FOCUS on Health Reform

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Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable

EXECUTIVE SUMMARY

Consumers and business owners are struggling to afford health insurance premium increases, particularly in the nongroup and small group markets. In the last year, health insurance carriers across the country have proposed raising rates by as much as 50 percent. In a number of those cases, subsequent independent evaluation of those rate increases found significant flaws in insurers' methodology, causing them to agree to rate reductions.

The Patient Protection and Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to work in collaboration with state insurance departments to conduct an annual review of "unreasonable increases in premiums" for "non-grandfathered" health plans. Plans that propose an unreasonable rate will be required to provide a justification for the increase to HHS, and post the justification on their websites. The ACA also provides a pool of $250 million in grant funding for state insurance departments to support an enhanced rate review process.

Yet the ACA does not alter states' existing regulatory authority over health insurance rates. Such state authority varies dramatically, ranging from states with no authority at all to those that have robust authority to review and approve or disapprove rates before they are implemented. To explore what authority states have and how they exercise it, the authors of this issue brief conducted a survey of fifty state rate review statutes, and then did follow up interviews with insurance regulators in a subset of ten states (Alaska, Connecticut, Colorado, Idaho, Louisiana, Maine, Ohio, Pennsylvania, South Carolina, and Wisconsin) to gain a deeper understanding of how rate regulation works in practice. Key findings include the following:

A state's statutory authority often tells little about how rate review is actually conducted in the state. We found that having approval authority over rates does not necessarily protect consumers from large rate increases, and that the rigor and thoroughness that states bring to rate review can vary widely, depending on motivation, resources, and staff capacity. Conversely, some states that had little express statutory authority to disapprove rates prior to their use have been able to get carriers to agree to reductions in rates through informal negotiations.

In many cases, statutory authority to disapprove rates does not extend to all market participants. A number of states only require certain carriers (i.e., non-profit Blue Cross Blue Shield plans or HMOs) to undergo rate review, and exempt other commercial carriers. Other state statutes provide alternative regulatory pathways, such as a minimum loss ratio guarantee, that allow carriers to avoid a state review of their rates.

Most states we interviewed use a subjective standard to guide the review and approval of rates. Common standards are that rates cannot be "excessive, inadequate, or unfairly discriminatory," or that "benefits are reasonable in relation to premiums charged." Such subjective standards allow states to regulate rates with more flexibility, but can make the process appear arbitrary and opaque to consumers and the public.

Most of the states we interviewed have made little or no effort to make rate filings transparent. Generally, states require the public to physically visit the department of insurance to access the documents in a rate filing. And many states allow carriers to designate some portions of the rate filing to be "trade secret" and thus not available to the public. Two that we interviewed have statutes that explicitly label all the information in a rate filing as proprietary. Only a few states we interviewed allow a policyholder to request a public rate hearing. And in no states do policyholders participate in the informal back-and-forth between insurance departments and carriers that underpins the actual practice of rate review. However, a number of states have proposed using federal grant funds to make rate filings more accessible and understandable to the public.

Many states lack the capacity and resources to conduct an adequate review. Many states do not have a sufficient number of trained actuaries to review all filed rates. In addition, statutory clauses that "deem" a rate approved if it is not acted on within 30 or 60 days can limit a state's ability to conduct a thorough review. State regulators told us that rate review is not a mechanical function, and requires significant expertise and nuanced judgment calls. And states that do not have adequate resources or staffing may miss those judgment calls or even mistakes made by a carrier in its filing.

In conclusion, we found great variety in state laws and practices for reviewing health insurance rates. However, we conclude that states with prior approval authority over rates appear to be better positioned to negotiate reductions in rate requests filed by carriers. In states that do not have this type of authority, it generally takes an egregious and unjustified rate increase for them to ask for reductions. Policymakers interested in assuring that rate increases are reviewed for reasonableness and accuracy need to look not only at the state laws that govern rate filings and approvals, but also at how rates are reviewed by states in practice. Giving states the explicit authority to review rates is important, but regulatory resources and a culture of active review may be equally important.

Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable

I. Introduction

Media reports over the last year have documented health insurance premium increases for consumers and small employers, particularly in the nongroup and small group markets. Insurance carriers across the country have recently proposed raising rates by as much as 50 percent, often with little review by state regulators.[1] In a number of those cases, subsequent independent evaluation of those rate increases found significant flaws in insurers' methodology, causing them to agree to rate reductions.[2]

The passage of health reform has focused attention on these double-digit rate increases imposed by some carriers. However, seemingly large increases in the nongroup and small group markets are not new phenomena. Insurers often claim that such increases are driven by the increasing costs of medical care and declining health status among enrollees, while consumers sometimes argue that insurers are inefficient or do not do enough to control rising medical costs. This brief looks at the standards and tools that states have and use to evaluate proposed premium increases. We focus on premiums for non-group and small group health insurance because states rarely review health insurance premiums that are charged to larger employers.

States have historically had exclusive authority to regulate the rates for private health insurance, and the passage of the Patient Protection and Affordable Care Act (ACA) has done little to change that authority. Over time, states have developed different sets of rules and approaches to regulate the private health insurance market, and the federal government has not set any sort of minimum standard relating to rates. However, as rates have continued to rise, policymakers, the media and the public have increasingly focused on what lies behind health insurance rate increases, and the extent to which states are empowered to reduce rate increases that are unjustified or unreasonable.

State authority to regulate rates varies dramatically. To learn more about what authority states have and how they exercise that authority, the authors conducted a survey of fifty state rate review statutes, and then did follow-up interviews with insurance regulators in ten states to gain a deeper understanding of how rate regulation works in actual practice. These states (Alaska, Connecticut, Colorado, Idaho, Louisiana, Maine, Ohio, Pennsylvania, South Carolina, and Wisconsin) were selected because they use a range of approaches to reviewing insurance companies' requests for rate

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[1] HHS, "New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/news/factsheets/rates.html.

[2] Ibid. See also Duke Helfand, "A Mathematical David Stuns a Healthcare Goliath," *Los Angeles Times*, Jul. 15, 2010, available at http://articles.latimes.com/2010/jul/15/business/la-fi-anthem-20100716.

increases, ranging from robust review and prior approval of all rate filings to "hands off" regulation that relies on market competition to keep rates reasonable.[3] Some states have no authority to review rates at all, but we chose states in which insurance carriers were at least required to file some information on rates.

Among the states we examined, we conclude that active rate review lowers the premium requests filed by insurers. States that have statutory authority to approve or disapprove rates before they are used, 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 carriers file. States that do not have prior approval authority and lack the capacity to comprehensively review rates are less likely to achieve reductions in requested rates.

II. Background

State Regulation of Insurance Rates – Pre-Reform

Regulation of health insurance varies dramatically from state to state. As one regulator put it, "It's a patchwork quilt out there." Some states have authority to disapprove rates and rate increases, while other states review rates and the justification for them but do not have the authority to disapprove an increase.[4] The former process entails a prospective review and/or approval of rates, while the latter is a retrospective form of regulation.

A common form of retrospective regulation is called "file and use," in which the rates will go into effect after a certain time period, but the state can take action later if the rates are found to be unreasonable. This type of regulation often relies on consumer complaints to indicate a problem.[5] Some states only require carriers to file an "actuarial certification" attesting that their rates are in compliance with state law, without providing any underlying documentation. And some states do not require carriers to file rates for their health insurance products at all.[6]

Aggressive rate regulation may not be considered necessary in states with competitive insurance markets where no carriers have a large percentage of the market. An example is Wisconsin where rate increases are not generally reviewed because price competition among the many insurers is assumed to hold rates down.[7]

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[3] Appendix A provides the results of our fifty-state statutory survey and Appendix B provides state profiles for each of the 10 states we interviewed.

[4] A "rate" is generally defined as the cost per unit, while the "premium" is the total cost paid by the group or individual. Rates are typically filed with state insurance departments as a formula that describes how to calculate a rate for each person or family covered, based on geographic location, claims experience, coverage and cost sharing, age, gender, and number of dependents.

[5] "NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act," May 12, 2010, available at http://www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf.

[6] See Appendix A.

[7] Interview with regulators, Wisconsin Office of the Commissioner of Insurance, Aug. 12, 2010.

Some states also regulate rates by requiring carriers to meet a minimum expected loss ratio.[8] In this scenario, rates are typically not reviewed before they are implemented, but refunds to policyholders may be required if the loss ratio is not met.[9]

States that review comprehensive medical insurance rates typically do so only for the individual and small group markets. Very few states review or approve rates for fully insured large employers, on the theory that those employers tend to have the capacity to negotiate rates with insurers and they can change insurers if they are unhappy.[10] Many states are also limited in the types of carriers they can regulate. For example, in some states the authority to regulate rates extends only to HMOs.[11] In others, the authority extends only to Blue Cross plans, while others can only regulate rates in the individual market because small group carriers are not required to file rates.[12] Federal law prohibits states from regulating employer-sponsored self-funded plans. While this brief focuses on comprehensive medical insurance for individuals and small groups, many states also review rates for other types of health insurance, such as disability income, Medicare supplement, dental, fixed indemnity, accidental death, and long term care insurance.

Even for states that have robust statutory authority to "prior approve" rates, they are often constrained by a lack of staff resources and tight timelines for review (many rates are "deemed" approved if they're not reviewed within 60 days or less).

The lack of rigorous regulatory oversight is a relatively recent phenomenon. Most states until the mid-1990s required insurance commissioners to conduct a robust review of rates to ensure that they did not increase faster than medical costs. These laws and practices were gradually rolled back in many states, as a result of a deregulatory wave and insurance industry complaints that the review process too often resulted in "price controls" and was too slow and burdensome.[13]

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[8] "Loss ratio," also referred to as "medical loss ratio" or "MLR," refers to the fraction of revenue from a health plan's premiums that goes to pay for clinical services.

