Rate Review: Need to Consider All Factors Driving Premiums

To make health care coverage more affordable for families and employers, the focus needs to be on all of the factors driving premium increases, including soaring medical costs, changes in the risk pool, new taxes, benefit mandates and regulations.

Rising medical costs drive premium increases.

- According to National Health Expenditure data released by the U.S. Department of Health and Human Services, from 2000-2011 the **growth in premiums tracked directly with the growth in benefits** – a trend that has been consistent for decades.
- Insurance commissioners say the key to affordability is controlling soaring health care costs:
  - As **Sandy Praeger, Kansas Insurance Commissioner** noted**,** "if you want to keep costs under control, it's not about managing health care premiums…it's about **managing the underlying health care costs**."
  - **Teresa Miller, former Oregon Insurance Division Administrator,** said, "'The key to stabilizing insurance rates is **controlling the underlying costs of medical care.'"**

Health plan profits and administrative costs are not driving premium increases.

- Health plan **administrative costs and profits account for only six percent of total health care expenditures**. In order to make health care coverage more affordable for families and small businesses, there needs to be much greater focus on the other 94 percent of health care spending.
- Health plans' administrative costs and profits are sometimes cited as a reason why premiums are rising. The evidence clearly contradicts this unfounded claim. **Health plan profits account for less than one penny out of every dollar spent on health care**.
- Government data show that last year the portion of premiums allocated to health plans' administrative costs was **the second lowest in the last nine years**, even though health plans have been incurring new compliance and regulatory costs related to the health care reform law.
- The ACA imposes a new arbitrary federal cap on health plans' administrative costs and profits (referred to as the "**Medical Loss Ratio**") and establishes a new federal **rate review** process on top of existing state laws and regulations governing premiums.

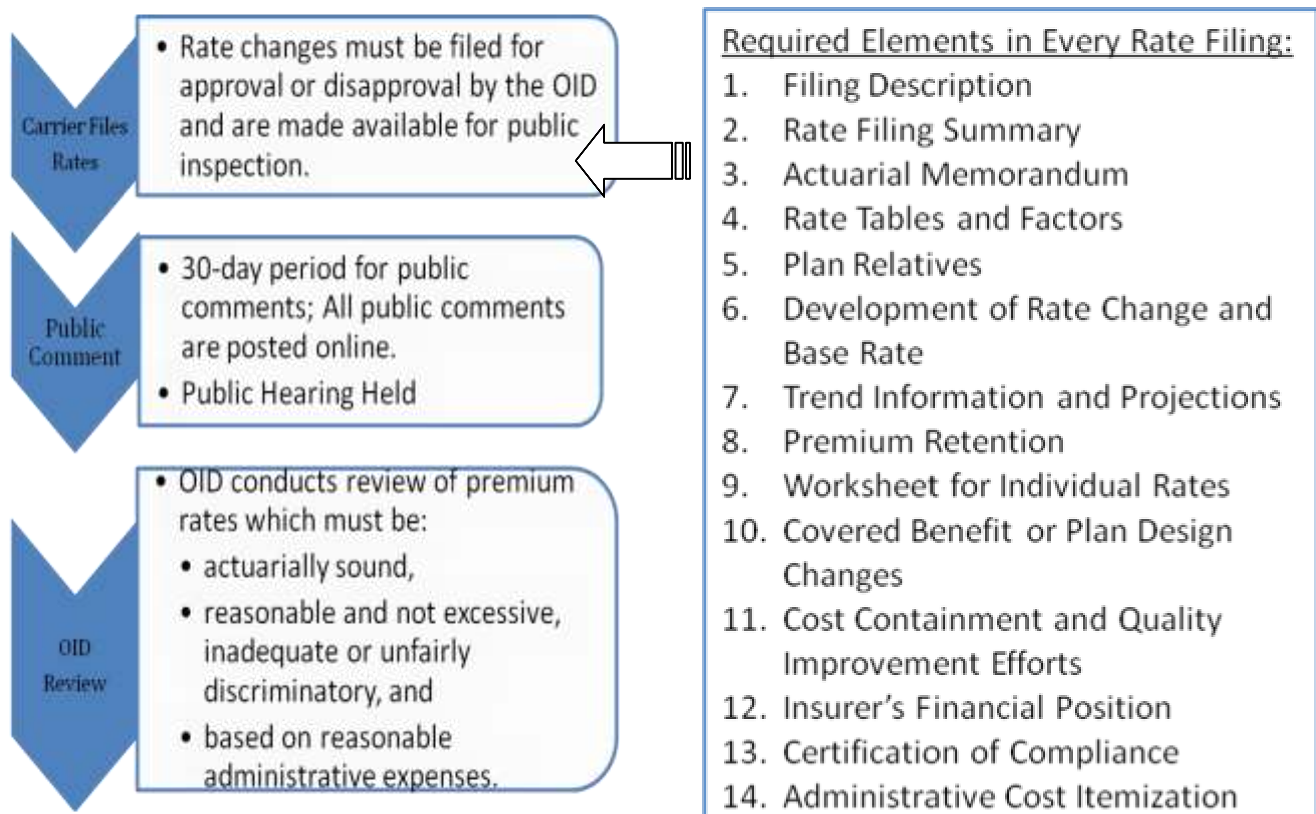
Review of premiums should be based on objective actuarial data and take into account all of the factors that contribute to premium increases.

