION IN STATE OVERSIGHT: Companies in the so-called large-group market (employers with more than 50 employees) typically either self-insure or, if they do purchase health insurance, negotiate premiums directly with insurers and brokers with little regulation by the state or federal governments. In the individual and small-group markets (employers with 50 or fewer employees) where, among other factors, buyers have far less leverage, states generally oversee insurance company offerings.

Regardless, little information is made public about the factors behind rate increases. As a result, people enrolled in health insurance plans often lack the tools and information they need to understand why rates have increased and whether the increases are warranted based on expected costs. This lack of information and transparency limits enrollees' ability to act as educated consumers in the health insurance market.

Although the federal government expanded its role in oversight of private health insurance under the Affordable Care Act, insurance is still largely overseen at the state level. What's more, oversight of private health insurance

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varies substantially from state to state. Most states require insurers to submit information on the premiums and rates that they intend to charge, but beyond that, there isn't much consistency from one state to another in how regulators can react.

Insurance terms can be confusing, but here is a brief explanation. "Premiums" are the amounts charged to individuals or groups for certain types of insurance. Premiums, in turn, are based on "rates," which are estimates of the costs and revenues associated with the insurance being offered. "Costs" include the payments insurers make for medical claims as well as their own administrative expenses and profits. (Starting this year, insurance companies must spend at least 80 percent of the premiums they collect on paying these medical claims and providing related health care services. See the Health Policy Brief published on November 24, 2010, for more information on the so-called medical loss ratio.)

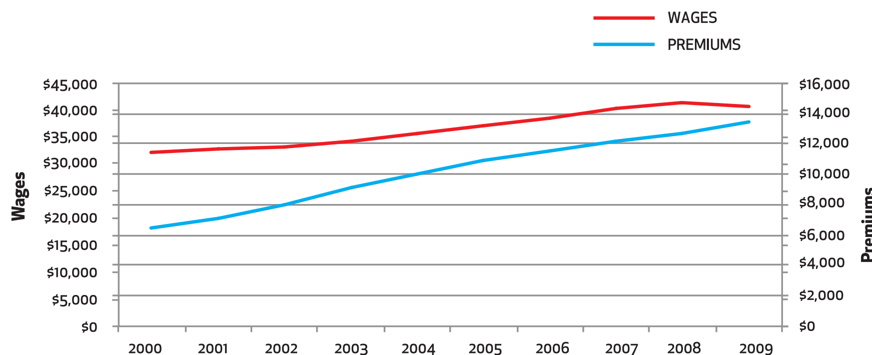
10%

Annual premium increase
Insurance rate increases averaging 10 percent or more will be reviewed to determine whether they are justified.

VARIATION IN STATE AUTHORITY: Forty-three states have some sort of process in place allowing state regulatory authorities to review health insurance rates in either the individual or small-group markets, or in both. The type and level of detail required in the rate review process varies by state; some states' regulators have the authority to disapprove rate increases while others can only review proposed increases but cannot deny them. Three states—Missouri, Montana, and Wyoming—do not require insurers to file rate information at all. The remaining states only require that insurers tell regulators about new rates on an informational basis or as they go into effect or soon thereafter (Exhibit 3).

EXHIBIT 1

Average Annual Premiums Versus National Wages, 2000-09



SOURCE Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2010 Annual Survey. Social Security Administration, National Average Wage Index 2009. **NOTES** Average total annual premiums for workers with family coverage. Premium estimates are significantly different from estimates for the previous year shown ($p < 0.05$).

In a recent study, the Kaiser Family Foundation found that the effectiveness of state review programs in protecting consumers from large rate increases depends on a state's underlying legal authority, staffing resources, and the time in which the reviews must be completed. The report concludes that states with more active rate review processes are more likely to extract significant reductions in the rates that carriers file than states that do not have prior approval authority and lack the capacity to comprehensively review rates.

WHAT'S IN THE LAW AND REGULATION?

The Affordable Care Act requires HHS, in conjunction with the states, to establish a process to review "unreasonable" increases in premiums every year. The law did not define what was meant by unreasonable, specify how the review should be conducted, or describe what information would justify a rate increase. HHS last year solicited public input and in December 2010 issued a proposed regulation outlining how the process would work. Following another period of public comment, a final rule is expected to be issued later this year.