[9] Op. Cit., "NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act."

[10] Ibid.

[11] See e.g., Conn. Gen. Stat. § 38a-183 (small group rate authority extends to HMOs only).

[12] See e.g., Alaska Stat. § 21.87.190 (Blue Cross plans only); Wis. Stat. § 625.13 (1) (no rate filing required for group plans).

[13] Paltrow, S. "The Case for a Stronger Federal Role in Insurance Regulation," Center for American Progress Action Fund, Jun. 2010. See also The Business Council for the State of New York, "Health Insurance Premium Rate Setting" (2009), available at http://www.bcnys.org/inside/Legmemos/2009-10/s5470a8280PremiumRateSetting.htm.

Rate Review Under the Affordable Care Act

Congress enacted the rate review provisions of the ACA to help consumers get "better value for their health care dollars."[14] Health insurance premiums have doubled on average over the past 10 years, much faster than wages and inflation, putting coverage out of reach for millions of consumers and business owners.[15]

The ACA requires HHS to work in collaboration with state insurance commissioners to conduct an annual review of "unreasonable increases in premiums."[16] The law does not define, however, what constitutes an "unreasonable" increase. HHS is expected to promulgate a regulation to define a potentially "unreasonable" rate increase so that carriers know when they will need to submit data to HHS and the states for review. There is no commonly accepted standard definition of an unreasonable rate increase for HHS to rely on. Some states apply the definition during rate review, while other states deal with problems on a case-by-case basis, often in response to consumer complaints.

The new law requires that plans submit justifications for any "unreasonable" rate increases to the states and HHS, and post them on their websites. HHS is also required to make those justifications publicly available.[17] In addition, in order to promote transparency, HHS asked the National Association of Insurance Commissioners (NAIC) to develop a standard rate filing disclosure form that all health plans must use when justifying unreasonable rate increases to HHS and the relevant state.[18] The goal of the form is to ensure that regulators and the public can access the data and justifications in a way that allows for "apples-to-apples" comparisons.

The ACA exempts "grandfathered" plans from the new rate review requirements.[19] State regulation of rates for all plans, including grandfathered plans, will likely continue in accordance with state laws, but the rate review information collected by HHS is required only of non-grandfathered plans.

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[14] Patient Protection and Affordable Care Act (ACA) § 1003, adding Public Health Service Act (PHSA) § 2794.

[15] Op. Cit., HHS, "New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes."

[16] PHSA § 2794(a).

[17] Ibid.

[18] NAIC, Speed to Market (EX) Task Force Meeting, Jun. 1, 2010 (via conference call). Draft available at: http://www.naic.org/documents/committees_ex_speed_to_market_tf_exposures_rate_filing_disclosure_clean.pdf.

[19] Section 1251 of the ACA provides for the "grandfathering" of certain plans that were in existence as of the date the law was enacted (March 23, 2010). These plans, which could be sold to individuals or groups, are exempt from many, but not all, of the new insurance market reforms.

The ACA also provides states with a pool of $250 million in federal grants from fiscal years 2010 to 2015 to support enhanced rate review. For the first round of grants, forty-five states and the District of Columbia were each awarded $1 million.[20] States are planning to use the funds in the following ways:

- 15 states and the District of Columbia (DC) will seek additional authority from their legislatures to review rates;
- 21 states and DC will use existing regulatory authority to expand what they are doing, for example, by expanding the number of rate filings reviewed;
- All the grantees will require plans to report more information on their rates and the underlying justifications;
- 42 states and DC will increase transparency of the review process and make consumer-friendly information about insurance rates available on existing or new websites;
- All 46 grantees will develop and upgrade existing technology to speed up the review process and disseminate information to the public.[21]

As a condition of these grants, states must pledge to provide HHS with information about trends in premium increases in their state, both inside and outside of the new insurance exchanges.[22] HHS is also charged with assessing the rate of premium growth inside and outside the state exchanges before allowing large businesses (greater than 100 employees) to participate.[23]

In addition to enhancing rate review, the ACA attempts to generate greater value for consumers' health care dollars by requiring health insurance companies to meet a minimum "medical loss ratio" (MLR) beginning in 2011.[24] The law defines the ratio to reflect the percentage of revenue spent on clinical services and quality improvement activities. Large group insurers must spend at least 85 percent of their premium revenue on health services and quality, while small group and individual market insurers must spend at least 80 percent. If insurance carriers don't meet the minimum loss ratio, then they must issue rebates to their policyholders. As required by the statute, NAIC recently developed uniform definitions and standardized methodologies for the MLR, which was submitted to HHS for certification on October 27, 2010 and was promulgated as a regulation by HHS on November 22, 2010.[25,26]

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[20] Five states did not apply for or receive a rate review grant: Alaska, Iowa, Georgia, Minnesota and Wyoming.

[21] HHS Factsheet, "Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities," available at http://www.healthcare.gov/news/factsheets/rateschart.html.

[22] PHSA § 2794(a) and (b).

[23] Ibid.

[24] ACA § 1001, adding PHSA § 2718.

[25] NAIC, "Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, 2013 per Section 2718(b) of the Public Health Service Act," Oct. 27, 2010, available at: http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

[26] See http://www.hhs.gov/ociio/regulations/medical_loss_ratio.html.

The ACA also appears to give the new state insurance exchanges some authority to regulate premium increases among participating health plans.[27] However, the scope of that authority, and how it intersects with the authority of state insurance departments, is relatively unclear. One section of the law provides that exchanges must take into account a plan's pattern or practice of "excessive" or "unjustified" premium increases when determining whether including a plan in the exchange is in the interests of policyholders.[28]

On the other hand, another section of the law prohibits exchanges from excluding a plan through "the imposition of premium price controls."[29] Presumably this means that exchanges cannot create arbitrary price caps on premiums, unrelated to actuarial factors or costs. However, the law does appear to envision that an exchange could negotiate lower rates for policyholders, with the threat that a plan could be excluded from the exchange if its rates are somehow deemed excessive or unjustified. In establishing exchanges, states will also need to determine how this function relates to the rate regulation responsibilities of their insurance departments.

III. Study Approach

This study examines state authority to review rates in the individual and small group markets for comprehensive medical insurance. We first examined the insurance statutes in fifty states (see Appendix A), then conducted in-depth research on the authority and practice of rate review in ten states, prior to their receipt of federal grants to expand rate review. The states were selected because they used a range of approaches to reviewing insurance companies' requests for rate increases. More details on each state program included in this study are available in the "Profiles of States Studied" section in Appendix B.

Reflecting the fact that state regulators often engage in an informal dialogue with carriers to discourage excessive rate increases, this brief includes not only a review of state statutory authority, but is also based on information collected from one-on-one interviews with officials in the insurance departments of the ten study states. These interviews were designed both to verify the results of our statutory research and to document the more informal elements of rate regulation that occur in many states.

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[27] State-based "American Health Benefits Exchanges" and the "Small Business Health Options Program (SHOP)" Exchanges are established under Section 1311 of the ACA to provide organized insurance marketplaces which, if they are designed and function well, could provide consumers and small business owners with a "one-stop shop" to determine eligibility for private or public coverage and any premium or cost-sharing subsidies, make comparisons among health plans based on benefits, price and quality, and purchase or enroll in coverage. For more information on insurance exchanges under the ACA, see T.S. Jost., "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," The Commonwealth Fund, Jul. 2010, available at: http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

[28] ACA § 1311(e)(2).

[29] ACA § 1311(e)(1)(B)(ii).

IV. Key Findings

In our analysis of state statutory authority to review and approve rates for health insurance in the individual and small group markets, we found that a majority of states (35, including the District of Columbia) had prior approval authority over at least some portion of the individual and small group market. Of these, 22 had prior approval authority over all major medical health insurance products in both the individual and small group markets. In another 13 states, prior approval authority was limited either solely to the individual market or to the small group market, or by the type of product they could review (i.e., only HMOs or only Blue Cross Blue Shield plans).[30]

Statutory Authority Not Always Reflective of Practice

Simply examining a state's statutory authority to review and/or disapprove rate increases often tells little about how rate review is actually conducted by state insurance departments, and having "prior approval" authority over rates does not necessarily protect consumers in that market from large rate increases. The rigor and thoroughness that states bring to rate review can vary widely from state to state, depending on motivation, resources, and staff capacity.

For example, the Connecticut Department of Insurance, which has prior approval authority in the individual market, recently became the target of controversy for approving 4th quarter 2010 rate increases for Anthem Blue Cross and Aetna ranging from 5.5 to 33 percent.[31] The state's attorney general alleged numerous flaws with the Department's rate review process, including a failure to require adequate documentation of Aetna's requested rate increases and inadequate Department resources to assess Anthem's explanation of projected costs.[32] In a letter released to the media, the attorney general concluded that the Department allowed Anthem and Aetna's rate increases to go into effect without "the detailed scrutiny and careful consideration of all the factors necessary to determine whether a rate is 'excessive.'"[33]

The Department vigorously refutes the allegations in the attorney general's letter, asserting that the carriers provided the necessary documentation to support their rate increases, and pointing to ACA benefit changes that significantly impact a number of Aetna's and Anthem's product lines. The Department found that the carriers' rate adjustments appropriately reflected the benefit changes required under the ACA.[34]

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30 See Appendix A.

31 Email from regulator, Connecticut Department of Insurance, Nov. 9, 2010; see also M. Sturdevant, "Anthem Approved For Health Insurance Rate Hikes As High As 47 Percent," *Hartford Courant* Insurance Capital Blog, Oct. 14, 2010, available at http://blogs.courant.com/connecticut_insurance/2010/10/anthem-approved-for-health-ins.html.

