



Deciphering the Data: Health Insurance Rates and Rate Review

In-Brief

Health insurers participating in the new Marketplaces are filing rates for 2015 during the next few months. A few states have already released data on proposed rates. There is substantial economic, policy, and political interest in the magnitude of proposed rate changes. This brief provides background for understanding the economic drivers of proposed rates, state and federal rate review authority, the effects of rate changes on Marketplace enrollees and federal spending on premium credits, and the economic and political dynamics of the rate review and approval process.

Premium rates for individual and small group health insurance generally must be filed with and often must be approved by state regulators, and the ACA requires health insurers to justify unreasonable rate increases. While individual market rates in the Marketplaces for 2014 received considerable attention when they were released by the federal government and the states in the latter half of 2013, the rate filing/approval process received relatively little public discussion. The discussion and debate promises to be broader and earlier this year, as insurers file their 2015 rates. A number of states have released these proposed rates, prompting highly partisan dialogue about what they mean. Many ACA opponents will claim that any non-negligible rate increases are further proof of an ACA train wreck. Many ACA supporters will claim that any percentage rate increases below double digit levels prove that the ACA is working. The facts, however, will be far more complex. Here we provide some context for understanding the proposed rates and the review process.

RATE DRIVERS

Insurance premium calculations for a given risk pool have three main components: the projected cost of medical claims, projected administrative

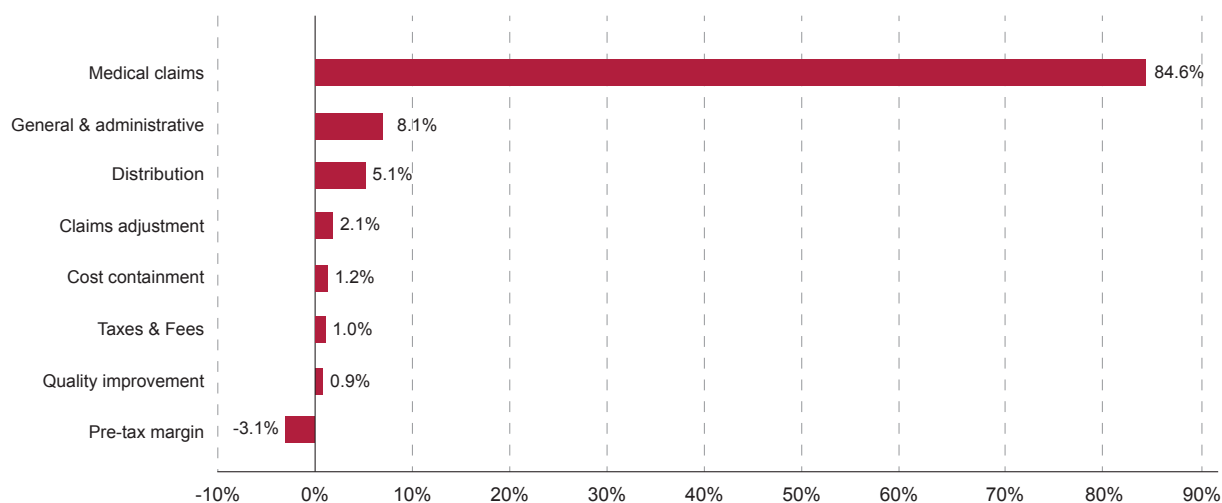
expenses (including taxes and fees), and, using language from DHHS' Unified Rate Review Template, an amount for "risk and profit." Medical costs are by far and away the largest component. To illustrate this point, we analyzed 2013 financial statement data filed by all health insurers, as reported by the National Association of Insurance Commissioners (NAIC). As shown below, medical costs equaled approximately 85% of individual market premiums countrywide in 2013. (The ACA requires insurers to rebate a portion of premiums if expenditures on medical claim costs and quality improvement in a state are less than 80 percent of premiums less certain taxes and fees in the individual and small group markets and 85 percent in the large group market.)

The 2014 premiums for Qualified Health Plans (QHPs) in state and federally-facilitated Marketplaces varied substantially across states (and rating areas within states), largely due to geographic differences in the projected cost of medical claims. Using [RWJF Breakaway](#) data, we mapped average silver plan premiums for a 30 year old couple with two children. Our analysis reveals that 2014 monthly premiums averaged \$1,000 or more in eight states and under \$700 in five states.