Under the proposed rule for plans with rate increases filed or effective on or after July 1, 2011, rate increases averaging 10 percent or more in the individual or small-group markets will be considered unreasonable and subject to further review to determine if they are justified. The review process will not apply to rate increases in the large-group market, such as for companies with more than 50 employees, or for plans that are "grandfathered" under conditions prior to enactment of the Affordable Care Act. (See the Health Policy Brief published on October 29, 2010, for more information on "grandfathered" insurance plans.)

HHS chose 10 percent as the threshold because it is greater than the overall national health insurance cost trends that have been manifest in recent years. After 2011, HHS will set different percentage thresholds by state that more accurately reflect the particular cost trends in each state.

HHS MAY CONDUCT THE REVIEW: Under the law, if a state lacks the resources or authority to conduct an "effective" review of a premium increase, HHS will conduct it instead. This decision will be based on whether the state has access to sufficient data and documentation and performs certain steps, such as analyzing specific trends in medical claims costs, cost-

$250 million

Federal grants to states
The Affordable Care Act will help states to develop or strengthen their rate review systems.

sharing and benefit changes, changes in enrollee risk profiles, administrative costs, and medical loss ratios. HHS expects that most of the 43 states with existing review programs will conduct effective reviews. These states will follow their established procedures and standards, and HHS will respect a state's decision as to whether or not an increase is unreasonable.

Whether a state or HHS conducts the review, the insurer will be required to submit a preliminary justification for all plans subject to review. A draft preliminary justification form recently issued by HHS asks insurers to include a summary of the rate increase request and an explanation of the data and assumptions used to develop it. In addition, if HHS is conducting the review, it will request additional information from the insurer to determine whether the increase is unreasonable due to one of these factors:

- **Excessive increase.** The premium charged for health insurance coverage is unreasonably high in relation to the benefits provided.

- **Unjustified increase.** Data or documentation are incomplete, inadequate, or otherwise do not provide a basis on which reasonableness may be determined.

- **Unfairly discriminatory increase.** The increase results in differences within similar risk categories that do not reasonably correspond to differences in expected costs. For example, an increase might be considered unfairly discriminatory if the premium increase differs for individuals with the same risk characteristics such as age, geographic location, or tobacco use.

Regardless of who conducts the review, information and results from the review will be posted on the HHS website. HHS will also post the additional information it has requested unless that information is marked "confidential" by the insurer.

INCREASES MIGHT NOT BE BLOCKED: Although some states may have the authority to reject unreasonable increases, under the Affordable Care Act and other laws, HHS does not. If HHS finds a rate increase to be unjustified, excessive, or unfairly discriminatory, it will be considered unreasonable. In that case, the insurer might choose to withdraw or reduce the requested rate increase, or it might choose to go ahead with it.

If an insurance company decides to proceed with a rate increase that has been determined to be unreasonable, the company must publicly disclose the increase on its own website and provide a final justification to HHS. State laws and regulations may affect what an insurer is permitted to do in response to a determination that a rate increase is unreasonable.

Under the proposed rule, the review process will begin for health insurance plans with rate increases filed or effective on or after July 1, 2011. (The rule represents a change from the original law, which made the rate reviews effective as of calendar year 2010.) HHS estimates that, for 2011, more than half of the rate filings in the individual market and 20–40 percent of filings in the small-group market will exceed the 10 percent threshold and be subject to review.

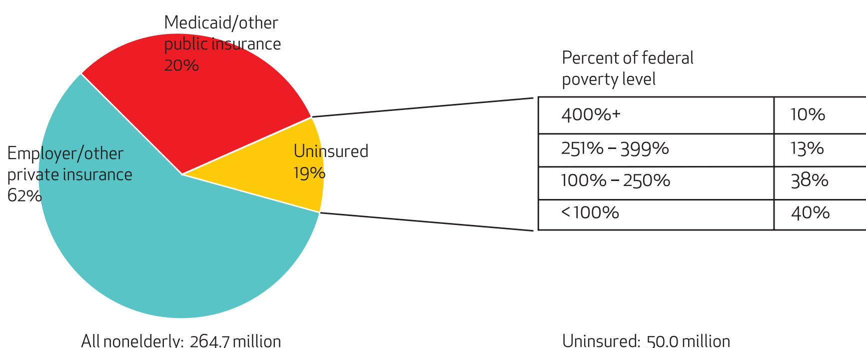
WHAT ARE THE CONCERNS?