32 Richard Blumenthal letter to Commissioner Thomas Sullivan, Oct. 6, 2010, available at http://blogs.courant.com/connecticut_insurance/Blumenthal%20Letter%20To%20Sullivan%2C%20Rate%20Hikes%2C%20Oct.%206%2C%202010.pdf.

33 Ibid.

34 Op. Cit., Email from regulator, Connecticut Department of Insurance.

Connecticut law requires that the Department review individual market rate filings within 30 days or they are "deemed" approved.[35] This requirement, coupled with the fact the Department has only one full time actuary on staff assigned to review individual and small group health filings, caused a Department official to note to us that they are "short staffed," particularly in the Fall, when many rate filings come in at once.[36] Staff with the Department also indicated that it is rare for them to formally disapprove a rate filing. Rather, because they have "good relationships" with insurance companies' actuaries, they tend to try to work things out through a back-and-forth dialogue with filers. If there are objections to the filing, the Department transmits those to the carrier, and in "most cases," companies modify their filings as requested. The Department rejects the notion that they "rubber stamp" proposed rate increases, and points to a number of circumstances in which they have garnered small reductions in proposed rates for consumers.[37] Under the federal grant to enhance rate review, the Department intends to use new analytic software and has contracted with a consulting actuary to evaluate proposed premium increases.[38]

Conversely, some states with little to no authority to regulate rates have been able to get carriers to agree to reductions in rates, and even refunds for policyholders. For example, Idaho is a "file and use" state, in which carriers are only required to submit an actuarial certification that the rates are compliant with the law.[39] However, the Department does have authority to disapprove rates if they don't meet statutory requirements (for example: small group rating bands and limits on increases from claims experience). Using this leverage, the Director has brought carriers in for informal discussions to work out concerns, in some cases resulting in reductions in the filed rates, and, in one circumstance, refunds for policyholders.[40]

In Alaska, the statute grants the state file and use authority over "hospital and medical service corporations" only, which for comprehensive health insurance includes only the local Blue Cross plan, Premera.[41] While Alaska statute does not expressly convey to the Division of Insurance "prior approval" authority over Premera's rates, staff with the Division told us that "as a practical matter," the company wouldn't use a rate until it has been reviewed and approved by an actuary on staff with the Division.[42] During the review, Premera is required to include justification for all rating components, including trend and experience information with its filing. There is frequently a "back and forth" process with Premera, and the Division has required them to reduce a proposed rate a

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35 Conn. Gen. Stat. §38a-481.

36 Interview with regulator, Connecticut Department of Insurance, Aug. 6, 2010.

37 Ibid.

38 HHS, "Connecticut is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/center/grants/states/ct.html; Email from regulator, Connecticut Department of Insurance, Nov. 19, 2010.

39 Idaho Code § 41-5206.

40 Interview with regulators, Idaho Department of Insurance, Aug. 24, 2010.

41 Alaska Stat. § 21.87.190.

42 Email from regulator, Alaska Division of Insurance, Nov. 15, 2010.

"number of times." However, Premera is the only comprehensive health insurance carrier required to file rates. Other commercial carriers (including Aetna, United HealthCare, Golden Rule and Mega Life and Health) do not have to file their rates, and the Division would only be authorized to review their rates in response to a consumer complaint.[43]

Similarly, Ohio regulators noted that while they don't have prior approval in the small group market, carriers know it is file and use "at their own risk."[44] The Ohio Department is allowed to disapprove rates if they don't meet statutory requirements (i.e., statutory limits on rate increases). Carriers have learned to file their rates well in advance of implementing them, particularly if there have been changes to the rating methodology or the rates are not clearly reasonable. While the Department rarely disapproves rates, it is not uncommon for them to ask carriers to refile or make changes to a filing to address their concerns.[45]

Some states that have not historically been aggressive rate reviewers have begun to expand their efforts in the last 12 months, in response to heightened media attention and consumer complaints.[46] One state regulator told us that the past year "has been a good time for us to strong-arm [the plans] because of all the media attention." And Ohio has seen carriers filing their rates earlier than in the past because they are expecting greater scrutiny as a result of the ACA.[47] Going forward, every department we spoke with intends to expand the comprehensiveness of its rate review as a result of the federal grant.

Limited Reach of State Laws

In some cases rate review authority does not extend to all market participants. For example, Pennsylvania regulators told us that their prior approval authority in the small group market is "more illusory than real" because it extends only to nonprofit Blue Cross Blue Shield plans and HMOs; other commercial carriers are exempt. Because Pennsylvania Blue Cross plans have increasingly been switching to for-profit status, the state can no longer review their rates. Since Pennsylvania has very low HMO penetration, the result has been that almost no plans in the small group market are subject to rate regulation.[48]

Similarly, Maine's statute would suggest that Maine has rate review and approval authority in the small group market. However, as a Maine regulator told us, they have

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43 Interview with regulator, Alaska Division of Insurance, Sept. 10, 2010.

44 Interview with regulator, Ohio Department of Insurance, Aug. 26, 2010.

45 Ibid.

46 See e.g., California (Op.Cit., Helfland, "Mathematical David Stuns Health Care Goliath," *Los Angeles Times*), New York (Susan Brady, "New York Passes Landmark Health Insurance Rate Review Law, *Health News*, Jun. 10, 2010), Pennsylvania (Kris Mamula, "Pennsylvania Investigates Insurance Rate Hikes," *Pittsburgh Business Times*, Jun. 9, 2010).

47 Op. Cit., interview with regulator, Ohio Insurance Department.

48 Interview with regulators, Pennsylvania Insurance Department, Aug. 14, 2010.

an exception in the statute that has "swallowed the rule."[49] Maine law allows small group carriers to choose one of two pathways on rates. Under the first pathway, they can file their rates and undergo a traditional rate review and prior approval process. They also have to meet a 75% minimum loss ratio.

Under the second pathway, carriers provide a guarantee that they will meet a 78% minimum loss ratio, averaged over three years. If they take the second pathway, their rate is deemed approved. If they miss the loss ratio target, they are required to pay refunds to policyholders. In spite of the fact that carriers have to meet a tougher loss ratio standard and face the risk of paying refunds, all of the major small group carriers in the state have chosen to follow the second pathway and bypass traditional rate review.[50] While meeting a higher loss ratio would be beneficial to consumers if it resulted in lower premiums, the lack of insurance department review and oversight of insurers' methods and even calculations may mean that rate changes based on mistakes or overly optimistic assumptions are able to go into effect.

In South Carolina, a provision in the group insurance laws has allowed most individual market carriers to bypass rate review, even though their statute generally provides for prior approval authority. This broadly-worded provision allows carriers to form out-of-state "trusts" and bypass rate review. This exemption, while intended for group carriers, has been used by individual market carriers, many of whom rushed to form these trusts to escape state regulation. As a result, the rates of many insurance companies that market individual policies are not reviewed at all.[51] The state is planning to use some of the funds under the federal rate review grant to study individual market rate increases that they are no longer able to regulate.[52]

Subjective Standards

State rate review statutes typically include a standard in order to guide the review and approval of rates. That standard can be objective – i.e., meeting a certain loss ratio requirement or keeping rate increases under a prescribed level. The advantage of an objective standard is that states can apply it consistently and fairly across all plans. The disadvantage is that it allows little regulatory flexibility to address changes in circumstance and issues of equity.

The standard can also be subjective. Almost all of the states we interviewed use a subjective standard to assess rate filings. A common subjective statutory standard requires that rates cannot be "excessive, inadequate, or unfairly discriminatory."[53] Some states will also look to see whether benefits are "not reasonable in relation to

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49 Interview with regulators, Maine Bureau of Insurance, Aug. 15, 2010.

50 Ibid.

51 Interview with regulators, South Carolina Department of Insurance, Sept. 1, 2010. See also S.C. Code Ann. § 38-71-750.

52 Ibid.

53 See e.g., Alaska Stat. § 21.87.190, Conn. Gen. Stat. § 38a-481, 24-A Me. Rev. Stat. Ann. § 2736.

premiums charged."[54] Subjective standards allow states to regulate rates with more flexibility, and adjust to changing circumstances. However, the more subjective the process, the more variability in its application, and state determinations can appear arbitrary and opaque.

While we did not speak to regulators in any state with an objective limit for rate increases, some states have a mix of subjective and objective requirements. For example, Colorado's standard requires that rates be disapproved if benefits are not reasonable in relation to premiums charged or the rate includes provision(s) that are excessive, inadequate, or unfairly discriminatory.[55] At the same time, Colorado's rate regulation provides guidelines on loss ratios – 65% in the individual market and 70% in the small group market.[56] While these are not required loss ratios, plans that deviate from these targets must provide justification to the Department.

Maine also uses a mix of subjective and objective standards to review rates. Generally, rates may not be "excessive, inadequate or unfairly discriminatory." Carriers also are required to meet a loss ratio of 65% in the individual market and 75% in the small group market.[57] And, as noted above, if a carrier makes a loss ratio guarantee of 78%, their rates are deemed to meet the standard.

Limited Transparency and Due Process

Most of the states we interviewed have made little or no effort to make rate filings transparent or facilitate consumer access to information about rate increases. Some states, like Idaho and Alaska, explicitly label the information in a rate filing "proprietary" and reveal none of the justifying data to the public. More commonly, states allow for public access to rate filings, but only after they have been approved. And plans are allowed to designate some portions of rate filings to be "trade secrets." In most cases, consumers are required to physically visit the department to access the necessary documents.[58] In addition, we found that much of the actual rate review process – during which regulators might question assumptions, state objections, and ask for reductions in rates - is conducted as an informal dialogue between Department staff and insurance carriers to which policyholders have no access.

