COMMUNITY CATALYST

The Advocate's Guide to:

RATE REVIEW

JULY 2020

Problem: Uncertainty and Affordability

Given record-high medical loss ratio rebates in recent years, there is reason to believe that health insurance rates are too high in many states. High rates make it challenging for consumers, especially those that do not receive marketplace subsidies, to enroll in coverage. Because health insurance premiums are set prospectively and on an annual basis, health insurers must make several assumptions about health care costs and utilization many months in advance in setting their rates for the following year. The significant uncertainty caused by COVID-19 could lead insurers to propose rates that are higher than warranted. Premium hikes in 2021 could put coverage further out of reach for many consumers who face significant financial uncertainty right now and undermine market stability at a time when coverage is critical.

Potential Solution: Robust Rate Review

Rate review is an underutilized tool to lower premiums and hold insurers accountable for unjustified premium increases. Amid affordability concerns and significant uncertainty, advocates have a critical role to play in holding regulators accountable for close review of proposed rates and requiring insurers to justify rate increases.

What Is Rate Review?

Rate review is the process used by state and federal insurance regulators to determine whether an insurer's proposed rate is based on accurate, verifiable data and realistic assumptions and projections. Robust rate review also helps control increases in health insurance premiums and can be used to address the underlying cost of health care.

How Rates Are Calculated. During the rate review process, insurers submit a rate filing—with underlying data, assumptions, and other information—to explain how they determine their proposed "base rates" and to justify why an increase is necessary and appropriate. Base rates reflect several factors, including the cost of medical care, the cost of prescription drugs, expected utilization, administrative costs, and profit. Base rates are then adjusted by a set of limited factors under the ACA: age, where you live, whether you use tobacco, and the number of people in your family. The base rate, adjusted by these factors, determines the amount that an individual or family will pay in premiums.

How Rates Are Reviewed. While many states had rate review processes already in place, the ACA strengthened the rate review process by providing new resources to conduct rate review, establishing new rate review standards, and requiring proposed rate increases to be publicly posted with an opportunity for comment. Under the ACA, all proposed rate increases in the individual or small group market must be publicly disclosed and posted online. Only those rate increases that exceed a certain threshold (currently 15 percent or more) must be reviewed to determine whether they are unreasonable. Insurers must also disclose any justification for unreasonable rate increases.

State insurance regulators continue to have the responsibility for reviewing health insurance rates. But the Department of Health and Human Services (HHS) will review rates if a state fails to meet federal standards for an effective rate review process. Nearly all states have effective rate review in the individual and small group markets under the ACA.[1] In these states, the state's own process is used to review proposed insurance rate increases, and HHS defers to the state's determination of whether a rate increase is reasonable or not. In the three states that do not have effective rate review—Oklahoma, Texas, and

Wyoming—HHS reviews rates in the individual and small group markets to determine whether those rates are unreasonable.

Although the ACA introduced some standardization, rate review continues to vary significantly by state. Some state insurance departments have the authority to reject rate increases. Under this "prior approval" authority, the insurance commissioner can approve, reject, or reduce proposed rate increases, usually through a negotiation with the insurer. Prior approval authority often has a deadline whereby if a rate is not disapproved or reduced, the rate goes into effect. Other state insurance departments may review rates but do not have the authority to reject an increase. Under this "file and use" authority, premium rates go into effect automatically without approval. Regulators can reject the rates later if they are found to be unreasonable, but advance approval is not required. This mechanism often relies on consumer complaints to indicate a problem with premiums before rates are examined.

EFFECTIVE RATE REVIEW

Under the ACA, a state with effective rate review in the individual and small group markets must:

- ✓ Request and receive adequate data from an insurer to examine whether rate increases are reasonable (based on consideration of factors such as medical cost trend, utilization, medical loss ratio, capital and surplus, etc.);
- ✓ Conduct effective and timely reviews of rate increases;
- ✓ Post rate filings on a public website; and
- ✓ Provide a method for public comment.