Individual insurers, trade organizations, provider associations, and consumer groups have submitted comments to HHS recommending changes to the proposed regulation in five main areas, as follows:

TIMING: Insurance industry groups are concerned that the proposed effective date of July 1, 2011, does not give HHS sufficient time to determine which state review programs are considered effective. They also worry that states and companies won't have enough time to comply with the necessary review requirements. They suggest that the effective date should be pushed

EXHIBIT 2

Uninsured as a Share of the Nonelderly Population and by Poverty Levels, 2009



Percent of federal poverty level	
400%+	10%
251% – 399%	13%
100% – 250%	38%
<100%	40%

SOURCE Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2010 US Census Bureau Current Population Survey/Annual Social and Economic Supplement. **NOTES** Federal poverty level was $22,050 for a family of four in 2009. Data may not total 100% due to rounding. Nonelderly means younger than age 65. Medicaid and other public coverage includes: Children's Health Insurance Program (CHIP), other state programs, Medicare, and military-related coverage.

back until July 2012. Some consumer groups, however, take the opposite tack, and are urging HHS to conduct retrospective rate reviews dating back to 2010, when the Affordable Care Act and the rate review provision took effect.

APPLICATION TO LARGE GROUPS: Insurers agree with HHS that the review process should not apply to large employers. Few states have regulatory authority in this area, and large employers, when they do purchase insurance coverage on employees' behalf, are typically in a better position to negotiate rates with insurers than are small firms. Nonetheless, provider associations and consumer groups have advocated that the review process should be expanded to the large-group market, arguing that larger employers' ability to negotiate is often limited by the small number of insurers that dominate many markets. They have not provided detailed recommendations about how this expansion could be accomplished.

TIGHTENING THE LAW: Consumer groups would like to see the Affordable Care Act amended so that any health insurance rates deemed unreasonable by the federal government could not be implemented. Advocates of this approach view the rate review process as a vehicle to control rising health care costs, and point to recent studies suggesting that the profits enjoyed by the largest insurers have increased dramatically during the past decade.

The insurance industry counters that rate increases are the result, not the driver, of rising health care costs, and that insurance companies' administrative costs and profits equal just 4 percent of national health expenditures. Rather than having regulators focus on restricting insurance rate increases, they say, government and others should make greater efforts to control underlying health spending, such as the outlays for hospital and physician services.

PUBLIC DISCLOSURE AND CONSUMER INVOLVEMENT: Consumer groups advocate that much or all information submitted by insurance companies to state or federal regulators should be made public, and that consumers should be given an opportunity to participate in the review process. However, the insurance industry considers much of this information to be proprietary and believes it must be kept confidential. Insurers also argue that much of the information would be incomprehensible to the general public and that allowing public comment periods would unnecessarily extend the time needed to conduct reviews.

EXPANDING REVIEW CRITERIA: Some consumer groups argue that the trigger for a review should include other factors beside the percentage change in rates. In particular, those groups want health insurance plans for which medical loss ratios fall below 80 percent to be subject to rate review. Insurers take the opposite view, arguing that the medical loss ratio requirements represent an added protection that will reduce the need for rate reviews overall. Under the law, insurers will have to return rebates to policyholders if the medical loss ratio requirements are not met. The insurers argue that this will, in fact, reduce the likelihood that any proposed rate increase will be inappropriate based on the anticipated medical costs.

