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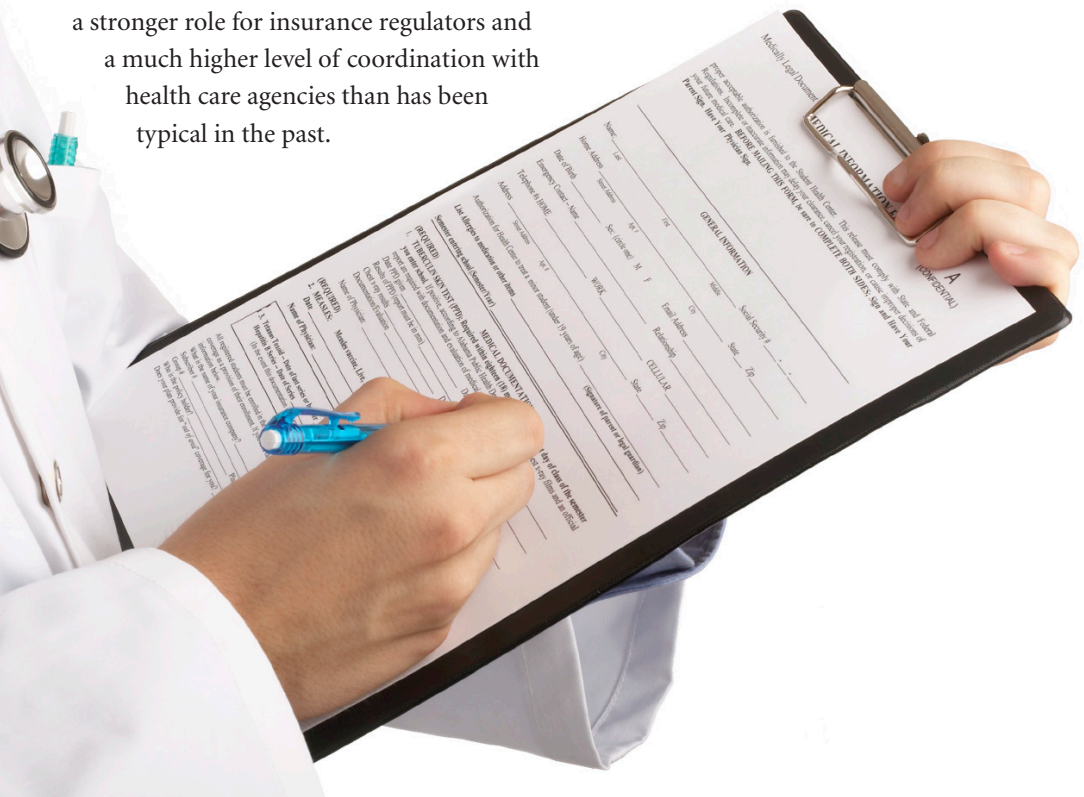
Chapter 6: Insurance Regulation Reform

State insurance agencies had a busy and important year in 2010 as they were tasked with implementing and enforcing several technical provisions of the Patient Protection and Affordable Care Act (ACA) that were among the first to go into effect. State insurance regulators were asked to enforce a series of insurance reforms that took effect on September 23, 2010 (including mandatory dependent coverage and guaranteed issue for children, among others), to expand their role in reviewing premium increases, and to prepare for new medical loss ratio (MLR) requirements. In addition, a number of state insurance departments worked with the federal government in planning for federally funded high risk pools[1] and many of them took the lead on health insurance exchange planning.[2]

Many insurance agencies became much more engaged in broader health policy discussions at the state level in 2010. The ACA requires a stronger role for insurance regulators and a much higher level of coordination with health care agencies than has been typical in the past.



The traditional role of insurance departments (which, in all states except Rhode Island, regulate all types of insurance) has been to protect consumers and ensure the solvency of insurance carriers selling policies in the state. Some states have taken a more activist role and also review premiums to prevent unreasonable increases or to insure that the methods used to set premiums are actuarially sound. The ACA envisions an even stronger role for insurance regulators in this area, and it designated $250 million to fund efforts to strengthen state rate review processes over the next five years. This chapter outlines the baseline practices among states in the area of rate review, their efforts in 2010 to expand their work in this area, and their plans going forward (as expressed in their rate review applications).