How Have Insurers Addressed Uncertainty in The Past? Uncertainty has historically led to premium hikes. Efforts to repeal the Affordable Care Act (ACA) in 2017 contributed to dramatic premium increases for 2018, followed by additional increases after the Trump administration stopped making cost-sharing reduction payments to insurers.[2] Uncertainty continued into 2019 when premiums were an average of six percent higher than they would have been due to elimination of the individual mandate penalty and expanded availability of non-ACA plans.[3]

What Happens if Rates Are Too High? Rate review works in tandem with the ACA's medical loss ratio (MLR) requirements. Under the ACA, insurers in the individual and small group markets must spend 80 percent of their premium revenue on health care claims or health care quality improvement expenses. The remainder of premium revenue can go towards other expenses, such as administrative costs, profit, and marketing. If insurers fail to meet an MLR of 80 percent, they must rebate the difference to enrollees. Thus, insurers that overprice their plans rebate excess premium revenue back to consumers.

After losses during the early years of the ACA, the marketplace stabilized in 2017 and ACA plans have been highly profitable since 2018.[4] As a result, insurers have had to pay record-high rebates to consumers—more than $1.37 billion in 2019 and an estimated $2.66 billion in 2020—after not spending enough premium dollars on health care costs and quality improvement.[5] These record-high rebates suggest that rates are already too high in many states.

While rebates help safeguard against overpricing, more effective rate review would help keep premiums low in the first place. This, in turn, would improve affordability and help ensure that more consumers—especially unsubsidized consumers—could enroll in coverage, especially as millions lose or need health insurance during the COVID-19 crisis.

Robust Rate Review Shows Promising Results

Without rate review, health insurers could raise rates without having to explain their actions to regulators or consumers. Available data suggests that independent scrutiny of rate filings has been an effective tool at reducing requested rates, especially in states with prior approval requirements.

- Rate review reduced total nationwide premiums by $1.2 billion in 2012.[6]
- In California, rate review saved an estimated $349 million between 2011 and 2014.[7]
- In Colorado, rate review saved consumers $125 million over five years.[8]
- In Oregon, rate review saved at least $69 million in premiums in 2014 due in part to the identification of calculation errors identified during the rate review process.[9]

Not all state rate review standards or processes are created equal, meaning policymakers in some states have created a far more robust process for analyzing and reviewing proposed rates.[10] Rhode Island, for example, has broad authority to address underlying health care costs through its rate review process. Using this authority, the Office of the Health Insurance Commissioner (OHIC) requires insurers to meet "affordability" standards, which include expanded investments in primary care and delivery system reforms.[11] OHIC also evaluates insurer contracts with hospitals as part of its rate review process and requires these contracts to include specific terms and conditions (to, for instance, promote quality incentives and care coordination). Thanks to these efforts, primary care spending in Rhode Island has increased by more than one third while the rate of hospital cost increases has slowed.[12]

Oregon also uses its rate review authority to address the underlying cost of medical care and strongly engages consumers in its rate review process.[13] The insurance department appointed a consumer advocacy organization to submit comments on behalf of consumers, initiated public rate hearings, and invested in consumer education about the factors driving premium rate increases.[14]

COVID-19 Cost Estimates Vary and Are Subject to Change

Rate review has always been a critical protection for consumers. But this process is even more important given uncertainty about COVID-19 and its implications for 2021 rates. The stakes could not be higher as state policymakers balance premium affordability with insurer solvency, particularly in the individual market which will need to accommodate many new enrollees this year and next.

The cost of COVID-19 testing and treatment is expected to be billions of dollars, but there is extreme variation in estimates, with current estimates of costs to the commercial insurance market ranging from $31 billion to $378.6 billion.[15] Key factors include the severity of the outbreak, the frequency of testing and hospitalization, reduced costs from cancelled procedures, pent-up demand for procedures in 2021, a transition to telehealth services, the cost of a future vaccine, and any effects on network dynamics (such as the closure of facilities or provider consolidation in the wake of the pandemic). Another key question is the degree to which COVID-19 will affect those with commercial insurance relative to those with other sources of coverage (such as Medicare or Medicaid) or the uninsured (which could rise to an estimated 40 million people due to the economic downturn).[16]

Some of these projections have been criticized in light of more recent data, which suggests a lower-than-expected hospitalization rate during the first wave of the outbreak. The projections also do not account for the effect of cancelled health care procedures coupled with reduced health care spending because of

physical distancing requirements. Incorporating this trend data suggests that overall health care costs—to the commercial market, Medicare, and Medicaid—will be an estimated $61 billion to $98 billion higher in 2020 and 2021.[17] Projections will be refined as more data becomes available.[18]

Policy Considerations

State Considerations

Even with uncertainty about COVID-19 costs and other factors, regulators must review proposed rates for 2021 during the summer and early fall. Regulators must balance premium affordability with insurer solvency. Losses from 2020 cannot be built into rates for the following year, which must be based on projected costs for 2021. However, insurers that experience significant losses in 2020 may need to increase rates to ensure solvency and replenish their surplus. At the same time, consumers could face inflated rate increases that are out of sync with actual costs if a worst-case COVID-19 scenario does not materialize.