While the competitive environment, company strategy, and other factors will play a role, proposed rates for 2015 will be heavily influenced by projected cost of medical claims, including the projected effects of any changes in total care costs, and provider networks, contracts, and fees. Projected characteristics of the risk pool for 2015 compared with projections used for 2014 rates will be a key determinant of the magnitude of proposed rate changes for 2015 rates. See further discussions [here](#) and [here](#).

An insurer has to price its individual market policies using a single-risk pool for ACA-compliant policies, excluding catastrophic policies, grandfathered plans, and non-compliant policies that are permitted to be renewed through October 2016. Evidence that enrollees in the 2014 risk pools in some states are older than had been projected will put some upward pressure on rates. Projections of the average projected medical expenses of enrollees of any given age will be critical. Insurers have substantial information on the age distribution and other demographics of 2014 enrollees, and many insurers have claims experience for large numbers of enrollees on or off the exchanges who were insured prior to

Percentage of Individual Market Premiums in 2013



Source: author analysis of industry aggregates based on company-level data from SNL Financial.

2014. But they have less data to assess the expected utilization of their newly insured enrollees this early in 2014, and the extent of adverse selection associated with guaranteed issue, limitations on permissible rating factors, relatively low penalties for not complying with the requirement to obtain coverage, and hardship exemptions from the mandate.

Insurer representatives have expressed substantial concern about the transitional policy that will allow individuals in states that permit to renew non-complying health plans through October 2016. Younger and healthier policyholders may be more likely to continue these plans, resulting in older and less healthy risk pools for QHPs and putting upward pressure on rates. Differences across states in the degree to which insurers are permitted to extend non-complying plans will contribute to differences in the magnitude of proposed rate increases, with states that allow extensions on average having a less healthy risk pool and higher increases. The assessment of expected utilization will also be complicated by any tendency of newly insured Marketplace enrollees to utilize relatively high levels of care right after obtaining coverage.

The bottom line is that insurers face substantial uncertainty about the magnitude of medical claim costs for 2015, in addition to the general risk in forecasting medical cost trends even when risk pools are relatively stable. Moreover, payments under the ACA’s risk adjustment will depend on how an insurer’s experience compares to other insurers, which for 2014 will not be known until early 2015. Insurers will continue in 2015 to receive partial protection against loss from higher than projected medical costs from the ACA’s temporary risk corridor program, and HHS made changes in risk corridor parameters to allow greater protection given continuation of non-complying plans.

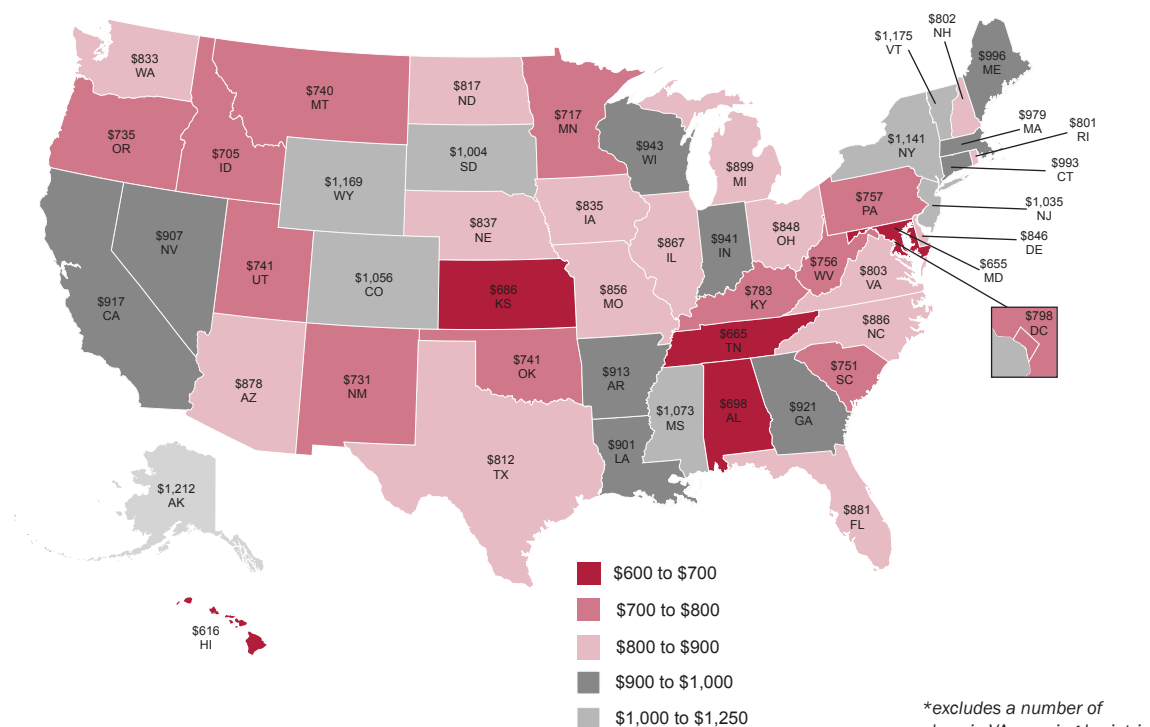
But possible constraints on program funding could occur if HHS is unable to allocate the necessary funds. Changes in the ACA’s transitional reinsurance program parameters already set for 2015 will increase projected medical costs net of reinsurance payments compared with 2014 and thus contribute to higher rate increases.