BACKGROUND: THE RISING COST OF HEALTH CARE

The rising cost of health care can be measured in numerous ways but, by all measures, spiraling cost increases are alarming and unsustainable. New estimates from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary project that health care costs will increase from 17.3 percent of gross domestic product (GDP) in 2009 to 19.6 percent of GDP in 2019.[3] This is a significant increase from the 13.6 percent of GDP that health care consumed in 1999.[4]

Private health insurance premiums are rising precipitously. Average family premiums in the employer-sponsored market have more than doubled in 10 years from $6,438 in 2000 to $13,770 in 2010. At the same time, out-of-pocket costs have mounted as deductibles and other cost-sharing arrangements have increased. For example, the number of people with employer-sponsored single coverage that had a deductible of $1,000 or more increased from 6 percent in 2006 to 17 percent in 2010.[5]

In early 2010, the Department of Health and Human Services (HHS) put the spotlight on insurance carriers with the claim that they were charging "unreasonable" premium increases to consumers. The report published by the department cited examples of proposed premium increases for policies sold on the individual market ranging from 13-16 percent in Rhode Island to 56 percent in Michigan. The secretary's report concluded that carriers were increasing premiums in spite of large amounts of surplus held in reserve.[6]

The carriers countered with claims that the majority of premium increases are driven by rising medical costs, including rising prices being paid to doctors, hospitals, and pharmaceutical companies, as well as increasing volume in the services being provided.[7]

The causes of increasing premiums are complex, and vary depending upon the characteristics of the market. In many states, growing provider consolidation has given many providers increased bargaining power with insurance carriers. Some consolidated hospital groups or specialty practices are considered "must-haves" in insurance networks; they can set their prices and carriers have little leverage to negotiate with them. At the same time, many markets have seen a growing consolidation of insurance plans, which could help to counterbalance the power of providers, but could also lead to a non-competitive environment where insurance plans can raise premiums at will.[8]

STATES RESPOND TO EARLY INSURANCE REFORMS IN THE ACA

One significant way insurance companies have managed health care costs in the individual and small group market has been to attempt to avoid covering people with expensive health care needs. They have utilized unpopular techniques such as denying coverage to sick people, refusing to cover pre-existing conditions, and rescinding coverage to people with existing policies if they become sick and the insurer discovers that the policyholders incorrectly reported any aspect of their health condition on their initial application. These practices will be unlawful after 2014 when the individual mandate takes effect and the health insurance exchanges are in place; a few provisions took effect six months after enactment on September 23, 2010. The provisions that deal with risk selection practices include the following:

- Plans can no longer limit or deny benefits for children under 19, if they offer child-only policies.
- Plans can no longer rescind benefits for honest mistakes on applications; they must be able to prove fraud.
- Those with insurance have a right to both internal and external appeal of decisions to deny coverage for care.

Other insurance provisions that took effect on September 23 are:

- No "unreasonable" annual benefit limits are allowed.
- No lifetime benefit limits are allowed.
- Plans must cover dependents up to age 26 (if their policies cover any children dependents).
- Plans must include preventive services with no cost-sharing, an ability to see a pediatrician or OB/GYN without a referral, and the right to use the nearest emergency room without penalty.

Since the ACA passed in late March, many states were unable to enact legislation giving their insurance departments authority to enforce these provisions before the end of their legislative sessions. While few states had official legal authority to enforce the provisions, most state regulators took an activist role in educating and working with insurers to promote compliance with the law. In the meantime, state insurance commissioners have worked through the National Association of Insurance Commissioners (NAIC) to develop model laws that will give states authority to enforce these provisions.[9] Many state legislatures plan to pass these bills during their 2011 legislative sessions.

RATE REVIEW: CURRENT STATE LAW AND PRACTICE

Currently, a great deal of variation exists among states with regard to the rate review process. To address this variation and to contain the rapid increase in health insurance premiums, the ACA sets out to increase the transparency and scrutiny of proposed health insurance rate increases. The new law provides funding and includes provisions that will help states strengthen or create rate review processes. A pool of $250 million in grant funding will go to state insurance departments over five years to support enhanced rate review processes.