Require 2021 Rates to Be Evidence-Based. Given the stakes, regulators must be even more diligent about reviewing insurer assumptions about COVID-19, disclosing the impact of COVID-19 on 2021 rates, and prioritizing a robust public comment process. Insurers may be especially prone to overprice in the individual market, where many enrollees are relatively insulated from premium increases because of subsidies. Recognizing the disproportionate impact that COVID-19 is having on communities of color, certain areas of the state, or even certain neighborhoods within a city, regulators should monitor insurer participation and variation in premiums based on rating area to ensure that insurers are not engaged in discriminatory rating practices or redlining.

States should consider replicating Oregon's process by engaging a consumer advocacy organization to provide formal feedback on behalf of consumers. States could also convene a neutral panel of actuaries and public health experts to provide public guidance on how COVID-19 costs should be addressed in 2021 rates.[19] Ensuring the engagement of a diverse set of voices representing both consumers and experts will provide regulators with an even stronger evidence-base to consider in weighing insurers' requests against community needs.

Regulators can also leverage an optional 2021 rate review guide from the National Association of Insurance Commissioners.[20] The guide includes a range of COVID-19 factors that may need to be considered, including testing and treatment assumptions, telehealth services, and disruptions to provider networks, among many other issues. Additionally, a tool developed by the Society of Actuaries allows users to estimate future health insurance costs based on a variety of factors and

FEDERAL RATE REVIEW DEADLINES FOR 2021 MARKETPLACE PLANS

Jun. 3	Insurers submit proposed rate filings to HHS in states without effective rate review
Jul. 22	Insurers submit proposed rate filings to HHS and the state in states with effective rate review
Aug. 14	HHS posts information on proposed rate filings at ratereview.healthcare.gov
Aug. 26	Insurers in HealthCare.gov states finalize rate filings
Oct. 15	Insurers in state-based marketplace states finalize rate filings
Nov. 2	HHS posts final rate information

Source: https://www.cms.gov/files/document/2020-revised-final-rate-review-timeline-bulletin.pdf

scenarios, including the potential impact of COVID-19. This tool will be updated periodically to reflect changing data on the outbreak and other costs.[21]

Allow for Updates to Capture Changing Estimates. Insurers may need additional flexibility to ensure that 2021 rates are based on the strongest data available and reflect informed assumptions that match real-time, real-world experience. To the extent that additional time is helpful for insurers to consider their rating assumptions, regulators should adjust the rate review timeline as needed while maintaining sufficient time for a robust rate review process. State regulators may also want to replicate a process that worked well for 2018 rates by requiring insurers to make provisional filings in the spring followed by a supplemental filing in the summer that reflects updated COVID-19 information.

Consider Implications for State-Run Reinsurance Programs. Finally, states with a reinsurance program should ensure that the program is prepared to address COVID-19 costs by adjusting program parameters, such as attachment points, and adding COVID-19-related conditions to a conditions-based reinsurance program.[22] States such as Alaska and Colorado have already taken steps to address COVID-19 in the context of their reinsurance programs: Alaska has added a COVID-19-related condition to the conditions eligible for reinsurance, while Colorado has updated their payment parameters based on estimated claims and enrollment impacts of COVID-19 in 2021.[23] States that have the authority to do so could also tailor their reinsurance programs to direct relief to areas that are more hard hit by COVID-19, similar to how Colorado operates a three-tier geographic reinsurance program.

Advocacy Considerations

Advocates play a critical role in promoting robust rate review. By requiring a thorough evaluation and public disclosure of proposed rate increases, rate review forces insurers to be accountable for the premiums they charge and protects individuals, families, and small businesses. Although the national average for marketplace premiums have been relatively stable in recent years, closer review of 2021 rates is needed. The uncertainty caused by COVID-19 could drive premiums higher at a time when record-high medical loss ratio rebates suggest that insurers are overpricing their plans. Rebates remain important for those who enroll in health insurance, but unaffordable premiums keep consumers from enrolling in coverage.

