



Questions to Ask Your Insurance Commissioner About Rates

Insurance companies must file rates, or the projected average cost of health plans with most state insurance departments each year. However, the ability to access rate filings varies widely from state to state. Some state insurance departments post rate filings online, but allow insurers to remove certain information. In other states, accessing a rate filing requires a formal request under the state's public records law. It is important to understand where your state falls on the transparency spectrum in order to effectively advocate for making filings public in your state. Regardless of your department of insurance's authority to make rate filings public or to review and approve (or disapprove) proposed rates, **all commissioners have a duty to ensure consumers are protected and that rates are not excessive and many have authority to question assumptions behind insurers' rates.**

In response to concerns that rates may increase in 2016, this brief includes some questions to ask your commissioner about proposed rates. We recommend also asking these questions *publicly* to educate consumers about rates and the commissioner's duties to provide transparent information and protect consumers.

Public availability

- *Will your department of insurance release proposed insurance rates to the public in an accessible form?*

This year, in an effort to encourage more uniformity, federal rules require all issuers to follow the same rate filing timeline regardless of whether they are certifying a qualified health plan (QHP) or not. All QHP and non-QHP rate filings were due to CMS and the state on May 15th (unless a state-based marketplace requested a one-time extension to June 2nd). Under [federal rules](#), public disclosure of the rate filing justification for rate increases subject to review (over 10%) are due ten business days following the receipt of the rate filing (in most cases this was June 1st). To comply with the requirement for public disclosure, the state can publish proposed rates on their own website, or link to CMS's [website](#) for rates.

Some states offer the public an opportunity to comment on the proposed rates. Transparency about rates and rate increases is important - consumers should be able to know what rate increases will be and how they are calculated. Rate filings can be complex and challenging to find and review, and insurance departments could provide more accessible information for consumers. Check out [Oregon's](#) website for a helpful example.

Medical cost trend

Trend is the rate at which the cost of medical insurance claims increase or decrease each year, and it has a significant impact on rates. The following questions can challenge an insurer's determination of trend

in their rate calculations. Actuaries have broad discretion in determining what historical data to use and what adjustments to make when projecting trends for the future.

- ***Is the insurer's calculation of medical costs (i.e. payments to doctors, hospitals, and other health care providers) reasonable in light of the state and national forecasts of medical cost trends?***

Unit cost trend is one factor influencing an insurer's medical costs calculation and it reflects the increase or decrease in prices the insurer pays to doctors, hospitals, and other health care providers. Another factor is the ***utilization trend***, which reflects changes in how much medical care is used. To the extent possible, the medical cost trend should be close to the change in state health care expenditures, or national trends if state data is not available. This medical cost trend report from [PriceWaterhouseCooper's Health Research Institute](#) is one national resource that can be used to help encourage a closer look at the insurer's assumptions of medical cost trend.

- ***Did the insurer take into consideration the more favorable risk pool in 2016?***

There are a number of reasons to assume that the risk pool, or general health of enrollees, will be better in 2016. Leading up to the release of rates the last two years, insurers argued that individuals with the greatest need for insurance were more likely to sign up for insurance in 2014 and 2015 than people in better health. If that was the case, then it follows that the 2016 risk pool will be healthier than in previous years. Also, people who were previously uninsured and became insured in 2015 will have already received care which will alleviate pent-up demand for health care. Finally, increased enrollment in qualified health plans due to larger penalties for not having insurance, and greater public awareness of programs should have a positive impact for consumers on the 2016 rates.

Administrative Expenses

Advocates can ask their DOI questions to challenge the administrative expenses accounted for in the rate filings. It is important to challenge the accuracy of administrative expenses.

- ***Did the insurer provide a breakdown of the anticipated Medical Loss Ratio (MLR) to demonstrate compliance with the federal requirement?***

The ***MLR*** requires insurers in the individual and small group market to spend at least 80% of consumers' premium dollars on health care services or activities that improve health care quality. Companies that do not meet the MLR must refund excess premium dollars that it collected to its enrollees (also known as an MLR rebate). At a minimum, DOIs should not approve any proposed rate in which an insurer projects that it will not meet its MLR, resulting in an MLR rebate.

- ***What administrative expenses has the insurer passed on to consumers?***

Advocates may argue that insurers should not be permitted to pass through particular types of expenses to consumers, for example: claims adjustment expenses, lobbying, or issue advertising campaigns.

Savings and Surplus

The ACA includes several mechanisms to help insurers manage risk as they insure a new pool of previously-uninsured people. In light of these mechanisms, proposed rates should take these mechanisms into account and should not result in the insurer accumulating excessive surplus, for example.

- *Are savings from risk-adjustment, reinsurance, and risk corridors reflected in the rates?*

Risk adjustment allows an insurer that ends up with a disproportionately *less healthy* pool of consumers to receive payments from insurers with disproportionately *healthy* people.

Reinsurance provides payments to insurers with unexpected high cost claims to insulate them from excessive losses. And under the risk corridor program, if an insurer's claims are worse than predicted, the insurer is partially reimbursed for high cost claims by the government. These programs all significantly reduce an insurer's risk of losses, and should be considered in the rate filing process. Notice of risk adjustment and reinsurance payment amounts from 2014 will not be available until June 30, 2015. Advocates should make sure that once the payment information becomes available they push DOIs to allow insurers to adjust their rates to reflect any significant savings.

- *Does the insurer have excess reserves or surplus?*

Insurance companies hold various types of reserves for expected claims' expenses, which can build up over time, resulting in a significant pool of money for an insurance company. Reserve information is usually not disclosed in a rate filing, but it can be found in financial statements. Advocates can locate financial statements on the following websites: your state insurance department, the [NAIC](#), or the insurance company itself. If an insurer seeks to increase rates, advocates should ask their DOI about reserve amounts to ensure that insurers are actually using them to pay claims and stabilize rates.

While **reserves** include liabilities of the insurance company for both known and estimated amounts, **surplus** is the amount insurers hold over and above what they project they need in order to pay claims. Surplus protects the insurer in the event that actual costs exceed the established reserve amount. Consumer advocates can argue that premiums should not be set so high that an insurer will accumulate excessive surpluses.

Using this guide, advocates should feel equipped to question their commissioner about rate transparency and proposed rate increases. This is an important opportunity for advocates to challenge negative media coverage of the ACA, and ask questions about rates that will better educate consumers and the public at-large.

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