A recent report by the Kaiser Family Foundation sheds light on how current state laws and practices lead to such tremendous variation in the rate review process among states. Although regulatory authority is an important factor, enforcement, and the extent to which state laws actively encourage the input of consumers also play a key role in why some states effectively monitor and address insurance rate increases, while others do not.[10]

According to the study, state laws giving insurance agencies authority to review rates vary dramatically from state to state. At one end of the spectrum are states with "prior approval" authority over rates; they prospectively review and approve rates. At the other end are states that do not require health insurance carriers to file rates for their products at all. There are a range of options in between, including states that only require insurance companies to file an "actuarial certification" attesting that their rates are in compliance with state law, without providing any documentation to substantiate their claim. In addition, some states review rates retrospectively to determine whether the filed rates are found to be unreasonable; this is called "file and use." A file and use inquiry can be done on every filing or it could be instigated by consumer complaints.

The study finds that:

1. *A state's statutory authority often tells little about how rate review is actually conducted in the state.*

   How states exercise their review authority over rates varies widely and depends on motivation, resources, and staff capacity. While some states with "prior approval" authority put virtually no pressure on insurance carriers to

reduce their rates, others, with only "file and use" authority, may work behind the scenes to compel insurance companies to lower their proposed rates.

For example, Connecticut, a state with prior approval authority over all health insurance products in the individual market, recently resisted calls from the state's attorney general for a more aggressive review of insurance companies rate increases requests.[11] On the other hand, states with little to no authority to regulate rates have used their limited authority to put pressure on insurance carriers to lower their rates. Idaho and Ohio[12] have used their file and use authority to obtain lower rates or make additional changes to a filing to address their concerns.

2. *In many cases, statutory authority is limited, in that it does not extend to all market participants.*

Some states have limited statutory authority that only applies to certain market segments. In Pennsylvania, prior approval authority in the small group market extends to nonprofit Blue Cross Blue Shield and HMOs but not to commercial carriers. In Maine, due to an exception in the statute, small group carriers can bypass the traditional rate review depending on the pathway they choose for filing their rates. In South Carolina, a provision in the statute allows most individual market carriers to bypass rate review, even though the statute generally provides for prior approval authority. As a result of these limitations in statutory authority, the rates of many insurance companies in the individual or small group market are not reviewed at all.

3. *Most of the states interviewed use a subjective standard to guide the review and approval of rates.*

State rate review can be based on either objective or subjective standards. Subjective standards generally mean that rates cannot be "excessive, inadequate, or unfairly discriminatory," or that "benefits are reasonable in relation to premiums charged." An example of an objective standard is an MLR. Both types of approaches have advantages and disadvantages. The primary advantage of an objective standard is that it can be applied consistently and fairly across all plans. The disadvantage is that it is more rigid, leaving little room to address differences in circumstance and equity. While a subjective standard offers flexibility, it can lead to variability in its application, resulting in the perception of an arbitrary and opaque state determination.

Most of the states interviewed for the study use subjective standards, while some have a mix of subjective and objective standards.

4. *Most of the states interviewed have made little to no effort to make rate fillings transparent.*

The study found that much of the rate review process is conducted as an informal dialogue between the insurance department staff and insurance carriers. Consumers and policyholders have no means to participate in this discussion.

Although—according to the study—there is evidence that the simple ability to hold a hearing is enough to give state regulators leverage to negotiate lower rates, only three of the 10 states interviewed for the study (Colorado, Maine, and Wisconsin) allow policyholders to request a public hearing prior to rate approval.

Most states, in theory, allow public access to rate filings after they have been approved. However, the rate filing may not be easily accessible because consumers are required to physically visit the agency if they want to access the necessary documents. In addition, regardless of whether the public has access to the rate filing before or after rates have been approved, access may be limited because parts of, or in some cases, the entire filing is labeled "proprietary" or a "trade secret."

Most of the states interviewed indicated they were planning to use some portion of their federal grant to improve their website and enhance consumer access to information about the rate review process.

