FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Quantifying the Effects of Health Insurance Rate Review

One way the Affordable Care Act (ACA) aims to ensure that health insurance premiums provide good value for consumers is through a program known as rate review, in which states and the federal government review proposed premium increases above a threshold amount (currently ten percent or more) in the small group and individual markets in order to determine whether these increases are reasonable. In most states, regulators have the authority to prevent rate increases from going into effect if an insurer's requested increase is determined to be unjustifiable. In other states, the judgment that a rate increase is unreasonable is publicly disclosed but the insurer does not need permission to implement the increase.[1] Sometimes regulators question or negotiate with insurers over the rates they file, and this can result in the insurer withdrawing or modifying the original request.

Most states had some form of rate review program in effect before the ACA was passed in 2010, including some with the authority to approve rates in advance.[2] These earlier rate review programs typically reviewed proposed rate changes regardless of size and are generally still in effect, so in some respects they go beyond the requirements of the ACA. However, these programs varied substantially in their review processes, which market segments they applied to (e.g., individual, small group), and in the type of information that they made available to the public.[3] The ACA provides a minimum set of requirements for rate review programs – whether operated by states or, where states do not have effective rate review programs, by the federal government – and also provides grants to states to enhance their rate review activities.

Beginning September 1, 2011, states with effective rate review programs (as determined by the federal government) are responsible for reviewing proposed rate increases of ten percent or more (based on criteria outlined in the ACA), and verifying whether the increase is reasonable under standards set by state law or regulation. These states are also required to make some

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[1] Kaiser Family Foundation, statehealthfacts.org, State Statutory Authority to Review Health Insurance Rates. Individual Plans, 2012, available at: http://www.statehealthfacts.org/comparetable.jsp?ind=887&cat=7; Small Group Plans, 2012, available at http://www.statehealthfacts.org/comparetable.jsp?ind=888&cat=7. Data compiled through review of federal and state law by the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

[2] National Conference of State Legislatures (NCSL). State Approval of Health Insurance Rate Increases, September 12, 2012. Available at: http://www.ncsl.org/issues-research/health/health-insurance-rate-approval-disapproval.aspx

[3] National Association of Insurance Commissioners (NAIC). Rate Review White Paper. June 27, 2012. Available at: http://www.naic.org/documents/committees_b_related_wp_rate_review.pdf

information from the review process available to the public.[4] In states without effective rate review programs, or with programs that are only partially effective, the Department of Health and Human Services (HHS) conducts the reviews for rate increases of ten percent or more.[5] All requests by insurers to raise premiums by ten percent or more, whether reviewed by a state or federally, are now published on HealthCare.gov, a federal website with information on health insurance and reform.

To examine the effects of rate review – including state programs established before and since the ACA, and rates reviewed by HHS in states without effective programs – we used publicly available information from state websites and HealthCare.gov to analyze requests filed by insurers in 2011 to increase or decrease premiums for individuals and small businesses. In this analysis, we compared the average rate change insurers requested to the rate that was ultimately implemented following state or federal review. We also looked at variations in rate requests throughout 2011 in states that published data across the whole year, to examine whether there were any measurable changes in rate requests following the September 1, 2011 implementation of the ACA's rate review requirements.

We analyzed rate filings that were reviewed by state regulators separately from those reviewed by HHS. In total, we analyzed 846 rate filings from 41 states and the District of Columbia (DC). Of these, 798 rate filings were reviewed by state regulators and 48 rate filings were reviewed by HHS. The sections below detail the key findings of this analysis. We also include an overview of the rate review information that is currently available for each state, as well as links to view rate information online. Although all states with effective rate review programs must meet certain transparency requirements for proposed increases of ten percent or more, there is still substantial variation from state to state as to how rate requests are filed, reviewed, and made publicly available.[6]

[4] For more information on the determination of effective state rate review programs, see: Center for Consumer Information & Insurance Oversight (CCIIO), Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses. Available at: http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

[5] For a list of state rate review processes, and states where the federal government reviews rate increases, see List of Effective Rate Review Programs at: http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

[6] For detailed information about rate review programs in 10 selected states, see: Corlette, Lucia, Keith, *Monitoring State Implementation of the Affordable Care Act in 10 States: Rate Review,* September 2012. Available at: http://www.urban.org/publications/412649.html

Rate Review Conducted by the States

As of August 1, 2012, 44 states and DC have rate review programs that have been deemed by HHS to be effective in at least one insurance market, meaning that they meet such criteria as having the authority under state law to determine the reasonableness of rate increases, having a transparent process for making the information publicly available, and allowing public comment on proposed rate changes.[7]

The action state regulators may take if they determine that a proposed increase is unreasonable depends on each state's review authority. Some states require "prior approval" of rate increases, meaning that state regulators may deny or modify an insurer's rate increase if it is found to be unreasonable and insurers cannot implement rate increases without approval. Other states have the authority to determine whether a proposed increase is unreasonable, but do not have the authority to stop unreasonable rate increases from going into effect. This type of review authority is sometimes called "file and use" or "use and file." Both review processes are considered to be effective under the ACA.