Some states are moving towards more transparency in their regulation of rates, and most states we spoke to were planning to use some portion of their federal rate review grants to improve their website and boost the accessibility of the process for consumers.[59] For example, Wisconsin allows consumers to access information from rate

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54 See e.g., Colo. Rev. Stat. § 10-16-107, S. C. Code Ann. § 38-71-310.

55 Colo. Rev. Stat. § 10-16-107(1.6)(a).

56 3 Colo. Code Regs. § 702-4-2-11.

57 As noted above, all small group carriers have chosen to provide a "loss ratio guarantee" of 78%. This guarantee allows them to bypass any state rate review but if they miss the target they must provide refunds to policyholders.

58 See Appendix B, Alaska, Colorado, Louisiana, South Carolina.

59 See State Health Insurance Premium Review Grants, interactive map, available at

filings on their website, but the current interface is not user-friendly. The Department intends to use federal grant dollars to enhance this part of their site.[60] Colorado provides a "rate summary" on the consumer page of their website, but the full rate filing is only available through a visit to the Division of Insurance.[61] Under its rate review grant, the state intends to make the rate summary more "consumer friendly."[62]

Only 3 states we spoke with (Colorado, Maine, and Wisconsin) allowed a policyholder to request a public hearing about a rate filing. Yet there is evidence that the simple ability to hold a hearing is enough to give state regulators leverage to negotiate lower rates. For example, staff with the Pennsylvania Department told us that they have had plans come in with significant rate increases – between 30 and 40%. Yet when the Department indicates that it may hold a rate hearing, the plans will often refile with much lower increases.[63]

Few states, however, rival the transparency and due process promoted by the Maine Bureau of Insurance, which posts proposed changes in rates on its website and requires plans to notify subscribers at least 60 days before the proposed effective date. The state makes only limited allowances for plans to designate portions of the filing as confidential information.[64] Maine was also the only state we spoke to whose Bureau of Insurance fully embraces the ability of consumers to request a public rate hearing, to the extent of holding field hearings during evening hours in order to facilitate the public's involvement. The state also allows the Attorney General to request a hearing on behalf of consumers. Over the past two years, Maine's Superintendent has held 5 rate hearings on individual and small group market insurance rates, resulting in "substantial reductions in the insurers' requested rates." The Maine proposal for a federal rate review grant also included $300,000 for "stronger consumer participation and greater transparency" in the rate review process.[65]

Limited Capacity and Resources

Simply checking to see if a carrier's actuary has certified the data and methodology in the rate filing may not be sufficient to determine if a rate increase is justified. State regulators told us several times that rate review is not a mechanical function. With each rate filing, the carrier's actuaries are making assumptions and projections that involve nuanced judgment calls. As one regulator put it, "if you're [the actuary] getting paid by the health plan it's more likely you'll make those judgment calls in favor of your employer. If you're an actuary for consumers, it's more likely you'll make those calls in

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http://www.healthcare.gov/center/grants/index.html.

60 Op. Cit., interview with regulators, Wisconsin Office of the Commissioner of Insurance.

61 Interview with regulator, Colorado Division of Insurance, Sept. 17, 2010.

62 Ibid.

63 Op. Cit., interview with regulators, Pennsylvania Insurance Department.

64 Op. Cit., interview with regulators, Maine Bureau of Insurance.

65 Maine Bureau of Insurance, Final Grant Narrative for federal rate review grant under the ACA, provided via Email from regulator, Aug. 5, 2010.

favor of the ratepayer."[66] States that don't have the authority or the staff capacity and expertise to conduct adequate rate reviews may miss those judgment calls or even fail to catch errors made by the carrier's actuaries that benefit the plan at the expense of the consumer.[67]

States that conduct a thorough, rigorous review of the rate filing and the underlying data and methodology report that they are often able to obtain significant reductions in rates from carriers. In Pennsylvania, if a carrier proposes a rate increase of any kind, particularly if it is over 10%, actuaries on staff reportedly "pore through the data, and often request additional data." According to the staff, more often than not, the Department's actuaries come to different conclusions than the plan's actuaries. The staff noted, "insurers usually pad what they're asking for. We know it and they know we know it." Thus, when the Department demands a reduction, the carriers generally don't dispute the state's conclusions.[68]

In a recent instance, Colorado invested months of staff time and resources in an in-depth review of Anthem Blue Cross' proposed rate increases for 2010. As a result of their effort, Anthem agreed to pay $20 million in refunds to approximately 90,000 policyholders.[69] However, staff with the Division of Insurance told us that as a practical matter, not all rate filings receive this kind of review. In fact, in an average year, only an estimated 25% of rate filings receive a comprehensive review by a staff actuary. Instead, the Division has to triage filings, focusing primarily on domestic carriers, those with a history of "less than rigorous" filings, and those undergoing a market conduct exam.[70]

Statutory "deemer" clauses, which require insurance regulators to review and disapprove rates within a specific time frame (typically 30-60 days), can limit a state's ability to conduct the necessary review, although in some cases the deeming period is stayed while insurers respond to questions and requests for additional information from regulators. Two states we spoke with indicated that carriers were willing to work with them to delay using the rates rather than face a formal disapproval.[71]

V. Policy Implications

Our research found significant variety in state laws and practices for reviewing health insurance rates filed by insurers in the nongroup and small group markets. Generally,

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66 Op. Cit., interview with regulators, Maine Department of Insurance.

67 See, e.g., *Los Angeles Times*, "Aetna Scraps 19% Rate Increase for Individual Policyholders," Jun. 25, 2010, available at http://articles.latimes.com/2010/jun/25/business/la-fi-aetna-rates-20100625.

68 Op. Cit., interview with regulators, Pennsylvania Insurance Department.

69 Trevor Thomas, "Colorado Blues Backtrack on Individual Health Premiums," *National Underwriter*, Sept. 17, 2010, available at: http://www.lifeandhealthinsurancenews.com/News/2010/9/Pages/Colorado-Blues-Backtrack-on-Individual-Health-Premiums.aspx.

70 Op. Cit., interview with regulator, Colorado Division of Insurance.

71 Op. Cit., interviews with regulators, Ohio and Pennsylvania departments of insurance.

states with prior approval authority over rates report being better positioned to negotiate reductions in rate requests filed by carriers. For example, regulators in Colorado, Maine, Pennsylvania, and Ohio told us that they "very often" or "frequently" require carriers to reduce rates before they are implemented.[72]

In states we interviewed with file and use authority, it generally takes an egregious and unjustified rate increase for them to ask for reductions or demand refunds for policyholders.[73] Some, like Wisconsin and Louisiana, do not have an actuary on staff assigned to review health insurance filings, and if they conduct a review it is only to determine the filing's "completeness" and compliance with statutory requirements.[74]

Regardless of the standard of review, the state officials we spoke with often work things out informally with carriers through a closed-door process to which policyholders have no access.[75] We also found that state insurance departments with statutory authority to review rates sometimes do not conduct a thorough examination of all the relevant filings. Some lack sufficient staff expertise and resources.[76] In some cases, the "deemer" requirement, limiting the prior approval review time to 30 or 60 days, causes departments to triage rate filings so that only those from certain carriers (i.e., domestic carriers, those requesting an increase, or those who have a history of inadequate filings) receive a thorough review by a licensed actuary.[77] Others, as explained above, have only illusory prior approval authority because carriers have taken advantage of alternative pathways under the statute that permit them to avoid rate review.[78]

Policymakers interested in assuring that premium increases are reviewed for reasonableness and accuracy will need to look not only at the laws that govern rate filings and approvals, but also insurance department resources and practices. Prior approval laws do not assure that thorough reviews will occur. At the same time, regulators can sometimes encourage insurers to reduce filed rates even when their authority is relatively weak. Giving regulators the explicit authority to review and approve rates prior to their use appears to provide the most leverage to encourage insurers to reduce filed rates, but regulatory resources and a culture of active review may be equally important.

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[72] Op. Cit., interviews with regulators, Colorado, Pennsylvania, and Ohio departments of insurance and the Maine Bureau of Insurance.

[73] Op. Cit., interviews with regulators, Louisiana and Idaho departments of insurance and the Wisconsin Office of the Commissioner.

[74] Op. Cit., interviews with regulators, Louisiana Department of Insurance and the Wisconsin Office of the Commissioner.

[75] Op. Cit., interviews with regulators, Alaska, Colorado, Connecticut, Idaho, Pennsylvania, and South Carolina departments of insurance.

[76] For example, the Colorado and Ohio departments do not have the staff resources for all rate filings to be reviewed by a fully licensed actuary. Op. Cit., interviews with Colorado and Ohio departments of insurance.

[77] Op. Cit., interviews with regulators, Colorado, Pennsylvania departments of insurance.

[78] Op. Cit., interviews with regulators, Maine Bureau of Insurance, South Carolina, and Pennsylvania departments of insurance.

Grant funds provided under the ACA will provide states with some of the resources that they would need to increase rate review activities. The ACA authorized $250 million in grants to help states improve their rate review capacity, and forty-five states and the District of Columbia were awarded grants in the first round of funding earlier this year. The funds will be used in a variety of ways by states, including expanding review authority, improving review processes, expanding actuarial capacity, and increasing public transparency of proposed rate changes.[79]

State rate review processes also may change in response to new federal regulations defining what constitutes an "unreasonable" rate increase. The ACA requires (for non-grandfathered policies) that plans proposing unreasonable rate increases submit a justification of the proposed increase to HHS and relevant state insurance departments, and post it on their websites.[80] Such a determination does not require disapproval of the rate filing, but states may react with additional scrutiny of the methodology and actuarial assumptions used to support the proposed increase, particularly given the enhanced resources provided by the new grant program.