5. *Many states lack the capacity and resources to conduct an adequate review.*

A rate review is not just a mechanical function—an actuary makes assumptions and projections that involve nuanced judgment calls. An actuary being paid by the carrier may make a judgment in favor of the carrier. With a sound rate review process, a state may question the assumptions that underpin a carrier's rate increase. Without the authority, staff capacity, and expertise, a state may not be able to conduct adequate rate reviews.

Having only a relatively limited time available to conduct such a review may diminish a state's ability to perform an adequate rate review. This limited time is usually imposed by state statute which requires that insurance regulators review and make a decision to approve or disapprove rates during a specific time frame (usually 30-60 days). In some cases, however, states may have a degree of flexibility. For example, sometimes the time clock is halted while insurers respond to questions and requests for additional information from regulators. Carriers may also be willing to work with the regulators to delay using the proposed rates rather than risk a formal disapproval.

RATE REVIEW: FEDERAL LAW, REGULATION, AND FUNDING

The ACA requires HHS, in conjunction with the states, to establish a process for annual review of "unreasonable" rate increases for non-grandfathered health plans. However, the law does not define what constitutes "unreasonable" increases. On December 21, 2010, HHS

issued a proposed rule[13] that provides clarification as to how HHS is planning to implement the requirement for reviewing "unreasonable" rate increases. According to the regulations, HHS defines a rate increase as "unreasonable" if it is "unjustified," "excessive," or "unfairly discriminatory."[14] Also, the agency would only apply this definition to rate increases that HHS reviews. The agency would not create a federal standard for states to use. In other words, states that have an effective rate review program would be permitted to use any applicable standard based on state law and regulation. However, for states that do not have the resources or authority to do thorough actuarial rate reviews, HHS would conduct them and apply its regulatory definition of "unreasonable."

In addition, to increase transparency of the rate review process, the ACA requires insurance companies to publicly disclose and justify unreasonable rate increases.[15] To that end, for 2011 (i.e., rate increases filed in a state on or after July 1, 2011, or effective on or after July 1, 2011), the proposed rule would require all insurers seeking rate increases of 10 percent or more in the individual and small group markets to publicly disclose the proposed increases and the justification for them. HHS clarifies that increases above 10 percent should not be presumed unreasonable. The extent to which such increases are unreasonable would be analyzed and determined subsequently. For subsequent calendar years, the threshold for disclosure would be state-specific and based on data and trends that better reflect cost trends specific to that state.

States' Proposed Use of Grant Funding: To date, 45 states and the District of Columbia (D.C.) have been awarded $1 million in grant funding each. According to HHS's website, states are planning to use the funds in the following ways:[16]

- *Additional Legislative Authority*: Fifteen states and D.C. will pursue additional legislative authority to create a more robust program for reviewing or requiring advanced approval of proposed health insurance premium increases to ensure that they are justified.
- *Expand the Scope of Health Insurance Premium Review*: Twenty-one states and D.C. will expand the scope of their current health insurance review, for example by reviewing and pre-approving rate increases for additional health insurance products in their jurisdictions.
- *Improve the Health Insurance Premium Review Process*: All 46 grantees will require insurance companies to report more extensive information through a new, standardized process to better evaluate proposed premium increases and increase transparency across the marketplace.
- *Make More Information Publicly Available*: Forty-two states and D.C. will increase the transparency of the health insurance premium review process and provide easy-to-understand, consumer-friendly information to the public about changes to premiums.
- *Develop and Upgrade Technology*: All 46 grantees will develop and upgrade existing technology to streamline data sharing and put information in the hands of consumers more quickly.

To receive the grants, states are required to provide HHS with information about trends in premium increases in their state, both inside and outside of the new insurance exchanges. HHS will then assess the rate of premium growth inside and outside the exchange before allowing large businesses (more than 100 employees) to participate in the exchange.[17]

RATE REGULATION: NON-ACA-RELATED STATE EFFORTS

Even before the federal government made grants available to states to help them improve their rate review process, some states were already strengthening their legislative authority to improve their ability to control the rapid rate increases. Two states—Rhode Island and Massachusetts—have been at the forefront of this movement, instituting measures to help them control the cost of health insurance. The approaches taken, however, have been very different.