Effect of State Rate Review on Premium Increases

To analyze the effect of rate review conducted by states, we collected rate filings from 32 states and DC (all with effective rate review programs), where data on rate requests filed in 2011 were available publicly, either on the state's website or on HealthCare.gov. In total, we identified 798 requests by insurers to change rates – both increases and decreases, when available – for individual and small group major medical coverage in 2011 in these states. When enrollment information was available, we limited our analysis to rate filings that would have affected at least 100 policyholders.[8]

Of the rate filings included in our analysis, one in five (20%) resulted in a lower premium increase than the insurer initially requested (either because the rate was modified during review by the state or the insurer, or the request was denied or withdrawn and not resubmitted) (Exhibit 1). The average rate requested would have resulted in a 6.8 percent increase, while the final rate implemented resulted in an average of a 5.4 percent increase. These figures are not weighted averages and in some cases include only filings in excess of 10 percent.[9] Therefore, they do not necessarily reflect the average rate changes for the year nationwide. However, the average 1.4 percentage point difference between rates requested

[7] Because several states do not review rate increases for products sold to associations, the federal government is conducting some or all of the reviews for association products in 20 states.
[8] See the Methodology section for more details on the rate filings and states included in this analysis.
[9] Although we included both rate increases and reductions (when this information was available on state websites), some states may review and publish only rate increases, and some states review only increases that are greater than 10 percent.

and rates implemented indicates the effect of the rate review process on premium increases. On average, the rates that went into effect were about one-fifth (20.1%) lower than rates initially requested by insurers.

The effect of state rate review programs on premium increases varied substantially by market segment (Exhibit 1). In the individual market, the average rate allowed was 2.6 percentage points lower than the average rate requested, compared to 0.5 percentage points in the small group market.[10]

Exhibit 1: 2011 Individual and Small Group Rate Filings Reviewed by States, by Market Segment

Market Segment	Number of Filings Submitted	Number of Filings Lowered, Denied or Withdrawn	Average Rate Change Requested	Average Rate Change Implemented
Individual	337	98	8.9%	6.3%
Small Group	461	63	5.2%	4.7%
Total	**798**	**161**	**6.8%**	**5.4%**

Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from websites of 32 states and the District of Columbia, as well as HealthCare.gov when reviews were conducted by states. Note that some filings labeled as small group may include filings from large group plans. For more information see the Methodology section of *Quantifying the Effects of Health Insurance Rate Review* , October 2012.

Effects also varied considerably by state. In 21 states, the average rates implemented were lower than the average rates requested (Exhibit 2). For example, in Iowa and Oregon, the average rate that went into effect was more than 4 percentage points lower than the average rate requested. By contrast, in 11 states plus DC there was no difference between the average rates requested and the average rates that went into effect.

[10] A recent Department of Health & Human Services (HHS) report on the impact of rate review found that in 2011, state reviews resulted in final rates that were 1.4 percentage points lower in the individual market and 0.8 percentage point lower in the small group market. This analysis used data provided to HHS by state recipients of the Rate Review Grants program which includes only rate increases, not decreases. This report can be found at: http://www.healthcare.gov/law/resources/reports/rate-review09112012a.html

Exhibit 2: 2011 Individual and Small Group Rate Filings Reviewed by States				
State	**Number of Filings Submitted**	**Number of Filings Lowered, Rejected, or Withdrawn**	**Average Rate Change Requested**	**Average Rate Change Implemented**
Arkansas	7	2	13.0%	10.2%
California	65	14	9.9%	9.3%
Colorado	45	9	7.1%	5.0%
Connecticut	25	19	7.0%	4.5%
DC	13	0	-1.9%	-1.9%
Delaware	13	3	11.1%	10.0%
Florida	55	11	5.3%	3.9%
Georgia	1	0	0.9%	0.9%
Illinois	2	0	11.1%	11.1%
Indiana	46	9	5.4%	3.8%
Iowa	33	14	12.0%	7.2%
Kansas	47	2	3.8%	3.6%
Kentucky	14	1	4.2%	3.5%
Maine	25	1	5.6%	5.4%
Michigan	50	7	7.9%	7.4%
Minnesota	17	0	5.0%	5.0%
Nebraska	14	2	9.1%	8.2%
Nevada	46	16	4.0%	-0.3%
New Hampshire	20	2	12.2%	10.7%
New Jersey	4	0	16.1%	16.1%
North Carolina	49	4	4.4%	4.3%
Ohio	3	0	10.9%	10.9%
Oregon	36	29	9.1%	4.6%
Pennsylvania	15	3	8.1%	7.7%
South Carolina	2	2	12.0%	4.0%
South Dakota	14	0	7.0%	7.0%
Tennessee	17	2	1.4%	-0.1%
Texas	1	0	10.6%	10.6%
Utah	1	0	18.1%	18.1%
Virginia	70	0	2.9%	2.9%
Washington	14	9	10.5%	7.2%
West Virginia	2	0	10.7%	10.7%
Wisconsin	32	0	11.5%	11.5%
Total	**798**	**161**	**6.8%**	**5.4%**

Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from websites of 32 states and the District of Columbia, as well as HealthCare.gov when reviews were conducted by states. For more information see the Methodology section of *Quantifying the Effects of Health Insurance Rate Review*, October 2012.