- Rate review must adequately factor in all of the components that determine premium rates, including geographic variation and the cost of benefit mandates.
- Capping premium increases **without looking at the underlying components** is similar to capping the prices auto makers can charge consumers, while allowing the steel, rubber, and technology manufacturers to charge the auto makers whatever they want.
- An arbitrary and easily politicized rate review process that ignores soaring medical costs will **destabilize the market and put at risk the coverage** families and employers rely on today.

Premium review should take into consideration new regulations and mandates included in the health care reform law.

- New federal cap on health plan administrative costs and profits.
- New $100 billion sales tax on health insurance.
- Minimum coverage requirement that will force families and employers to buy more expensive health insurance.
- Restrictions on age rating that will force younger people to subsidize coverage for older individuals.

Oregon has a robust rate review process:



State Regulation of Health Policy Rate Filings:
Summary of State Requirements

States have taken a variety of approaches in enacting laws affecting rate and form filings by health insurance plans, including adopting the *Major Medical Insurance Health Policy Rate and Form Filing Model Act* (Model Act) or variations of the Model Act. Adopted in 2006, the Model Act applies specifically to health insurance filings and requires all policy forms (and rates if applicable under state law) to be filed with and approved by the regulator.

Regardless of a state‘s law on rate and form filing, the vast majority of states reserve the right to disapprove rates retroactively should they prove to be extreme or unreasonable by the Commissioner. Additionally, nearly all states provide the Commissioner a wide range of discretion in the application of statutory insurance provisions.

The Affordable Care Act (ACA) contains several provisions impacting rate filing procedures at the state level. While the ACA generally preserves the traditional role of state regulation of health insurance rates, it does require ‘unreasonable' rate requests (10 percent or greater) to be filed with the Secretary of the United States Department of Health and Human Services (HHS) (in addition to any requirements to file at the state level).

Initial Rate Filings:

Insurers	
Prior Approval	Nine states (NH, NM, NY, NC, OK, OR (individual/small group), TN, TX, and VA) require prior approval of initial rates of insurers before such rates may be used.
Prior Approval with Deeming*	Nineteen states (AK, FL, HI, IA, KS, LA, ME (individual/small group), MA, MI, MS, ND, OH, PA, RI, SC (individual), SD (individual), VT, WA, and WV) plus DC states require prior approval of initial rates for insurers within a certain timeframe or else the rates are deemed approved.
File and Use	Nineteen states (AL, AZ (individual), AR (individual), CA, CO, DE, GA, ID, IL, IN, KY, MN , MT, NM, NV (individual), NJ, SC (small employer), UT, and WY) allow insurers to file and then use those initial rates submitted.
Health and/or Medical Service Corporations/Nonprofit Health Care Plans	
Prior Approval	Six states (CT, NH, NY, TN, VT, and VA) require prior approval of health or medical service corporation initial rates before such rates may be used.
Prior Approval with Deeming*	Seventeen states (AL, AK, AR, KS, KY, MD, MA (individual/nonprofit), MN, NV, NM, NC, ND, OK, PA, RI, WA, and WV) plus DC require prior approval of initial rates for health or medical service corporations within a certain timeframe or else they are deemed approved.
File and Use	Eight states (CO, DE, GA (nonprofits), ID, ME, MA (group), NC, and SD) allow health or medical service corporations to file and then use those initial rates submitted.
HMOs	
Prior Approval	Fourteen states (AR, CT, MI, MS, NE, NV, NH, NY, ND, RI, TN, VT, VA, and WY) require prior approval of HMO initial rates before such rates may be used.
Prior Approval with Deeming*	Sixteen (AL, AK, FL, GA, IN, KS, KY, MD, NJ, NM, OK, PA, SC, SD, WA, and WV) plus DC require prior approval of initial rates for HMOs within a certain timeframe or else they are deemed approved.
File and Use	Seven states (CA, CO, IL, ME, MA, MN, and TX) allow HMOs to file and then use those initial rates submitted.