Rhode Island – Driving toward Payment Reform[18]

Rhode Island's unique approach is based on the belief that controlling health care costs cannot be addressed through rate review alone. Rather, rate review can be used as a tool to drive payment reform. Through a process that has included stakeholder input and partnership with existing quality improvement initiatives, Rhode Island has established rate review standards that promote increased spending on primary care, that restrict increases in payments to hospitals, and that work to promote care coordination and quality improvement. The rate review standards also restrict the administrative costs of the health plans.

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has a unique mandate: to ensure overall health care system affordability and efficiency. To this end, in 2009, OHIC embarked on a project to strengthen primary care. In 2010, OHIC sought to expand its oversight into health plan contracts with hospitals.

Strengthening Primary Care: OHIC's decision to focus on primary care stems from a concern that payment policies have led to a shortage of primary care physicians. In addition, population-based quality and cost measures, both nationally and internationally, are positively correlated with the supply of primary care physicians.[19] Moreover, because primary care constitutes a small percent of overall health care costs, payment reform in this area seemed like a relatively easy place for OHIC to start. As a result, there has been wide acceptance from stakeholders of the idea that an investment in primary care is a worthwhile goal.

The priorities, established through the office's Advisory Council, seek to strengthen primary care without adding to the overall cost of care. They include:

- Expanding and improving the primary care infrastructure in the state;
- Promoting the adoption of medical homes based on the Chronic Care Model;
- Promoting the adoption of electronic health records by physicians; and
- Implementing more comprehensive payment reform.

Based on these priorities, the Advisory Council developed the following four regulatory standards aimed largely at increasing payment for primary care physicians and promoting delivery system reform through support for the medical home:

- "Health plans would increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.
- As part of the increased primary care spending, health plans would promote the expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) project, or an alternative all-payer medical home model with a chronic care focus, by at least 25 physicians in the coming year.
- Health plans would promote the adoption of electronic medical records (EMR) programs that meet or exceed a minimum value.
- Health plans would commit to participation in a broader payment reform initiative as convened by public officials in the future."[20]

Importantly, these regulatory standards were linked to the rate review process—if carriers did NOT meet the primary care investment requirements outlined above, it would detrimentally affect their proposed rate increases.

Hospital Payment and Care Delivery: Since physician payment reform only addresses part of payment and delivery system reform, in 2010 OHIC included new insurer regulations aimed at altering payment to hospitals to provide incentives for efficient use of health services while increasing the quality of services.

According to OHIC, the impetus for hospital payment reform stems from concern over significant variations—up to 85 percent—in payment rates among hospitals for the same sets of services. In addition, data presented by health insurers in their most recent filings to OHIC indicate that a significant proportion—40 percent—of insurers' medical costs is spent on hospitals. In almost every case, inpatient and outpatient hospital expenses are growing faster than expenses in any other medical service category.[21]

To create incentives for hospitals to provide quality health care in a more efficient manner, on July 7, 2010, OHIC announced six new conditions with which health insurers must comply as part of the rate factor approval process effective in 2011. The six conditions that new contracts with hospitals must meet are:

1. Efficiency-based units of payment for both inpatient and outpatient services modeled on Medicare's payment system, which has moved away from fee-for-service and toward bundling certain services.
2. Annual maximum price increase for services based on a weighted amount equal or less than the CMS National Prospective Payment System Hospital Input Price Index. Currently, hospital price increases can exceed this index by a factor of multiple times.
3. Quality incentives whereby a hospital can increase its total annual revenue for enrollment under contract by at least two percent over the previous year if it attains performance levels for no less than three nationally accepted clinical quality, service quality, or efficiency-based measures. The measures and the required achievement levels should be subject to negotiation between the insurer and the hospital.
4. Administrative efficiency standards that would stave off the rapid increase in administrative costs, which are rising at rates of insurance premium inflation—several times the rate of general inflation.
5. Provider communications standards that would promote and measure improved clinical communications between the hospital and the patient's physician or other practitioners.
6. Carriers must provide public access to health plan payment terms and conditions with hospitals.

It should be noted, however, that these hospital contracting requirements are not without controversy as one large hospital system is contesting OHIC's authority in this area.