Effect of the Affordable Care Act's Rate Review Standards

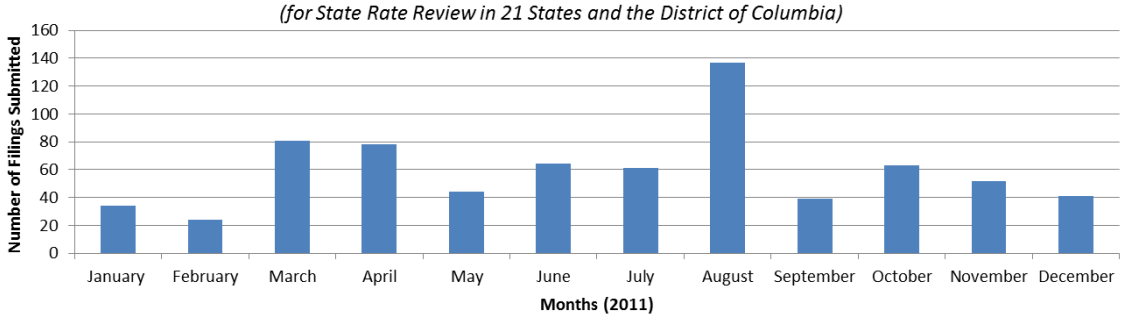
Because many states had some form of review process in effect prior to the September 1, 2011 implementation of the ACA's rate review standards, the reduction in requested rate increases as a result of rate review cannot be attributed fully to the ACA. In states that did not have rate review programs in effect before the ACA, the new 10 percent threshold for review under the ACA may have discouraged insurers from proposing increases of ten percent or more to avoid triggering a review. However, there are reasons to believe that the ACA may have had an effect, even in states with review programs in effect before the ACA. For example:

- Greater transparency associated with requested premium increases may have encouraged some insurers to file more modest rate increases.
- Increased emphasis on rate review and transparency may have created an incentive for state regulators to apply greater scrutiny during rate review.
- Federal rate review grants provided to states enabled many states to enhance their rate review processes, for example, by hiring additional actuarial staff.

We examined proposed premium increases and state reviews before and after September 1, 2011 (in states with public data throughout the year) to gauge the potential effects of the new federal rules.

Of the states included in the overall analysis, 21 states plus DC had publicly available rate data for the entire period of January through December 2011.[11] These states received an average of 60 filings per month in 2011. However, they saw a surge in rate filings in the month of August, with a total of 137 filings submitted just prior to implementation of the federal review standards. The average number of filings for months other than August was 53 (Exhibit 3).

Exhibit 3: Number of Individual and Small Group Rate Filings Submitted by Month, 2011
(for State Rate Review in 21 States and the District of Columbia)



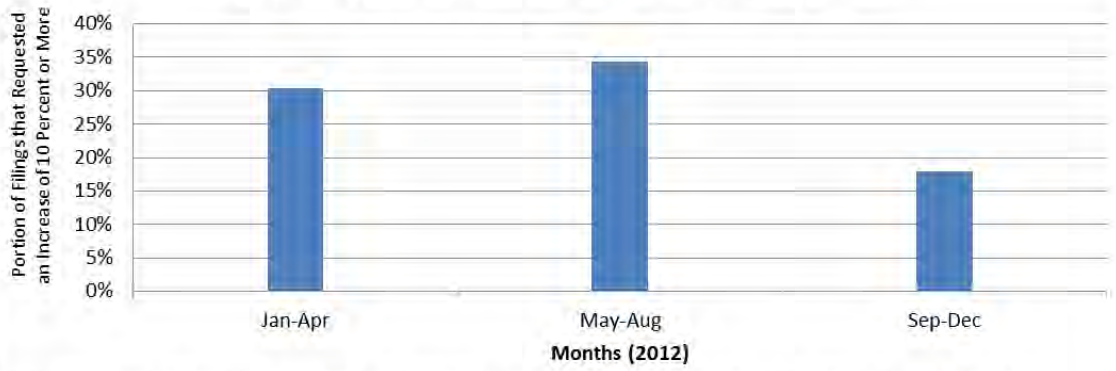
Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from websites of 21 states and the District of Columbia, as well as HealthCare.gov when reviews were conducted by states, for states in which 2011 rate information is available from throughout the year. For more information see the Methodology section of *Quantifying the Effects of Health Insurance Rate Review,* October 2012.

[11] In addition to the District of Columbia, the following states were included in this section: Arkansas, California, Colorado, Connecticut, Florida, Indiana, Kansas, Maine, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, North Carolina, Oregon, Pennsylvania, South Dakota, Tennessee, Virginia, Washington, and Wisconsin.

Despite the unusually high number of rate requests submitted in August, it appears that the average size of rate changes requested by insurers stayed fairly consistent throughout the year. On average, filings submitted during the period of January through August requested a 6 percent increase (with an average increase of 5 percent implemented), about the same as for the September through December period.

However, the share of requested rate increases above 10 percent declined markedly following September. In the 21 states plus DC for which rate information is available throughout 2011, one out of every three filings (33 percent) requested an increase of 10 percent or more in the January through August period, compared to fewer than one in five filings (18 percent) submitted from September through December (Exhibit 4).