REVIEW OF “UNREASONABLE” RATE INCREASES

Section 2794 of the ACA, “Ensuring that Consumers Get Value for Their Dollars,” charged HHS, in conjunction with the states, to establish a process for annual review of “unreasonable” health insurance rate increases. It requires insurers to justify unreasonable rate increases to HHS and relevant state regulators prior to implementation, and to “prominently post such information on their Internet websites,” with public disclosure otherwise ensured by HHS. The ACA, however, did not require regulatory approval of rate changes by the states or permit HHS to deny rate increases.

HHS set 10% as the threshold for “unreasonable” rate increases beginning September 1, 2011, and has maintained it at that level. (Although the statute permitted adoption of state-specific thresholds, HHS denied requests by Alaska and Wisconsin for higher thresholds in 2012.) Insurers that propose increases of 10% or more must file a preliminary justification with HHS and the state, which is posted on an HHS website and the insurers’ websites. If the state or HHS deems the increase unreasonable and the insurer nonetheless implements the increase (in those states that do not require prior regulatory approval of rates), the insurer must submit a final justification to regulators and post it on the insurer’s website. HHS has provided a number of [examples](#) where it asserts that enhanced rate review

Average 2014 Silver Plan Premiums for Couple Aged 30, 2 Children



Source: author analysis of RWJF Breakaway data.

*excludes a number of plans in VA covering bariatric surgery with extraordinarily large premiums

saved consumers money by reducing insurers' requested rate increases, as has the [Kaiser Family Foundation](#).

The ACA authorized the HHS to assume responsibility for review of proposed rate increases at or above the 10% threshold if it deems that a state does not have an effective rate review process. HHS regulations subsequently established detailed criteria for effective rate review. As of [April 2014](#), HHS was responsible for the reviews of rates for the individual market in five states (Alabama, Missouri, Oklahoma, Texas, and Wyoming).

The ACA also authorized \$250 million for Health Insurance Rate Review Grants for states to improve their rate review. The [funds](#), which have been authorized to specific states in several cycles, have been used to expand the scope of rate review and rate filing requirements, improve information technology, improve consumer interfaces (such as rate review websites), and hire staff.