Rhode Island has been able to introduce regulations aimed at controlling costs and improving care, largely because its statutory authority goes beyond what most states currently allow. In addition, transparency of the process and continuous engagement of stakeholders in the development of the regulations have helped decrease resistance. Although it may take time for this approach to show results, its design includes features that can be incorporated by other states interested in achieving similar goals.

Massachusetts – Direct Rate Regulation

Massachusetts' variations in provider reimbursement rates mirror those in Rhode Island. According to a *Boston Globe* article published in late 2008, several high profile hospitals (particularly the two Partners Hospitals: Brigham and Women's Hospital and Massachusetts General, and Children's Hospital) were being paid 15-60 percent more than their competitors.[22] These

findings were confirmed by a subsequent report by the attorney general, which also found that price variations are not correlated to quality of care, the complexity of the patient population, the proportion of Medicare/Medicaid patients receiving services, or teaching status.[23] The report also indicated that price variations are correlated with market leverage of particular hospitals or provider groups and that the commercial health care market place has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

Although Massachusetts has seen similar variations among providers as Rhode Island, the state has chosen a different approach to address that variation and control costs. Massachusetts attempted to use its regulatory authority over the insurance carriers to indirectly pressure providers to reduce their reimbursement rates. The state also attempted to use the legislative process to hold down the cost of insurance for small businesses and individuals.[24] Specifically, the Massachusetts Senate approved a bill in May that would have required hospitals in the state to make one-time payments totaling $100 million to reduce premiums in the small group and individual markets; ultimately the bill was not enacted.[25]

The state took aggressive regulatory steps in February, when the Division of Insurance (DOI) issued emergency regulations triggering review of all premium increases at or above 150 percent of the New England medical consumer price index (5.1 percent in 2009)[26]—the equivalent of a 7.7 percent rate increase over the previous year—and required carriers to submit rate filings, which were subject to review and approval by the DOI, one month prior to their effective date. As a result of the regulations, in April, the DOI rejected 235 of the 274 rate filings by insurers in the small group and individual market, calling them "excessive and unreasonable."[27] Insurers had proposed rate increases ranging from 8 percent to 32 percent.[28]

In response, the insurance carriers appealed the rulings with the DOI and challenged the rejection of the proposed premium increases in court. In June, an appeals panel within the DOI rejected the denial of rate requests that had been filed by one insurer, Harvard Pilgrim Health Care. By the beginning of July, the insurer reached a compromise with the DOI, which allowed it to raise rates by slightly less than it had originally requested. The settlement also removed Harvard Pilgrim from the lawsuit filed in April by all of the state's other major carriers.

Since then, two of the six carriers—Tufts Health Plan and Blue Cross and Blue Shield of Massachusetts (BCBSMA)—have reached agreement with the DOI on rate increases, and one—Fallon Community Health Plan—was successful in its appeal of rate hike rejections by the DOI. Tufts Health Plan agreed to rate increases ranging from 5.8 percent to 12.8 percent [29] and BCBSMA agreed to increases below 13 percent compared to the original 23 percent increase requested.[30]

Another step toward containing rate increases for small employers is the passage of legislation in August, which was supported by some members of the business community—most notably small business advocacy organizations—as well as the Massachusetts Hospital Association. The new law includes:

- Authority for the state insurance commissioner to approve policies that do not cover some mandated benefits, for a period of up to five years, for small businesses that previously did not offer health insurance to their employees.
- A requirement that companies that insure at least 5,000 subscribers in the state offer in at least one geographic area, a plan with a reduced or selective network of providers, or with a tiered network of providers with cost sharing based on tier selection. The base premium for such plans must be at least 12 percent lower than the base premium for similar plans without reduced networks.
- Up to six "small business group purchasing cooperatives," consisting of member-employers with no more than 50 workers each may be formed under the new law. Total enrollment of the six groups may not exceed 85,000.
- A reduction in the number of enrollment periods to two in 2011, and one for each year thereafter, to limit the number of people who sign up for coverage, undergo expensive (typically elective) procedures, and subsequently drop coverage after the procedure has been completed.
- Allowing carriers to make age rate adjustments every year, instead of every five years.
- Prohibition of anti-competitive contract provisions linking rates to those charged by large providers.
- Promotion of wellness plans.