Exhibit 4: Portion of Individual and Small Group Rate Filings Submitted for State Review in 2011 Requesting an Increase of 10 Percent or Greater, by Month

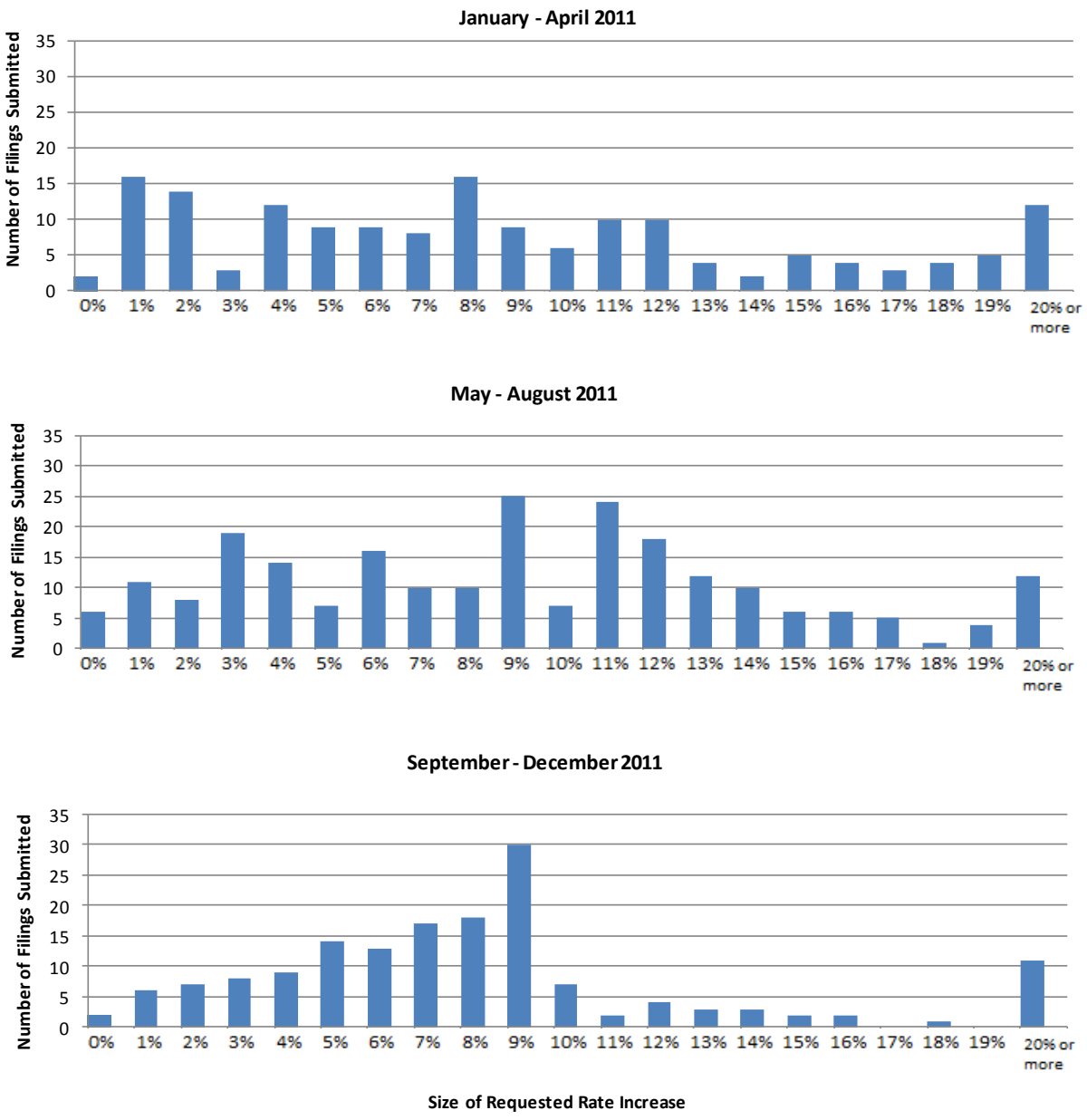


Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from the websites of 21 states and the District of Columbia, as well as Healthcare.gov when filings were reviewed by states, for states in which 2011 individual and small group rate information is available from throughout the year. For more information and methodology see the Methodology section of *Quantifying the Effects of Health Insurance Rate Review,* October 2012.

See Exhibit 5 for more detail on the number of filings submitted during these months and the size of the proposed increases.

Following September 1, 2011, insurers in these states were also more likely to lower, withdraw, or be denied requests for rate increases of 10 percent or more. Of the requests to raise rates by 10 percent or more submitted between January and August of 2011, 34 percent resulted in a lower rate than the insurer initially requested, compared to 43 percent of similar filings submitted between September and December.

Exhibit 5: Number of Filings Requesting an Increase, by Size of Proposed Increase



Note: There were 54 filings during the January - April period, 75 filings during the May - August period, and 36 filings during the September - December period that requested rate decreases (not shown).

Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from the websites of 21 states and the District of Columbia, as well as Healthcare.gov when filings were reviewed by states, for states in which 2011 individual and small group rate information is available from throughout the year. For more information and methodology see the Methodology section of *Quantifying the Effects of Health Insurance Rate Review,* October 2012.

Rate Review Conducted by HHS

In states that lack effective rate review programs (and for some categories of filings in states with partially effective programs), rate increases of 10 percent or more are reviewed for reasonableness by the federal government through HHS. Many of the requests reviewed by HHS are for plans that sell individual or small group coverage through associations, as this coverage has not been included in some state rate review programs historically.