Subsequent Rate Changes:

Insurers	
Prior Approval	Four states (NM, NC, TN and VA) require prior approval of rate revisions before they may be implemented.
Prior Approval with Deeming**	Sixteen states (AK, AR, CO, DE, FL, HI, KY (health insurance policies), MA, NH, OH, OK, NY, PA, SC, SD, WA, WV) plus DC (for policies providing mental health/substance abuse coverage) require prior approval of rate changes for insurers within a certain timeframe or else the rates are deemed approved.
File and Use	Twenty-one states (AL, AZ, CA, CT (individual w/loss ratio guarantee), GA (45-day waiting period), IL, IA (individual), KY (health benefit plans), ME (60-day waiting period), MD (90-day waiting period), MS, MO, MT, NV (individual), ND, OR, TX, UT, WI, and WY) allow health insurers to file and then use those rate changes submitted.
No filing Reqd	Two states (AK and MN) do not require submission of rate revisions.
Health and/or Medical Service Corporations/Nonprofit Health Care Plans	
Prior Approval	Five states (PA, RI, TN, VT, and VA) require prior approval of rate increases before implementation.
Prior Approval with Deeming**	Fourteen states (AL, AK, AR, CO, DE, MD, MA, NV, NY, NC, ND, SC, WA, and WV) and DC require prior approval rate changes within a certain timeframe or else the rates are deemed approved.
File and Use	Four states (AK, ID, IA (individual), and ME (60-day waiting period)) permit service corporations or plans to file and then use those rate revisions submitted.
HMOs	
Prior Approval	Eight states (ME, MS, NV, ND, RI, TN, UT and VA) require prior approval of rate increases for HMOs before implementation.
Prior Approval with Deeming**	Twenty states (AL, AK, AR, CO, FL, GA, IN, MD, MA, MI, NE, NJ, NM, NY, NC, OK, PA, SD, WA, and WV) require prior approval of rate changes for HMOs within a certain timeframe or else the rates are deemed approved.
File and Use	Three states (CA, IL and WY) and DC permit HMOs to file and then use those rate changes submitted.

*** "Deemer" Timeframes for Initial Rate Filings**

States imposing timeframes on rate and form filings ranging from 30 to 90 days after which policy rates are deemed approved.

- 30 days – AL, AK (HMO), AZ, AR, DE, DC (HMOs), FL, IN, IA, KS, LA, ME, MA, MI, MN (service corporations), MO (insurers), NE, NV, NM (nonprofits), OH (insurers), OK (HMOs), OR, SC (insurer forms/HMO forms and rates), SD (small group), VT (insurers), WA (insurers),
- 45 days – AK (insurers/service corporations), MO (service corporations), PA (insurers/HMOs),
- 60 days – AR, CO, DC (service corporations), HI, ID, KY, MD, MN (insurers), MS, MT, NJ, NM (insurers), NC (insurers, HMOs), ND, OH (insuring corporations), OK (insurers/service corporations), PA (service corporations), RI, SD (individual), TX (forms), WA (service contractors/HMOs); WV,
- 75 days - CT
- 90 days – DC (insurers), GA, NH, NY (insurers), NC (HMOs), SC (insurer rates),

**** "Deemer" Timeframes for Rate Revision Filings**

States imposing timeframes on rate and form filings ranging from 30 to 90 days after which policy rates are deemed approved.

- 30 days—AL (HMOs and service corporations), AK (HMOs), AR (insurers and service corporations), DE (insurers and service corporations), FL (insurers and HMOs), IN (HMOs), MA (all), NE (HMOs), NV (service corporations), NH, NM (HMOs), OH, OK (HMOs) SC (service corporations), SD (small group), and WA.
- 45days—AK (insurers/service corporations), NC (HMOs) and PA (insurers and HMOs).
- 60 days—AR (HMOs), CO (all), DC (service corporations), HI, KY, MD (HMOs and service corporations), NJ, NM (small group), ND, NY, SD (individual), WA (HMOs and service corporations), and WV (all).
- 90 days—DC, GA (HMOs), and SC.