MEDICAL LOSS RATIO

As part of the effort to contain rising health care costs and provide better value for consumers, the ACA includes a requirement that insurance companies spend at least 80 to 85 percent of premiums paid on medical costs. In other words, administrative expenses and profits are limited to 20 percent in the small group and individual markets and 15 percent in the large group market. An exception is made for the individual market in that the secretary of HHS can adjust the MLR percentage if she determines that the application of the 80 percent MLR may destabilize that market in the state.

The legislation called for the National Association of Insurance Commissioners (NAIC) to develop draft MLR standards and submit them to HHS. In October, NAIC presented its recommendations along with a separate letter asking the secretary to be responsive to requests from state regulators for a phase-in period of the MLR standard if it is determined that meeting the standard may destabilize the individual market and result in fewer choices for consumers. HHS incorporated NAIC's recommendations and published an interim final rule on December 1, 2010.[31]

The MLR rule is expected to take effect in 2011. The ratios will be calculated annually at the state level. Insurers that spend less than these ratios must refund the difference to their policyholders starting in 2012.

To guard against destabilization of the individual market when insurance carriers cannot immediately comply with the new regulations, provisions in the rule allow for a phase-in period of the MLR standard requirement.[32] In other words, if a state can demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers, the rule establishes a process for states to request an adjustment to the MLR standard for up to three years. This provision is consistent with NAIC's recommendations in its accompanying letter to HHS.[33]

The requests must be submitted by the state insurance commissioners on behalf of the state individual insurance market as a whole. The request may be made for one, two, or three MLR reporting years. The request must include the state's own assessment of how best to address any risk of destabilization through an adjustment to the MLR standard. To this end, the state must submit an appropriate alternative MLR standard for each year for which it is requesting an adjustment.

The regulations establish the following five criteria HHS will use to determine the risk of destabilization:

1. The number of carriers reasonably likely to exit the individual market or cease offering specific products in a state absent an adjustment.
2. The number of individual market enrollees covered by carriers that are reasonably likely to exit the state absent the adjustment.
3. Whether, absent an adjustment, carriers would reduce compensation to agents and brokers to the point where agents and brokers would leave the market and consumers would lose access to their services.
4. Alternate coverage options available within the state for enrollees of carriers that are reasonably likely to exit the market.
5. The impact on premiums charged, the benefits offered, and the cost-sharing provided to consumers by carriers remaining in the market in the event one or more withdraw from the market.

For more information about the MLR standard in the individual insurance market and provisions within the ACA for addressing any potential market destabilization, see *Recognizing Destabilization in the Individual Health Insurance Market*, an issue brief produced by the Changes in Health Care Financing and Organization (HCFO) initiative.[34]

CONCLUSION

Rapid and steep increases in private insurance rates are quite prevalent and there is growing concern that these rate increases will price more and more people out of the insurance market and make access to services increasingly more difficult. In addition, the need to find affordable products will increase once the ACA's requirement that everyone buy insurance takes effect in 2014. The federal government, in particular, will have a strong interest in containing the cost of health insurance premiums as they will be covering a portion of those costs for many Americans.

The interaction of the rate regulations outlined above with the advent of health insurance exchanges will be a significant issue for states going forward. They will need to consider how the insurance market restructuring contemplated by exchanges will interact with the work of the state's insurance department. Effective communication between the leadership of both entities will be critical to ensure that the right policy tool is being used for the job and that the work of rate regulators and exchange implementers does not conflict. Working in partnership, these two policy levers—rate regulation and a health insurance exchange—could be a powerful force for increasing access, containing costs, and improving quality in the health care market.

ENDNOTES

1 See *State of the States* Chapter 4: First Hurdle: Pre-Existing Condition Insurance Plans.
2 See *State of the States* Chapter 5: Laying a Foundation for State-Based Exchanges.
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18 The approach described in this report applies to the small and fully insured large group insurance market. The regulatory approach applied to the individual market is different, and may not be relevant to other states as Rhode Island's individual market has some unique characteristics including a single insurance carrier for the entire individual market.

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