Federal reviewers at HHS do not have the authority to disapprove rate increases they determine to be unreasonable. Rather, they rely on public disclosure of any determinations that a rate increase is judged to be unreasonable. Requests to increase rates by 10 percent or more – as well as determinations by HHS as to the reasonableness of the increase and responses from insurers – are posted for public access on HealthCare.gov.

Exhibit 6: 2011 Individual and Small Group Rate Filings Reviewed by the Department of Health and Human Services

State	Number of Filings Submitted	Average Rate Change Requested	Number of Requests Withdrawn	Number of Requests Found to be Unreasonable	Number of Requests Found to be Not Unreasonable
Alabama	2	21%		2	
Alaska	1	26%			1
Arizona	7	17%	2	5	1
Idaho	2	13%		2	
Louisiana	3	12%		3	
Mississippi	2	11%		2	
Missouri	6	16%	1	4	1
Montana	10	14%		5	5
Nebraska	3	20%		3	
Pennsylvania	2	13%		2	
Virginia	3	14%		3	
Wisconsin	2	24%		2	
Wyoming	5	18%		4	1
Total	**48**	**16%**	**3**	**37**	**9**

Note: These figures are not weighted averages. One Arizona filing was found to be unreasonable, subsequently withdrawn, then resubmitted at the same rate and found to be unreasonable again; it is labeled as both withdrawn and unreasonable.
Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from Healthcare.gov. For more information see the Methodology section of *Quantifying the Effects of Health Insurance Rate Review,* October 2012.

Using the searchable rate review data from HealthCare.gov, we analyzed a total of 48 filings that met our criteria for inclusion (see the Methodology section for more details). These filings, which came from 11 insurers across 13 states, requested an average rate increase of 16 percent (Exhibit 6). Note that HealthCare.gov posts only those filings for rate increases of 10 percent or more, so the average rate increase is higher than the average of rates reviewed by states, as many states review all rate changes. As shown in Exhibit 6, of the 48 filings we analyzed, 37 (77 percent) were determined by HHS to be unreasonable, 9 (19 percent) were found to be "not

unreasonable," and 2 were withdrawn by the insurer prior to review. Of the 37 filings HHS determined to be unreasonable, one was subsequently withdrawn by the insurer. However, the insurer resubmitted the request at the same rate.

In most cases in which HHS determined a request was unreasonable, regulators cited the plan's low projected medical loss ratio (MLR) as at least one factor in this determination. Under the ACA's MLR provision, insurers are generally required to issue a rebate if they fail to spend at least 80% of their premium income on health care services and quality improvement activities for enrollees in the individual and small group markets.[12] In their responses to HHS's determination that their requested premium increase was unreasonable, insurers typically justified their increase by stating that they would issue rebates to consumers if their actual MLRs fell below the federal floor.

Rate Review Transparency

Under the ACA, states that review rate requests of 10 percent or more must post information about these requests on a state website and have a mechanism to receive public comments. States may satisfy this requirement by linking to filings on HealthCare.gov, the HHS website.

We obtained information about state postings of health insurer requests for rate changes by searching state websites, usually those of the state insurance departments. Information about rate filings on state websites generally fell into one of three categories:

(1) A state-generated summary table highlighting topline information about what rates were filed and approved. Such a summary is helpful for consumers and other members of the public who seek an overview of increases that were filed, actions by state regulators, and increases that were implemented.
(2) A link to a database of rate filings (which usually directs users to a search engine). The filings themselves typically contain more detailed information than many consumers might need, although researchers and other analysts might seek more detailed information in order to independently evaluate rate increases or state determinations or for other purposes. In a number of states, however, filing information is incomplete as insurers are permitted to redact or otherwise restrict public access to data considered proprietary.

[12] The medical loss ratio (MLR) is often used differently for rate review and rebate calculation. The MLR is traditionally calculated by dividing health care claims by premiums. But for the purposes of calculating rebates, insurers can make adjustments for quality improvement, taxes, and other expenses, and may receive other adjustments depending on enrollment and the type of plan. HHS applies an 80% MLR threshold in its federal rate review, but several states with effective rate review programs apply a lower MLR standard as part of their review. For more information on MLR, see: http://www.kff.org/healthreform/upload/8282.pdf

(3) A link to the federal website (companyprofiles.healthcare.gov). This site has an overview of rate review information, but tends to have less information than would otherwise be available in SERFF filings. Insurers can also redact what they consider proprietary information in federal filings.

Some states utilize more than one of these approaches, whereas three states have no information about insurer rate requests on their websites. Two of the three states without rate review information are states without effective rate review programs and are therefore not required to post such information. West Virginia has an effective rate review program, but requires consumers to request all information about filings in person.

Of the 24 states and DC that link to the original filings, most use a system called SERFF (System for Electronic Rate and Form Filing), which was developed by the National Association of Insurance Commissioners (NAIC) to handle insurance policy rate and form filings submitted by insurance companies. SERFF filings can contain information useful to those interested in insurer requests for rate changes and state responses, but not all states that use SERFF utilize it in the same way. For the states that post or provide a link to SERFF filings, considerable variation exists in the format of the SERFF filings and the elements of the filings that states post on their websites. Exhibit 7 presents an overview of the information that is publicly available on the websites of states with effective rate review programs, and the format in which the rate review information is presented.