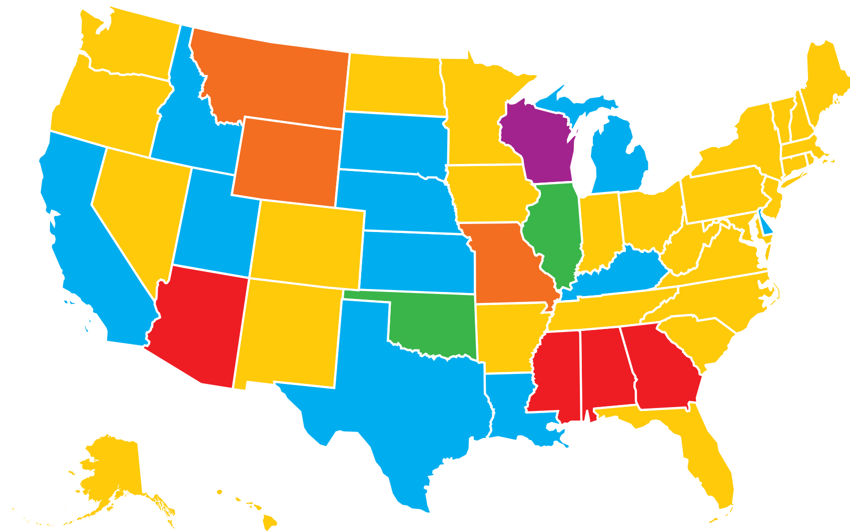
Insurers also warn that the Affordable Care Act's requirement to cover additional benefits is likely to mean that most, if not all, health plans will be forced to seek rate increases at levels that will subject them to reviews anyway. HHS officials say they are not seeking to conduct reviews on all plans and attempted to choose a threshold that would avoid being overly inclusive when identifying plans for review.

50 million

Uninsured nonelderly people
The number of Americans younger than age 65 without health insurance in 2009.

EXHIBIT 3

Legal Authority of States Over Health Insurance Rates in the Individual Market



SOURCE National Association of Insurance Commissioners.
NOTES "File and use" means insurers must tell regulators about new rates before they go into effect. "Informational" means insurers must tell regulators about new rates, but states cannot reject them. "No requirement" means insurers don't have to inform regulators about rate changes. "Prior authorization" means regulators must approve all rates before they go into effect. "Use and file" means insurers must tell regulators about new rates as they go into effect or soon thereafter. "With form" means insurers must tell regulators about rates only when changing them or creating new policies.

WHAT'S NEXT?

The Affordable Care Act provides $250 million in grants to the states to develop or strengthen their rate review systems. The law also requires additional rate review activity by HHS and the states, such as monitoring premium increases for plans within and outside the exchanges.

So far, HHS has awarded $46 million in grants to states and the District of Columbia to expand the scope of their premium review processes, improve information reporting, seek additional legislative authority to strengthen their programs, make more information available to the public, and upgrade technology to streamline data sharing and put information in the hands of consumers more quickly. HHS recently announced the availability of an additional $199 million in funding to build on these efforts.

HHS is expected to respond to public comments and release a final rule later this year. While the details of the review process are being finalized, insurers will continue to request rate increases and states will continue to use existing procedures to review them.

In 2010, some rate increases were denied or reduced by states that already possessed the authority to do so. In other cases, proposed rate increases were withdrawn by insurers in response to public hearings or to audits that identified errors in the data supporting the increase. Whether regulators will continue to achieve such concessions remains to be seen. Insurers have raised the possibility that, if they are forced to accept rate increases that fail to keep pace with health costs trends, pricing will be unsustainable in the long run. Some insurers, they say, could be driven out of business or forced to abandon particular markets or states.

CHANGES UNDER EXCHANGES?: Under the Affordable Care Act, in 2014 states are set to launch health insurance exchanges to facilitate the purchase of insurance coverage by individuals and small groups. States will have the option of excluding from participation in the insurance exchanges any insurers that have a history of excessive or unjustified premium increases. Consumer groups say this will provide states with another way to pressure insurers to keep rates reasonable.

In the end, as the Congressional Budget Office noted in a 2009 analysis, "the factors affecting premiums are complex and interrelated—and thus can be difficult to disentangle." It will be at least several years before it can be determined whether the authority to review unreasonable rates makes any difference in premiums, especially in the context of many other changes that will take place as the Affordable Care Act is implemented.■

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About Health Policy Briefs

Written by
Amanda Cassidy
Principal
Meitheal Health Policy
(Cassidy previously worked for the Centers for Medicare and Medicaid Services, in the Office of Legislation and the Center for Medicare Management.)

Editorial review by
Len M. Nichols
Director
Center for Health Policy Research and Ethics
George Mason University

Mark V. Pauly
Professor
Department of Health Care Management
The Wharton School
University of Pennsylvania

Ted Agres
Senior Editor for Special Content
Health Affairs

Susan Dentzer
Editor-in-Chief
Health Affairs

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