Review Proposed Rate Increases. Advocates can engage directly in the rate review process by reviewing and analyzing proposed rate increases. Organizations with this expertise could take this on themselves—or, if possible, hire or work with a volunteer actuary to review rates. Advocates can also urge regulators to partner with diverse community organizations to provide feedback on rate increases on behalf of consumers. This has been a strong model in Oregon that other states could replicate. Advocates and regulators should ensure that the appointed organization is representative of, or at a minimum in coalition with, diverse communities that are affected by COVID-19 and rate increases. At a minimum, advocates can request answers to rate filing questions outlined in Community Catalyst resources.[24]

Advocates can also ensure that regulators are reviewing COVID-19-related assumptions and clearly specifying the projected amount of rate increase due to COVID-19. General statements or premium surcharges based on uncertainty are insufficient for regulators and the public to evaluate rate increases. The inclusion of specific information—ideally alongside assumptions about the COVID-19 infection rate, assumed morbidity rate, and other data—will help insurers demonstrate that they are adequately responding to the COVID-19 crisis.

Increase Transparency and Public Participation. Public participation—through comment periods, public hearings, or formal appeals process—ensures that consumers and advocates can weigh in effectively on proposed rate increases. Increased scrutiny can help improve the fairness of the final rate and ensure meaningful oversight. While the ACA imposed several new rate transparency requirements, much more can be done to promote consumer input.

Advocates should ensure that states have a robust process for public participation. This process should include a way to notify policyholders when an insurer files a rate change, access to full rate filings coupled with consumer-friendly summaries, a public comment period, and public hearings (including remote hearings). As noted above, states such as Oregon and Rhode Island have adopted many of these practices.[25]

Advocates can also push for better public access to comprehensive rate review information. This information, while posted online, can be challenging to access by the public, is not easily understood by consumers, and is difficult to compare across insurers. Further, many states allow insurers to shield rate filings from public scrutiny by citing a trade secret exemption while advocates argue that rate setting and actuarial calculations do not implicate trade secrets. States such as California and New York agree and do not permit rate filings to hide trade secrets.[26] Instead, these states require insurers to publicly disclose a complete justification for their rate increases.

Expand Rate Review Requirements. Advocates should consider longer-term goals to improve the rate review process and expand rate review requirements. First, advocates can ensure that regulators have prior approval authority. If your state does not have prior approval authority, advocates should work with the insurance commissioner to determine what is needed. Second, regulators should review all proposed rate changes (not only those above the minimum federal rate review threshold) as some states, such as California and Oregon, already do.[27] Finally, advocates can expand the range of factors that can be considered during rate review, with the goal of improving affordability and promoting delivery system reform and quality improvement. Regulators in states such as California, Oregon, and Rhode Island consider insurers' cost containment efforts during the rate review process.[28]

Elevate Consumer Stories on The Importance of Rate Review. Advocates can collect stories from consumers about how premium increases for 2021 will affect their families and their health. It is particularly important to collect stories and input from a diverse set of communities in the state. Given the disproportionate impact of COVID-19 on communities of color, stories should reflect the needs of community members from those hardest hit by the pandemic in order to illustrate to state regulators what is necessary to meet the coverage and affordability needs of those communities. These stories can help elevate the need for robust rate review, especially during this period of extreme economic uncertainty, and can be used to bolster public comments or testimony from consumer advocates during the rate review process.

Conclusion

Robust rate review remains a crucial tool for regulators and advocates to promote affordability, increase transparency, and address uncertainty. The ACA included some rate review requirements that apply nationwide, but states can and should exceed these standards to protect consumers from unnecessary and unreasonable premium increases. Advocate engagement on the 2021 rate review process is particularly important given the high degree of uncertainty that insurers, regulators, and consumers face about health care costs and the economy. Advocates can work with regulators, consumers, and the media to ensure that proposed rate increases are evidence-based, reasonable, and fully justified.

This policy brief was developed with the support of JoAnn Volk and Katie Keith of Georgetown University's Center on Health Insurance Reforms. For questions please contact Ashley Blackburn, Policy Manager, at ablackburn@communitycatalyst.org

Endnotes

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