The information about rate review that states post on their websites varies considerably in terms of breadth of information available and the ease of access. Many states post rate review information that exceeds federal standards, whereas other states were inconsistent or lacking information needed to understand the review or reasoning behind the determination. For example:

- We identified 24 states plus DC that post rate increases of any size, whether above or below 10 percent, including 22 states plus DC that also post requests for rate decreases.
- 22 states plus DC have consumer-friendly summary tables on their websites that provide basic information about rate requests (Exhibit 7). However, for many of these states, either the proposed rate change or the implemented rate change is not included in the summary table, requiring consumers to open complex filings to access this information. Conversely, other states offer only a summary table and do not give access to the original filing.
- The websites of 12 states plus DC include a short narrative or description of the filings or the reasoning behind the state's review separate from the filing itself (Exhibit 7).

Exhibit 7: Overview of Publicly Available Information on State Rate Review Websites
(For states with effective rate review programs, as of September 2012)

State	State Website has Rate Filing Information or Links to HealthCare.gov	State Summary of Filings (Including Rates Requested or Implemented)	State Narrative or Description of Each Filing (Separate from the Filing Itself)	Links to Initial or Final Filing (SERFF or Other Format)	Links to HealthCare.gov for Rate Review Information
Alabama	*N/A*				
Alaska	✓	✓	✓		✓
Arizona	*N/A*				
Arkansas	✓			✓	✓
California	✓	✓	✓	✓	✓
Colorado	✓	✓		✓	
Connecticut	✓		✓	✓	✓
Delaware	✓	✓		✓	
District of Columbia	✓	✓	✓	✓	
Florida	✓			✓	
Georgia	✓	✓			✓
Hawaii	✓				✓
Idaho	✓	✓			✓
Illinois	✓	✓			✓
Indiana	✓	✓	✓		✓
Iowa	✓	✓			✓
Kansas	✓			✓	✓
Kentucky	✓	✓	✓		
Louisiana	*N/A*				
Maine	✓			✓	
Maryland	✓	✓	✓		
Massachusetts	✓				✓
Michigan	✓			✓	
Minnesota	✓			✓	✓
Mississippi	✓	✓			✓
Missouri	*N/A*				
Montana	*N/A*				
Nebraska	✓	✓		✓	
Nevada	✓	✓		✓	✓
New Hampshire	✓			✓	✓
New Jersey	✓				✓
New Mexico	✓	✓			
New York	✓	✓			✓
North Carolina	✓			✓	
North Dakota	✓	✓			✓
Ohio	✓				✓
Oklahoma	✓			✓	✓
Oregon	✓	✓	✓	✓	✓
Pennsylvania	✓		✓	✓	
Rhode Island	✓			✓	✓
South Carolina	✓	✓			✓
South Dakota	✓			✓	✓
Tennessee	✓	✓		✓	
Texas	✓		✓		✓
Utah	✓	✓	✓		
Vermont	✓		✓	✓	
Virginia	✓			✓	✓
Washington	✓	✓	✓	✓	
West Virginia					
Wisconsin	✓			✓	✓
Wyoming	*N/A*				
Total	**44**	**23**	**13**	**25**	**28**

Note: Information is current as of September 27, 2012. States labeled "N/A" (AL, AZ, LA, MO, MT, and WY) do not have rate review programs that have been deemed by HHS to be effective as of August 1, 2012.

Source: Kaiser Family Foundation analysis of publicly available 2011 rate review information from websites of 44 states and the District of Columbia. *Quantifying the Effects of Health Insurance Rate Review,* October 2012.

Keeping in mind that different users of state rate review websites may have different needs – for example, consumers may wish to access only their own insurer's rate filings, whereas researchers, consumer advocates, and members of the press may wish to access all filings of a certain type or from a given time period – we found that state websites varied substantially in their accessibility and ease of use. For example:

- Some states (e.g., California, Indiana) allow users to download summary spreadsheets of all rate requests in recent years, and sort by time period, insurer, and market segment.
- Other states do not allow users to sort the filings, or their search engines do not allow much specificity, so users must look through many filings to find information on a particular review. For example, Florida's website does not allow users to limit their search to major medical policies, so users must request multiple PDFs to be emailed to them before being able to locate a particular filing or type of filing.
- Some states (e.g., New York, Connecticut) show quarterly rate changes for some or all of their filings. These can be difficult to understand in terms of the annual rate increase if no yearly average is provided.
- Some states (e.g., Washington) allow users to set up email notifications that alert consumers when their insurer submits a request to raise rates.

Finally, in the 13 states that provide access to SERFF filings without a corresponding summary or narrative, consumers may have difficulty obtaining basic information about the request. For example, the original rate requested and final rate implemented are not always clearly labeled or consistently located in these filings. In states that link to SERFF filings along with a state summary or narrative, there were sometimes discrepancies between numbers in the SERFF submission and a state's summary that were not explained.

Discussion

Our analysis of publicly available information about state rate review programs suggests that these programs have a material influence on the premiums that ultimately get charged to individuals and small businesses. For filings submitted to state regulators during 2011, the rates that went into effect were on average one-fifth (20%) lower than the rates initially requested. Nationwide, about one in five requests by insurers to change premiums were denied, lowered, or withdrawn during state review. As might be expected, particularly given the historical variation in state rate review programs, the effect of state rate review programs varied by state, as well as by market segment. The difference between average rates requested and implemented was greater in the individual market than in the small group market (though the individual market also saw higher average requested rates).