[79] Op. Cit., HHS, "New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes."

[80] Op. Cit., PHSA § 2794(a) and (b).

This issue brief was prepared by Sabrina Corlette of the Georgetown University Health Policy Institute and Janet Lundy of the Kaiser Family Foundation.

The authors gratefully acknowledge the expertise and insights provided by staff with the following departments of insurance: Alaska, Colorado, Connecticut, Idaho, Louisiana, Maine, Ohio, Pennsylvania, South Carolina and Wisconsin. Their willingness to share their valuable time and answer our questions about the rate review process contributed immeasurably to this project.

In addition, the authors are indebted to the important contributions of Lisa Taylor and Ashley Mester to the legal research and analysis supporting this issue brief.

Appendix A

State Statutory Authority to Review Health Insurance Rates

State	Plan Type	Rate Filing Required?	Review Authority?
Alabama	Individual	Yes (informational use only)	File and use
	Small Group		
Alaska	Individual	Yes (hospital and medical service corporations only i.e., Blue Cross Blue Shield (BCBS))	File and use (for hospital and medical corporations only; in practice BCBS does not use rate until it has been approved)
	Small Group		
Arizona	Individual	Yes	File and use
	Small Group	Yes (informational use only)	File and use
Arkansas	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
California	Individual	Yes	File and use
	Small Group		
Colorado	Individual	Yes (if rate increase requested)	Prior approval (60 day deemer); file and use if no increase
	Small Group		
Connecticut	Individual	Yes	Prior approval (30 day deemer)
	Small Group	Yes (HMOs only); all other carriers file actuarial certification only	Prior approval for HMOs only
Delaware	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
District of Columbia	Individual	Yes	Prior approval (60 day deemer; 30 day deemer for HMOs)
	Small Group		
Florida	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
Georgia	Individual	No	N/A*
	Small Group		
Hawaii	Individual	Yes (HMOs only)	Prior approval (HMOs only – 60 day deemer)
	Small Group		
Idaho	Individual	Actuarial certificate only	File and use
	Small Group		
Illinois	Individual	Yes	File and use

State	Plan Type	Rate Filing Required?	Review Authority?
	Small Group	No	N/A
Indiana	Individual	Yes	Prior approval (30 day deemer)
	Small Group		File and use
Iowa	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
Kansas	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
Kentucky	Individual	Yes (if rate increase)	Prior approval for rate increase (30 day deemer)
	Small Group		
Louisiana	Individual	Yes	File and use
	Small Group		
Maine	Individual	Yes	Prior approval
	Small Group	Yes (informational filing if carrier elects 78% guaranteed loss ratio option)	Prior approval unless carrier elects 78% guaranteed loss ratio option
Maryland	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
Massachusetts	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
Michigan	Individual	Yes	Prior approval for HMOs and BCBS plans (60 day deemer for HMOs, either 30 or 120 days for BCBS); file and use for all other carriers
	Small Group	Yes (BCBS and HMOs only)	Prior approval (BCBS and HMOs only)
Minnesota	Individual	Yes	Prior approval (60 day deemer)
	Small Group		
Mississippi	Individual	Yes	File and use
	Small Group		
Missouri	Individual	No	N/A
	Small Group	Actuarial certificate only	File and use
Montana	Individual	No	N/A

State	Plan Type	Rate Filing Required?	Review Authority?
	Small Group	Actuarial certificate only	File and use
Nebraska	Individual	Yes	Prior approval (30 day deemer)
	Small Group	Actuarial certificate only	File and use
Nevada	Individual	Yes	Prior approval (60 day deemer for commercial carriers; 30 days for nonprofit Blues)
	Small Group	Yes (BCBS only); all other carriers only file an actuarial certificate	Prior approval for BCBS only (30 day deemer); file and use for all others
New Hampshire	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
New Jersey	Individual	Yes	File and use (with 80% MLR requirement)
	Small Group		Prior approval (60 day deemer)
New Mexico	Individual	Yes	Prior approval
	Small Group		Prior approval (60 day deemer)
New York	Individual	Yes	Prior approval
	Small Group		
North Carolina	Individual	Yes	Prior approval (90 day deemer)
	Small Group		
North Dakota	Individual	Yes	Prior approval (60 day deemer)
	Small Group		
Ohio	Individual	Yes	Prior approval (30 day deemer; 60 day deemer for HMOs)
	Small Group		File and use (except for certain group trusts and associations)
Oklahoma	Individual	Yes (HMOs only)	Prior approval for HMOs only (30 day deemer)

State	Plan Type	Rate Filing Required?	Review Authority?
	Small Group	Yes	Prior approval (30 day deemer)
Oregon	Individual	Yes	Prior approval
	Small Group		
Pennsylvania	Individual	Yes	Prior approval (45 day deemer)
	Small Group	Yes (nonprofit BCBS plans and HMOs only)	Prior approval for nonprofit BCBS plans and HMOs (45 day deemer); other commercial carriers exempt
Rhode Island	Individual	Yes	Prior approval (60 day deemer)
	Small Group		
South Carolina	Individual	Yes	Prior approval (90 day deemer)
	Small Group	Actuarial certificate only	File and use
South Dakota	Individual	Yes	File and use (30 day deemer)
	Small Group		File and use
Tennessee	Individual	Yes	Prior approval (30 day deemer)
	Small Group	Actuarial certification only	File and use
Texas	Individual	Yes (informational use only)	File and use
	Small Group	Actuarial certificate only	File and use
Utah	Individual	Actuarial certificate only	File and use
	Small Group		
Vermont	Individual	Yes	Prior approval (30 day deemer)
	Small Group		
Virginia	Individual	Yes	Prior approval
	Small Group		File and use
Washington	Individual	Yes	Prior approval (60 day deemer)
	Small Group		Prior approval
West Virginia	Individual	Yes	Prior approval (60 day deemer)
	Small Group		
Wisconsin	Individual	Yes	File and use

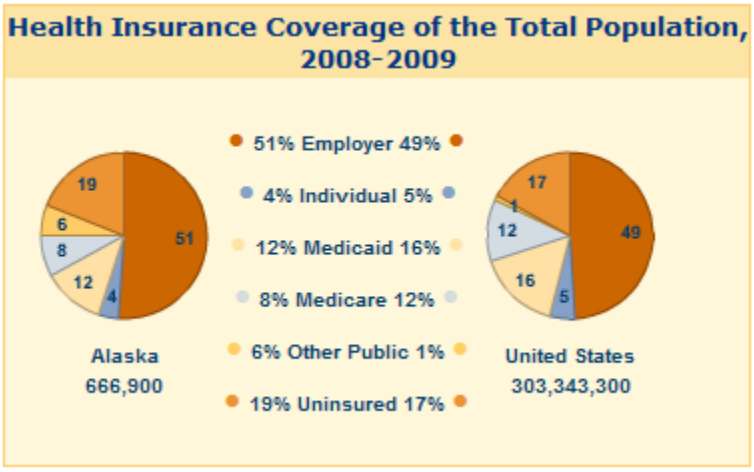
State	Plan Type	Rate Filing Required?	Review Authority?
	Small Group	Actuarial certificate only	File and use
Wyoming	Individual	Yes	File and use
	Small Group	Actuarial certificate only	

*N/A = Not Applicable
Source: Data collection and analysis by researchers at Georgetown University's Health Policy Institute and Kaiser Family Foundation, June 2010.

Appendix B

Profiles of Interview States

Alaska



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate health insurance rates[81,82]

Alaska only has statutory authority to review rates for "Hospital or Medical Service Corporations (HMSC)" (ex., Blue Cross Blue Shield plans). There is only one HMSC writing comprehensive health insurance in the state – Premera Blue Cross. While the Alaska statute does not convey express "prior approval" authority on the Department for HMSCs, as a practical matter, Premera does not implement a rate until it has been reviewed and approved by the Department's life and health actuary. She assesses the filing based on the statutory standard that rates cannot be "excessive, inadequate or unfairly discriminatory." There are no objective limits on rate increases. Premera is required to include justification for all rating components with its filing, including trend and experience information, but this data is required by statute to be kept confidential.

In our interview with Alaska's life and health actuary, she indicated that as a matter of practice, rate filings are not formally disapproved. Rather, they engage in a "back and forth" process until they reach approval. Premera has had to reduce rates a number of times, but she could not say how often.

Other carriers are not required to file rates with the Department, but the Department is authorized to review rates retrospectively in response to consumer complaints. This happens very rarely and upon review the carriers have been found to be in compliance with the statute.

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81 Alaska Stat. §§ 21.87.190, 21.56.120.

82 Op. Cit., interview with regulator, Alaska Department of Insurance.

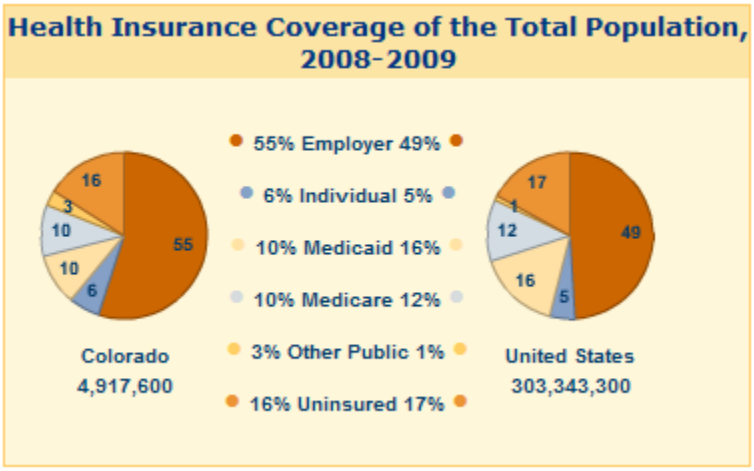
Individual Market			
Filing required?	Prior approval?	Public access?	Comments
HMSC only	File and use for HMSC only (but in practice Department prior approves rates)	Rates are publicly available after rates have been approved. Detailed rate justification is confidential by statute.	

Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
HMSC only. Other commercial carriers file only an actuarial certification attesting that rates are in compliance with the law.	File and use for HMSC only (but in practice Department prior approves rates)	Rates are publicly available after rates have been approved. Detailed rate justification is confidential by statute.	

Proposed activities under federal rate review grant

Alaska is one of five states (the others are Iowa, Georgia, Minnesota, and Wyoming) that did not apply for or receive a federal rate review grant.

Colorado



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[83,84]

Colorado passed a law in 2008 granting the Division of Insurance prior approval authority over both the individual and small group markets if a carrier requests an increase in rates. If the carrier does not request an increase, carriers may implement the rate without seeking prior approval. However, in the health insurance market it is quite rare for a carrier to not seek an increase.

Not all rate filings are reviewed by an actuary on staff with the Division, but generally the Division tries to have an actuary review the filings of all the domestic carriers in the state, as well as those that may have had a history of "less than rigorous" filings, and those undergoing a market conduct exam. Staff with the Division estimated that in an average year, roughly 25% of rate filings receive a comprehensive review by an actuary.

The statutory standard for review of rates is that they must be disapproved if (1) the benefits are not reasonable in relation to the premiums charged and (2) the rate increase requested contains provision(s) that are excessive, inadequate, unfairly discriminatory, or otherwise not in compliance with the statute. Colorado also has a regulation that provides guidelines for carriers on loss ratios – 65% in the individual market and 75% in the small group market. These are guidelines and not requirements, but plans that don't meet the loss ratios must justify their rates. There are no other objective constraints on rate increases.

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83 Colo. Rev. Stat. § 10-16-107.

84 Op. Cit., interview with regulator, Colorado Division of Insurance.

In rate filings, Colorado requires the carrier to provide an actuarial certification, as well as trend and experience information. Generally the Division collects Colorado experience data, but if the carrier's Colorado experience is not credible, the Division will ask for regional or national data. Once a rate is approved, a consumer can access the information through a "rate summary" on the Division's website and by visiting the Division to review the underlying data. While Colorado law allows consumers to request a public rate hearing, the Division has never held one.

The Division often asks carriers to reduce filed rates to come into compliance with the statutory standard, and carriers often do so. Staff could not tell us the percentage of filings that are reduced before rates are implemented. Staff estimated that roughly 10-15% of filings are formally disapproved, but this does not include the number of filings in which issues were resolved or rates were reduced prior to a formal disposition.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes, if carrier requests a rate increase. 60 day deemer clause	Yes, a "rate summary" is posted on the website, and consumers can access the full filing	State may require correction of deficiencies after the 60 deemer period but any correction is prospective

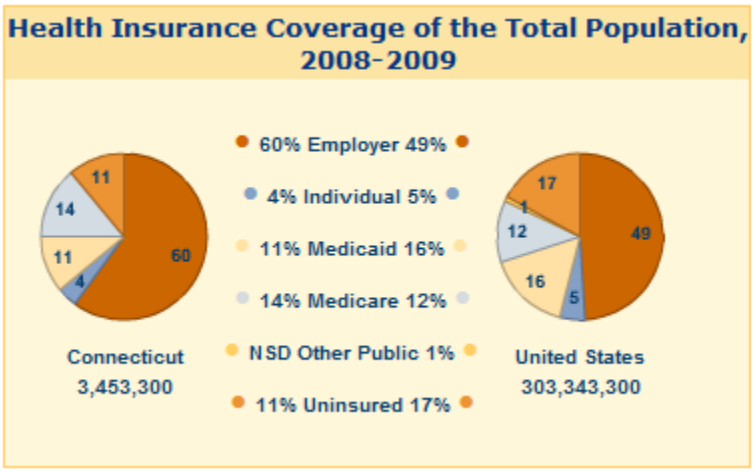
Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes, if carrier requests a rate increase. 60 day deemer clause	Yes, a "rate summary" is posted on the website, and consumers can access the full filing	State may require correction of deficiencies after the 60 day deemer period but any correction is prospective

Proposed activities under federal rate review grant[85]

- Hire additional rate financial analysts and actuaries to review rate filings and comply with the new federal requirements;
- Hire additional staff in Consumer Complaints and outreach; and
- Enhance its website to make rate filing more accessible and understandable to consumers, in addition to hosting web-based town hall meetings to educate consumers as well as public rate hearings.

[85] HHS, "Colorado is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/center/grants/states/co.html. See also Colorado Press Release for the $1M Grant: http://www.colorado.gov/cs/Satellite/GovRitter/GOVR/1251579785203.

Connecticut



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[86,87]

Connecticut has prior approval authority over all health insurance products in the individual market. In the small employer market, only HMOs are required to file rates for prior approval. All other small group carriers are only required to file an annual actuarial certification attesting that their rates are in compliance with the statutory rate restrictions. In the individual market, the statute gives the Department only 30 days to disapprove a rate, but in practice that deemer period is extended to allow for negotiation with plans. For both the Department and the carriers this is preferable to issuing a disapproval of a rate increase request. Group rates do get a review by the Department to ensure they meet statutory standards, and the Department typically asks carriers to file group rates 3 months in advance of use.

Connecticut law does allow carriers to provide a loss ratio guarantee and thereby bypass rate review, but only one carrier has taken that path, and it was later required to issue a refund to policyholders because it failed to meet the loss ratio target.

Under the statute, rates cannot be excessive, inadequate or unfairly discriminatory, but there are no objective constraints on rate increases and no minimum loss ratio is required. The Department asks for past claims history and trends, and all rates are reviewed by an actuary on staff. The Department does ask for reductions in rates, but usually "small changes," i.e., from an 11% increase to a 10% increase.

The data to justify rates is not typically made public in Connecticut because carriers can ask for much of it to be deemed trade secret. However, the Department has more

86 Conn. Gen. Stat. §§ 38a-481, 38a-183.

87 Op. Cit. interview with regulator, Connecticut Insurance Department.

recently been asking carriers to make more information public and in some cases they've agreed. The Department is now posting some rate filing information on its website. The Insurance Commissioner can call a public rate hearing at his or her discretion, and recently called for one regarding the 2011 rate filing from Anthem Blue Cross.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes, with 30 day deemer clause	Some rate filing information available on Department website	Rates deemed approved if accompanied by a loss ratio guarantee

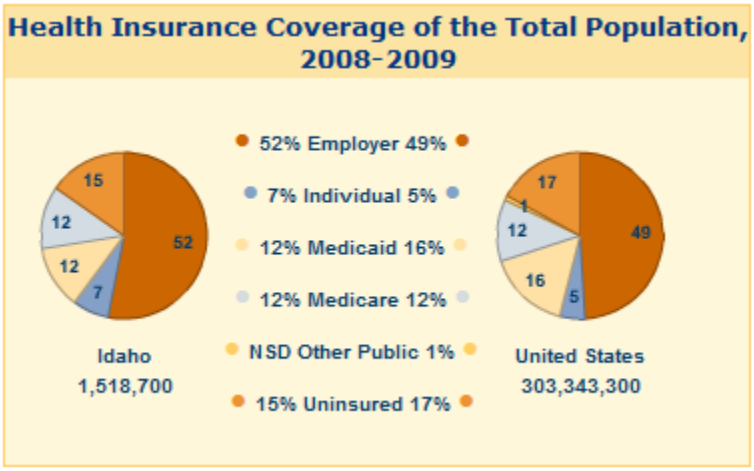
Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Yes, for HMOs only. Other carriers are required to file an actuarial certification that their rates are in compliance with the law.	No.	Some rate filing information on Department website	

Proposed activities under federal rate review grant[88]

- Improve the rate review process to better evaluate proposed premium increases by hiring actuaries and utilizing new analytic software;
- Increase transparency and accessibility of health insurance premium filings by making them available online to the public and providing a public comment period; and
- Develop and upgrade technology to streamline data sharing and give information to consumers more quickly.

[88] HHS, "Connecticut is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/center/grants/states/ct.html.

Idaho



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[89,90]

Idaho does not have authority to prior approve rates, so carriers typically file rates with the Department right before they go into effect (usually no more than 30 days in advance). The Department's authority only allows them to check the filing to see if it is complete and meets statutory requirements (carriers must file rates within prescribed rate bands, may not increase rates for health status or claims experience by more than 15% per year, and may not implement more than one rate increase per year). If it is incomplete or doesn't meet the statutory requirements, then the Department can disapprove the rate.

Idaho has no actuaries on staff with the Department. If an issue comes up with a rate (usually in response to a consumer complaint), they will contract with a consulting actuary to determine whether the carrier is meeting the requirements of the statute.

Idaho has had carriers reduce their rates after negotiations with the Department. In one instance, the state required a carrier to issue refunds to policyholders because a retrospective review found it to be using rates it hadn't filed.