GENERAL RATE REVIEW AUTHORITY

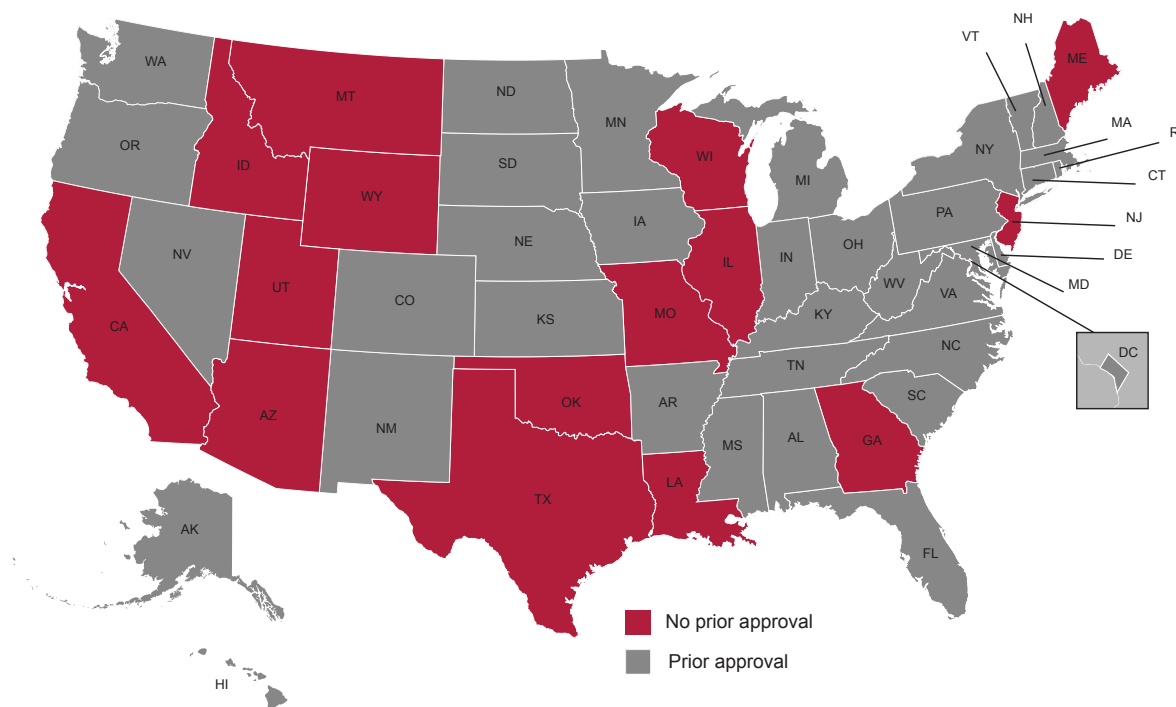
The overall standard for the review and regulation of insurance rates by the states typically is that rates be adequate but not excessive or unfairly discriminatory. Specific types of authority for individual health insurance vary across states and are often complex. As is true for property/casualty insurance, however, an important distinction is whether regulators must approve rates.

"Prior approval" laws require rates to be filed with regulators for approval. Rates often are deemed approved if the regulator takes no action within a specified time of the rate filing (such as 30 or 60 days). Rates generally can be disapproved after initial approval if regulators determine they no longer meet regulatory standards. A variety of other laws require rates to be filed with regulators either before or after they take effect, without requiring prior approval, although some laws allow regulators to challenge rates for not meeting regulatory standards.

Thirty-five states and the District of Columbia had prior approval rate review authority for individual health insurance as of January 2012 (see map and [Kaiser Family Foundation](#)). A few additional states had prior approval authority only for coverage provided by health maintenance organizations. While a few states enacted such authority following the passage of the ACA, many others beefed up their rate review in conjunction with the law's establishment of criteria for effective rate review and rate review grant program. Rate review statutes, whether for health insurance or general insurance, are only one indicator of the likely intensity of rate review. States with prior approval authority, for example, may vary considerably in how they exercise their statutory authority to disapprove proposed rates.

In contrast to health insurance rate regulation, a significant amount of research has considered the effects over time of

States with Prior Approval Rate Review Authority for Individual Health Insurance



Source: Kaiser Family Foundation, 2012.

state rate regulation of automobile [insurance](#) and, to a lesser extent, workers' compensation insurance. The results suggest that prior approval authority on average had little or no effect on rates in relation to claim costs. There is evidence, however, that regulators sometimes did not permit rate increases to keep pace with increases in claim costs in some states with prior approval authority, which contributed to less coverage being available and exits by some insurers. In addition, the rate review and approval process in some states and time periods has been characterized by lengthy hearings on proposed rates, including claim cost projections, administrative costs, and proposed profit margins.