Early evidence from filings submitted just before and just after the implementation of the ACA's rate review requirements suggests that these requirements are having an effect. Although the average rate change requested remained fairly constant throughout the year (in states for which data are available), insurers appear to be submitting fewer requests above the 10 percent threshold following implementation of the ACA's rate review standards. Also, following September 1, 2011, rate requests above the 10 percent threshold were more likely to be denied, modified, or withdrawn than similar requests made earlier in the year. Though it is possible that differences between the rates filed before and after September 1, 2011 could be due to other factors, the increase in the number of filings submitted in August – more than double the average number of filings in other months of the year – also suggests that the new requirements have had an effect on insurer behavior.

The ACA's rate review transparency requirement also may be encouraging insurers to moderate their rate increases, particularly those in excess of ten percent. Proposed increases of ten percent or more are now published on HealthCare.gov (whether reviewed by state or federal regulators). While the information on HealthCare.gov is not always exhaustive, this information is generally presented in an accessible format for consumers. Most states with effective review programs also have accessible rate review information on their websites, often surpassing the requirements set by the ACA. This information has the potential not only to promote accountability among health plans and insurance regulators, but also to increase public understanding of the many factors that drive increases in insurance premiums. However, there is still considerable variation in the quantity and quality of information available to consumers.

In conjunction with medical loss ratio rebate requirements, state and federal rate review programs can help ensure that the premiums charged to individuals and small businesses are fair with respect to the underlying medical claims paid by insurance companies. However, while regulators may be able to exert pressure on insurers to control costs more aggressively, rate review itself cannot alter the factors driving increases in health care costs (such as the underlying prices charged by doctors and hospitals, the amount of health care utilized by enrollees, and new medical technologies).

This report was prepared by Cynthia Cox, Janet Lundy, Jamie Firth, Karen Pollitz, Gary Claxton, and Larry Levitt of the Kaiser Family Foundation, as part of the Kaiser Initiative on Health Reform and Private Insurance, which examines the implications of changes in the private insurance market under the ACA and informs federal and state policymakers as they implement provisions of the law.

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Methodology

We collected health insurance premium change requests and enrollment data from 2011 rate filings that are publicly available on the website of states and DC and on HealthCare.gov, a federal website run by the Department of Health and Human Services (HHS). Data were gathered from state and federal websites during the month of September 2012. Rate requests that were reviewed by states were collected and analyzed separately from those reviewed by HHS. We contacted a few state regulators to confirm our understanding of the filings in their state, California's Department of Managed Health Care provided us with missing data, and Nevada clarified some resubmissions.

In general, rate filings that met the following criteria were included in this analysis:

- Submitted between January 1, 2011 and December 31, 2011, and reviewed by either the state or federal government before May 1, 2012;
- Available publicly online (either in the form of a summary or the actual rate filing);
- Filings pertained to comprehensive major medical coverage in the individual or small group markets (conversion policies were typically treated as individual major medical unless the filing or summary stated otherwise);
- Filings were for either an increase or a decrease in the rate (no neutral rate filings);
- Requests were not the result of a new state or federal coverage mandate; and
- Affected at least 100 policyholders or people.

Additionally, we followed the guidelines below:

- If a filing was withdrawn by the insurer or denied by the state, we generally considered the implemented rate change to be zero percent. However, if the request was resubmitted and reviewed before May 1, 2012, we amended the original rate filing to show the final rate change as that which was approved for the resubmitted filing.
- For reviews with a determination of "not unreasonable," we considered the rate increase to be implemented at the same rate as initially requested, unless otherwise indicated.
- If an insurer submitted a request for quarterly increases without providing a yearly weighted average for the rate increase, we treated the quarterly rate increases as four separate filings.
- One insurer group (Assurant Health) often filed identical requests for its two insurers (Time Insurance Company and John Alden Life Insurance Company). If these requests appeared to be duplicates (meaning that the same rate was requested and implemented, and the same product and number of policyholders were affected), we treated these as a single filing.

- If the state summary page linked to the actual rate filing and there was a discrepancy between these two sources of information, we generally relied on the information presented in the rate filing itself, unless there was reason to believe that the summary contained more accurate data.
- In at least six states (Arkansas, Delaware, New Hampshire, North Carolina, Tennessee, and Virginia) and DC, insurers sometimes filed rate increases for groups of any size, meaning that rate changes affecting large and small businesses are grouped together into a single request. In these cases, we included the rate request in this analysis as a small group filing.
- In at least six states (Delaware, Nevada, New Jersey, Pennsylvania, Kentucky, and Iowa), some or all 2011 rate information was available only in the form of a summary page that does not link to the actual rate filing. In these cases, filings that do not meet the criteria above may have been included in the analysis if information was not available on the number of policyholders affected, type of coverage, or review date.