The Idaho code deems rate filing data proprietary and not publicly accessible.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Actuarial certification only	No	No	

89 Idaho Code § 41-5206.

90 Op. Cit., interview with regulators, Idaho Department of Insurance.

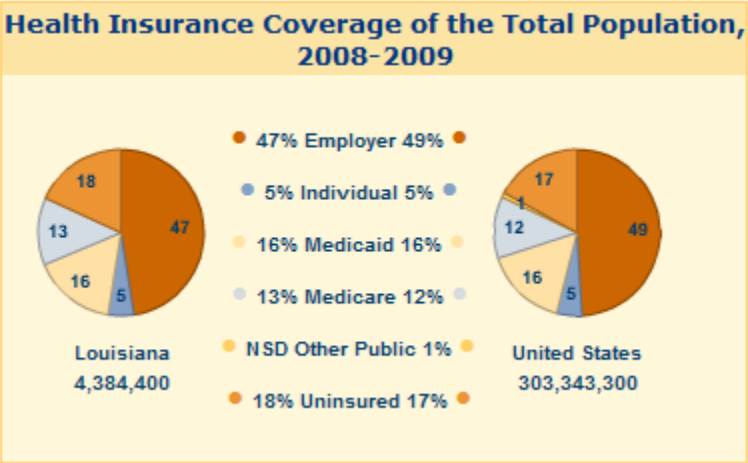
Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Actuarial certification only	No	No	

Proposed activities under federal rate review grant[91]

- Expand regulatory authority over health insurance rates by enacting laws that enable oversight of large group products and stronger standards for reasonableness;
- Develop and standardize filing templates and require insurers to file such rate adjustment templates for review by the State prior to use;
- Contract with actuaries to conduct in-depth premium reviews;
- Establish a data center to compile and publish fee schedule information.

[91] HHS, "Idaho is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at: http://www.healthcare.gov/center/grants/states/id.html.

Louisiana



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[92,93]

Louisiana has only file and use authority over rates in the individual and small group markets. Carriers in the small group market only have to certify that they are in compliance with the statutory rate bands. The Department generally only reviews filings for completeness. In the individual and small group markets, the Department reviews carriers every five years through financial audits, and determines whether their rates fall within the rate bands.

The Department currently has no licensed actuary on staff trained to review comprehensive health insurance product filings, although it does have an actuary to review Medicare supplemental policies.

The public can access rate filings by visiting the Department.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	No	Yes, by visiting the Department	

Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Actuarial certification only	No	Yes, by visiting the Department	

92 La. Stat. Ann. §§ 22:972, 22: 1093, 22:1094.

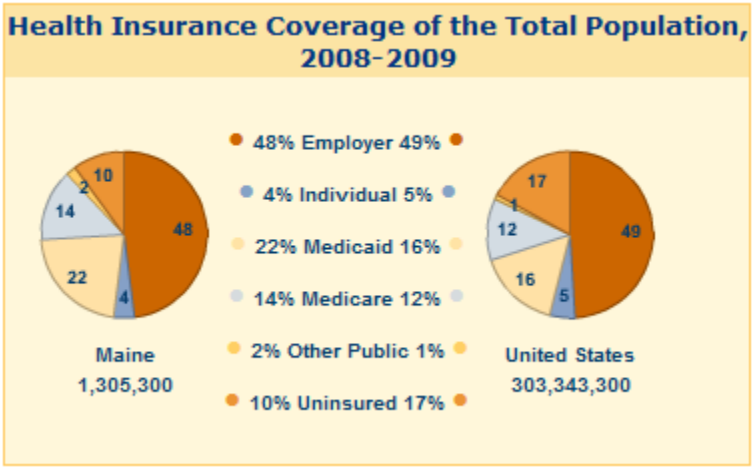
93 Interview with regulator, Louisiana Department of Insurance, Aug. 24, 2010.

Proposed activities under rate review grant[94]

- Develop a comprehensive proposal and seek legislative authority to review and approve major medical rates; and
- Conduct review of all unreasonable rates in accordance with federal law.

[94] HHS, "Louisiana is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at: http://www.healthcare.gov/center/grants/states/la.html.

Maine



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[95,96]

Maine has prior approval authority over individual market rates. The statutory standard requires that rates cannot be "excessive, inadequate or unfairly discriminatory" for health insurance products. Rates in the individual market must meet a prospective MLR of 65%. While the Bureau applies no objective limits on rate increases, they operate on the general principle that the steeper the rate increase, the more critical they will be in looking at the carrier's profit request.[97]

In the small group market, carriers must meet a prospective MLR of 75%, or for carriers with over 1000 covered lives, they can choose to bypass rate review and prior approval if they make a loss ratio guarantee of 78%, averaged over a three-year period. All but one eligible carrier in the state has chosen to make this loss ratio guarantee. Those plans need to file a rate summary form that includes underlying rate justifications. Most plans meet the 78% target, although in one case a carrier issued a refund for missing it.

All rate filings are reviewed by an actuary on staff at the Bureau, although on occasion they have had to hire consulting actuaries when the staff is too busy. The Bureau requires submission of trend and experience information, and makes those data available to the public. Further, if a carrier requests a change to its rates, the Department notes that on its website and requires the plan to notify subscribers at least 60 days before the proposed effective date.

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95 24-A Me. Rev. Stat. §§ 2736, 2808-B.

96 Op. Cit., interview with regulators, Maine Bureau of Insurance.

97 Anthem Blue Cross filed suit against the state in early 2010, arguing that the Superintendent's denial of a profit margin for the plan exceeded her statutory authority. In April 2010, the Superior Court rejected Anthem's suit. The case is on appeal. For more information see: http://www.maine.gov/pfr/insurance/bluecross_anthem/2009_rate_filing/ins-09-1000_rate_filing_press_packet.htm.

The state also embraces public rate hearings as a way to solicit consumer input on rates. Any policyholder can request a public hearing, which may or may not be granted, or the Superintendent can call a hearing of her own volition. In addition the state's attorney general can call a rate hearing.

Typically, when a hearing is not held, the state does not have to go so far as to disapprove a rate since it is not uncommon for carriers in Maine to reduce their rates after discussions with the Bureau. Generally there is an informal back and forth with the carrier before it refiles with a lower rate.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes	Yes	

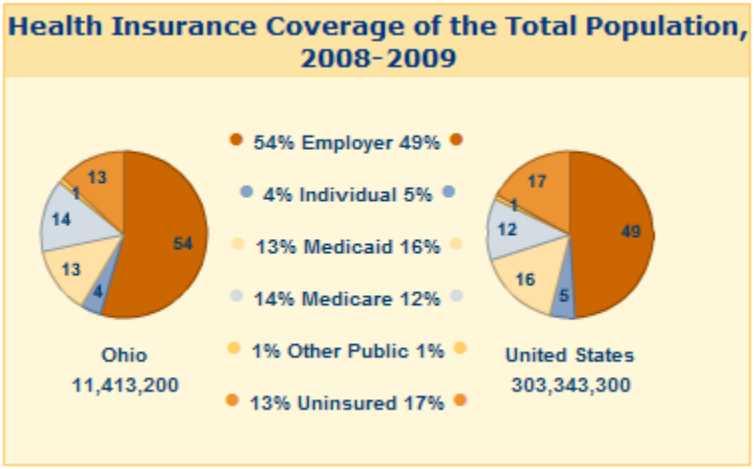
Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes	Yes	Statute allows carriers with over 1000 covered lives to make medical loss ratio guarantee of 78% and bypass prior approval process. All but one eligible carrier has taken this option

Proposed activities under rate review grant[98]

- Expand rate review process by collecting additional information on small group rates and insurers' historical and projected cost and utilization trend data to establish benchmarks;
- Collect data to review and determine whether rates are reasonable;
- Develop educational materials and train consumer advocacy groups on rate filings and the rate review process, in addition to funding consumer advocacy groups to attend and host rate hearings; and
- Compile and submit rate filing information into a consumer friendly format and post on its website along with a guide to understanding the data.

[98] Email from regulator, Maine Bureau of Insurance, Aug. 4, 2010; see also HHS, "Maine is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/center/grants/states/me.html.

Ohio



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[99,100]

Ohio has prior approval authority in the individual market, with a 30 day deemer (60 day deemer for HMOs) requirement. In the small group market, it's file and use, except for certain small group market products such as group trusts and associations. Rates are reviewed by the Department based on the statutory standard that rates must be "reasonable in relation to benefits" and based on actuarially sound principles.

While Ohio doesn't have prior approval authority in the small group market, most carriers file their rates well in advance of use. The state can disapprove the rate if it doesn't meet statutory requirements.

Rates are generally reviewed by actuarial "analysts" within the Department. These analysts are one step away from an actuary in their training. If there are complex issues or problems, the filing is sent to a health actuary on staff with the Department. The Department requires submission of trend and experience data, and makes that data available to the public. However, state law makes no provision for policyholders to request a hearing.

The Department prefers to work with rate filers in place of outright disapproval of rates, and they give carriers time to refile. It is not uncommon for carriers to reduce rates after discussions with the Department. Over the last five years, Department staff estimate that 35% of rates have been disapproved in both the small group and individual markets. Of those, about 10-15% are a result of incomplete filings.

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99 Ohio Rev. Code Ann. §§ 3923.021, 3923.15, 1751.12, 149.43.

100 Op. Cit., interview with regulator, Ohio Insurance Department.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes (with 30 day deemer, 60 day deemer for HMOs)	Yes. Rate filings are publicly disclosed for HMOs after they are approved, and for all other products are public when they are filed	

Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	No (all small employer groups are file and use, except for group trusts or associations, over which the Department has prior approval authority)	Yes. Rate filings are publicly disclosed for HMOs after they are approved, and for all other products are public when they are filed	

Proposed activities under rate review grant[101]

- Hire additional staff to increase rate review and upgrade processes, systems, and data analysis capabilities; and
- Develop a consumer friendly application on the State's website to assist consumers in using and understanding the rate filing information.