The lessons from this research for health insurance are not clear, in part because of the higher market concentration in many states' individual (and small group) health insurance markets compared with property/casualty insurance markets, and also because of potentially new dynamics for the health insurance Marketplaces. If health insurers proposed large increases, extensive concern with the affordability of health insurance and the history of politically sensitive automobile and workers' compensation insurance in some states could presage significant regulatory pressure for restraining rate increases.

ECONOMIC AND POLITICAL DYNAMICS OF RATE REVIEW AND APPROVAL

Proposed Marketplace rates for 2015 will vary widely across states due to differences in underlying rate drivers and market conditions. The extent to which proposed rates are approved without changes will depend on states' general statutory authority over health insurance rates and specific implementation of that authority. It also could depend on the operation of ACA-required review of proposed increases of 10% or more by the states and HHS, as well as possible influence from HHS on state regulators implementing their general rate authority, perhaps especially in states with federally-facilitated Marketplaces.

Increases in rates for 2015 vs. 2014 will have diverse effects on consumers in a given market, depending in large part on their eligibility for premium subsidies. A significant majority of Marketplace enrollees countrywide are subsidy-eligible. Given that premium subsidies are calculated as the difference between the premium for the second lowest cost Silver plan in a market and specified percentages of income (up to 400% of the Federal Poverty Level), many enrollees will be at least partially shielded from rate increases, with federal spending on premium subsidies making up the difference.

If a subsidy-eligible person's income does not change, increases in the 2015 premium for the second lowest cost silver plan would increase the subsidy on a dollar-for-dollar basis, and most if not all of the premium increase would be borne by the federal government. Depending on the specifics, subsidy-eligible persons with growing incomes may face higher prices for coverage net of premium subsidies, but less than the entire increase. Some persons with incomes below 400 percent of FPL who were not eligible for subsidies in 2014 will become subsidy eligible in 2015 due to increased rates for the second lowest cost Silver plan, thus partially shielding them from rate increases. On the other hand, persons with incomes above 400% of FPL in 2014 and 2015 will face the full increase in premium rates.

There are at least three implications of these diverse effects on enrollees and potential enrollees. First, the mechanics of premium subsidies (and the individual mandate) will limit downward pressure on enrollment from rate increases for subsidy eligible persons. Second, potential Marketplace enrollees who are not subsidy-eligible could have greater incentive to seek or maintain jobs with employer-sponsored coverage, purchase coverage directly from insurers who sell only off-exchange policies, or forgo coverage and pay the penalty for violating the mandate. Third, consumer discontent with rate increases and any attendant political pressure on regulators to hold down rate increases could be greater in states where more potential enrollees are not subsidy-eligible.

Regulators in states with explicit authority to approve rate increases, and those in some states that may otherwise be able to affect rates, will likely face a difficult balancing act if confronted with proposals for large rate increases. At least two

factors favor regulatory accommodation to proposed increases. First, to encourage insurer participation in the Marketplaces in 2015 and beyond in an environment of substantial uncertainty, it remains fundamentally important for regulators to approve rate increases accompanied by reasonable but necessarily uncertain projections. Attempts to reduce proposed rate increases significantly could cause some insurers to exit and others to forgo plans to enter in 2015 or later. Second, regulatory suppression of rate increases could increase pressure for narrower provider networks and lower provider reimbursement and, other things being equal, undermine insurers' financial strength and increase insolvency risk, especially for smaller and newer insurers.

On the other hand, some state regulators may have and exert leverage to deny proposed rate increases, betting that insurers will submit reduced requests rather than exit. Insurers that have made significant investments in entering the Marketplace in a state could be reluctant to exit in the face of short-run suppression of rates by regulators. Larger insurers also might be concerned with unpredictable political responses at the state or federal level to any threat of exit or actual exit.

Some insurers might anticipate that certain regulators will face strong political pressure to reduce proposed rate increases. In that case, proposed rates might contain an extra element of conservatism in anticipation that rates ultimately approved will be lower than those initially proposed. Under that scenario, regulators would be able to claim savings for consumers even though all or part of the savings would be illusory. The extent to which any of these scenarios play out will depend heavily on the magnitude of proposed rate increases in different markets.

About the Authors

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The [Leonard Davis Institute of Health Economics](#) (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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