Twelve states with effective rate review programs were not included in the state rate review section of this analysis. In nine of these states (Alaska, Hawaii, Idaho, Maryland, Massachusetts, New Mexico, North Dakota, Rhode Island, and Vermont), there were either no 2011 filings reviewed by the state, or none that matched our criteria for inclusion. In two of these states (Mississippi and Oklahoma), not enough information was consistently available to evaluate 2011 filings because either the rate requested or implemented was missing or unclear. New York was not included because at the time we collected state rate review data, the format of their public information was not compatible with our methods.

Finally, some states (e.g. Alabama, Arizona) have public rate filing information on their websites, but were not included in our analysis of state rate review because their review program have not yet been deemed to be effective by HHS.

Sources

All data on rate filings reviewed by HHS are from HealthCare.gov at http://companyprofiles.healthcare.gov/. The sources for filings reviewed by states are listed below. These websites are current as of September 27, 2012. Note that some filings reviewed by some states may be listed on HealthCare.gov in addition to, or instead of, the websites below:

State	Website(s)
Alabama	*N/A (no effective program)*
Alaska	http://commerce.alaska.gov/ins/Insurance/programs/Consumers/justifications.cfm
Arizona	*N/A (no effective program)*
Arkansas	http://www.insurance.arkansas.gov/hirrd/index.html
California	*Non-HMOs:* http://www.insurance.ca.gov/0250-insurers/HlthRateFilings/ *HMOs:* http://wpso.dmhc.ca.gov/ratereview/
Colorado	http://doraapps.state.co.us/Insurance/Consumer/pages/filingsSearch.aspx
Connecticut	http://www.catalog.state.ct.us/cid/portalApps/RateFiling.aspx
Delaware	http://delawareinsurance.gov/departments/rates/ratefilings.shtml
District of Columbia	http://disr.dc.gov/disr/cwp/view,a,1299,q,645536.asp
Florida	http://www.floir.com/Office/FilingSearch.aspx
Georgia	http://www.oci.ga.gov/Insurers/RateReviewPreliminaryJustifications.aspx
Hawaii	http://hawaii.gov/dcca/ins/health-insurance.html
Idaho	http://www.doi.idaho.gov/company/ratereview.aspx
Illinois	http://insurance.illinois.gov/hiric/rate-filings.asp
Indiana	http://www.in.gov/idoi/ratewatch/
Iowa	http://www.iid.state.ia.us/raterequesthistory
Kansas	http://www.ksinsurance.org/consumers/hfai.php
Kentucky	http://insurance.ky.gov/RateFil/default.aspx
Louisiana	*N/A (no effective program)*
Maine	http://www.maine.gov/pfr/insurance/PPACA/HFAI.htm#
Maryland	http://www.mdinsurance.state.md.us/sa/consumer/health-insurance-rate-review.html
Massachusetts	http://www.mass.gov/ocabr/consumer/insurance/health-insurance/
Michigan	http://www7.dleg.state.mi.us/SerffPortal/Default.aspx
Minnesota	http://mn.gov/commerce/insurance/topics/medical/Access-Filings.jsp
Mississippi	http://www.mid.state.ms.us/MidRateChanges/RateChangesDashBoard.aspx?compID=4
Missouri	*N/A (no effective program)*
Montana	*N/A (no effective program)*
Nebraska	https://doi-ratechanges.ne.gov/DOIRateChange/faces/dsp_rateChange.xhtml
Nevada	http://rates.doi.nv.gov/
New Hampshire	http://www.nh.gov/insurance/consumers/fedhealthref.htm
New Jersey	http://www.state.nj.us/dobi/lifehealthactuarial/rateinfo/index.html

New Mexico	http://nmhealthratereview.com/
New York	http://www.dfs.ny.gov/insurance/health/prior_app/prior_app_comment.htm
North Carolina	http://www.ncdoi.com/Smart/HCR_MM_RateFilings.aspx#
North Dakota	http://www.nd.gov/ndins/consumer/reform/rates/
Ohio	http://www.insurance.ohio.gov/Company/Pages/RecordsRequest.aspx
Oklahoma	http://www.ok.gov/oid/Regulated_Entities/Rate_and_Form_Filing/HFAI_Search.html#
Oregon	http://www.oregonhealthrates.org/
Pennsylvania	http://www.insurance.state.pa.us/dsf/ppaca_related_filings.html
Rhode Island	http://www.ohic.ri.gov/Fed_HFAI_SERFF%202011.php#
South Carolina	http://doi.sc.gov/Pages/ratereview.aspx http://doi.sc.gov/consumer/Pages/InsuranceRates.aspx
South Dakota	http://apps.sd.gov/applications/CC57SERFFPortal/basicsearch.aspx
Tennessee	http://www.state.tn.us/commerce/insurance/consumerRes.shtml http://www.state.tn.us/commerce/insurance/documents/PersonalHealthRateChanges.pdf
Texas	http://www.tdi.texas.gov/health/lahlhiosrateincreas.html
Utah	http://insurance.utah.gov/transparency/index.html
Vermont	http://www.dfr.vermont.gov/insurance/rates-forms/health-insurance-rate-review-data
Virginia	http://www.scc.virginia.gov/boi/SERFFInquiry/LHAccessPage.aspx
Washington	http://www.insurance.wa.gov/health-rates.shtml
West Virginia	http://www.wvinsurance.gov/RatesForms.aspx
Wisconsin	http://oci.wi.gov/consumer/health.htm
Wyoming	*N/A (no effective program)*

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