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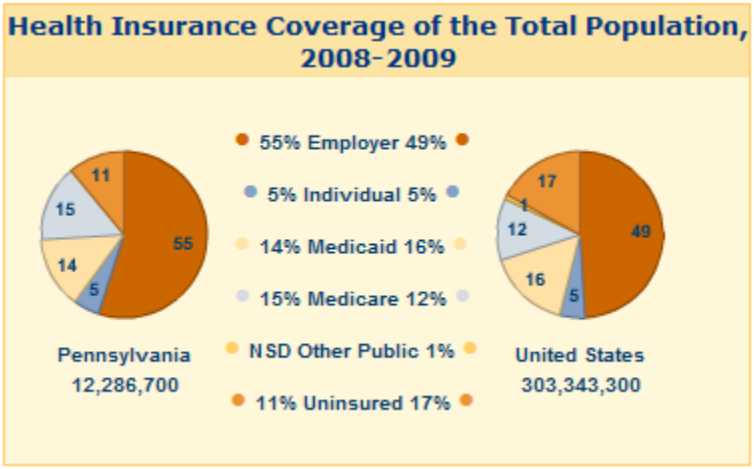
[101] HHS, "Ohio Cracks Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/center/grants/states/oh.html.

Pennsylvania



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[102,103]

Pennsylvania has prior approval authority over individual market rates, with a 45-day deemer clause. In the small group market, Pennsylvania has prior approval authority over non-profit Blue Cross Blue Shield plans and HMOs, but all other commercial carriers are exempt. The for-profit Blues and other commercial plans do not need to file their small group rates at all.

Under the statute, rates must be reasonable and not excessive. There are no objective statutory constraints on rate increases. If a plan requests an increase in rates, that information is posted on the Department's website.

The state has actuaries on staff with the Department, and every filing requesting a rate increase receives a rigorous review. Plans must submit trend and experience data to justify their proposed rate.

The Department publishes all individual and small group filings on the Web in the Pennsylvania Bulletin to give the public a 30 day period to review the proposed change and comment on its impact. The public posting includes the entire filing, unless the carrier requests portions to be redacted as "trade secret." Pennsylvania does not permit policyholders to request a rate hearing, but the Commissioner may call one at his discretion.

While the Department rarely formally disapproves a rate, individual market carriers frequently reduce their filed rates after they are reviewed by the Department.

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102 40 Pa. Consol. Stat. Ann. § 3803, 73 Pennsylvania Statutes § 136.

103 Op. Cit., interview with regulators, Pennsylvania Insurance Department.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	Yes (45 day deemer)	Yes but carriers can ask for some information to be confidential	

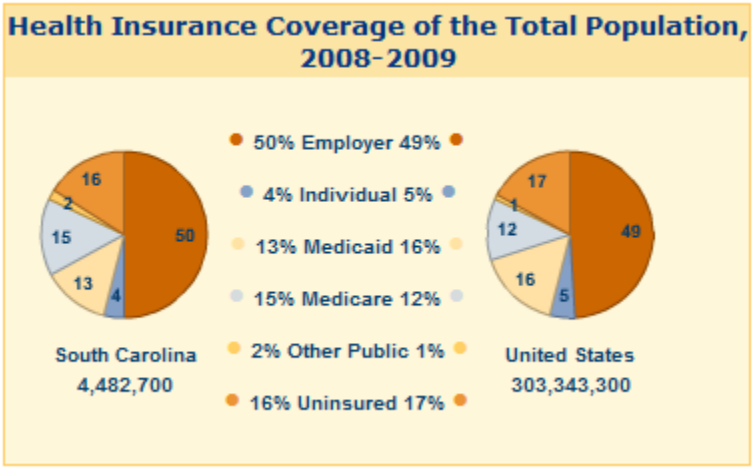
Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Yes, for HMOs and BCBS (nonprofit) only (other commercial carriers exempt)	Yes, for HMOs and BCBS (nonprofit) only (other commercial carriers exempt)	Yes but carriers can ask for some information to be confidential	

Proposed activities under rate review grant[104]

- Collect relevant rate data from insurers and create a database for individual and small group markets for consumer rate comparison;
- Enhance and develop a more robust regulatory review of rates and unreasonable rate increases; and
- Enhance regulatory oversight of market practices that generate consumer complaints or otherwise appear to be causing market disruption.

[104] HHS, "Pennsylvania is Cracking Down on Unreasonable Health Insurance Premium Hikes," available at http://www.healthcare.gov/center/grants/states/pa.html. See also Pennsylvania Insurance Department, Premium Rate Review, "Application Cover Letter and Cover Sheet," available at http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/federal_health_insurance_reform/713453.

South Carolina



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[105,106]

South Carolina has prior approval authority in the individual insurance market, with a 90 day deemer. However, a number of carriers in the individual market have taken advantage of a statutory provision that allows them to form an out of state "trust." By doing so they are effectively treated under the law like small group plans, which are only required to file an actuarial certification with the state attesting that their rates are in compliance with state law. There are some plans in the group market that must file rates and are subject to prior approval under the statute (mass marketed group plans and blanket health (i.e., college plans)).

Where South Carolina does have rate review authority over individual market products, carriers have two regulatory pathways. They can make a loss ratio guarantee, in which case their rates are assumed to be reasonable. If they do not, the Department will assess their rates under the statutory standard that benefits cannot be "unreasonable in relation to premiums charged." While the loss ratio standard is only 55%, the majority of carriers choose the second pathway.

Rates are initially reviewed by an actuarial analyst with the Department, and are accompanied by trend and experience data from the carrier. All rates receive a review on a "first come-first served" basis.

Only occasionally do carriers reduce rates after review. The Department engages in an informal back-and-forth with carriers if they find a problem with a filing. In some cases if a carrier requests a big increase, the Department will make them spread it out over a few years in order to limit "rate shock" for consumers.

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105 S.C. Code Ann. §§ 38-71-310, 38-71-740, 38-71-750, 38-71-1020, 38-71-1110, 30-4-40.

106 Op. Cit., interview with regulators, South Carolina Department of Insurance, Sept. 1, 2010.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes*	Yes (90 day deemer)	No	Deemed approved if carrier meets loss ratio requirements and files a loss ratio guarantee *Carriers can bypass this requirement by creating an out-of-state "trust"

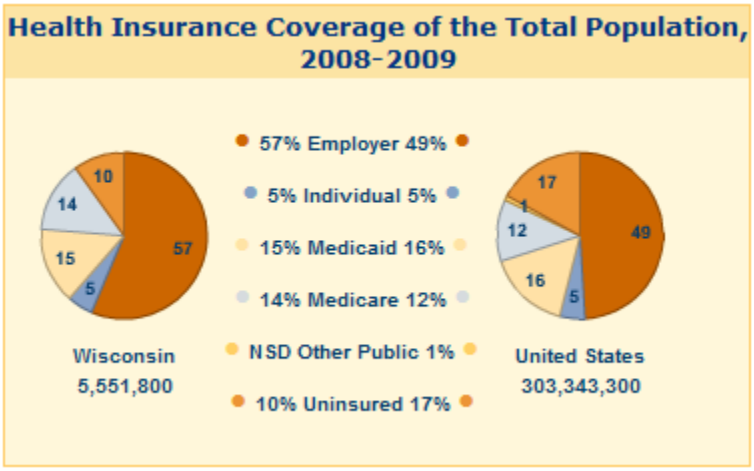
Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Actuarial certification only for most small group products*	No	No	*Group mass marketed, blanket health and franchise health. are subject to prior approval authority unless they meet loss ratio requirements

Proposed activities under rate review grant[107]

- Expand capacity by hiring a consultant actuary to review all individual and group rates;
- Review all individual and group rates and develop new processes for comprehensive review of rate filings. This review will inform a future determination of whether additional legislative authority is required;
- Study historical rates and their reasonableness, making results available to consumers;
- Develop a "consumer-friendly" website.

[107] HHS, "South Carolina is Cracking Down on Unreasonable Health Insurance Rate Hikes," available at: http://www.healthcare.gov/center/grants/states/sc.html.

Wisconsin



Source: Kaiser statehealthfacts.org, 2010

State authority to regulate insurance rates[108,109]

Wisconsin does not have prior approval authority over rates, and carriers are only required to file rates within 30 days of use. The state's assumption is that if there is a competitive insurance market there is no need for rate regulation.

Rates are generally reviewed only in response to consumer complaints. However, that review is constrained by a statutory presumption that if price competition exists in the market, then the rates are not excessive.[110] More typically, filed rates are only checked for completeness. There is no actuary on staff.

The public has access to rate information on the Office's website, but it is not user-friendly. However, Wisconsin generally presumes that all information included in a rate filing should be public, and staff have never seen a carrier ask for part of the filing to be kept confidential.

A policyholder could request a rate hearing, but the Commissioner has the discretion to determine whether there is sufficient cause to hold one.

Individual Market			
Filing required?	Prior approval?	Public access?	Comments
Yes	No, but rates must be filed within 30 days of use.	Yes	

108 Wis. Stat. §§ 625.13, 625.14, 625.21.

109 Op. Cit., interview with regulators, Office of the Commissioner of Insurance.

110 Wis. Stat. § 625.11.

Small Group Market			
Filing required?	Prior approval?	Public access?	Comments
Actuarial certification only	No	Yes	

Proposed activities under rate review grant[111]

- Assess need to pursue additional statutory authority to collect and review rate information for the large group market;
- Expand rate review in the individual and small group markets;
- Retain consulting actuaries to develop standardized requirements for review;
- Develop a public hearing and comment process;
- Establish a data center to compile and publish fee schedule information.

111 HHS, "Wisconsin is Cracking Down on Unreasonable Health Insurance Premium Hikes," available

This publication (#8122) is available on the Kaiser Family Foundation's website at www.kff.org.