Health Reform and Insurance Regulation: Can't Have One Without The Other

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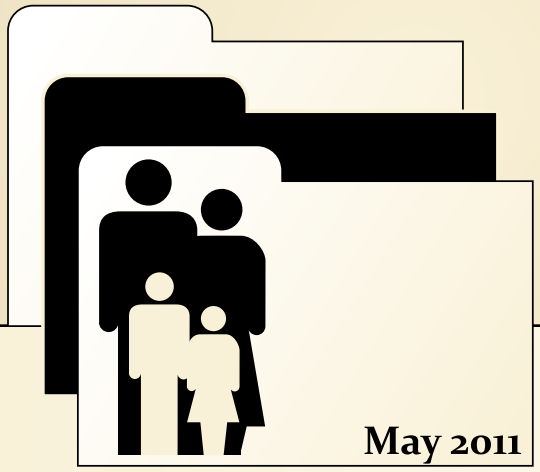

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Consumer Watchdog

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Prior Approval of Health Insurance Rates Is Key to Making Health Reform Affordable

A Consumer Watchdog Report
By Judy Dugan and Carmen Balber

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EXECUTIVE SUMMARY

Health insurance premiums are increasing at a rate faster than medical inflation, especially in the volatile individual and small group markets, and worker incomes have not kept pace. The passage of the federal reform law triggered further outsized increases by insurance companies apparently seeking to establish high base rates in advance of the law's implementation.

Consumers are increasingly unable to afford the coverage they have, and more and more are being priced out of private health coverage altogether. The number of uninsured increased by 7 million between 2004 and 2010, and the losses began before Americans began losing jobs to the recession. The nation's total uninsured rose to 49 million by 2010.

The federal health reform law seeks to expand access to health care through this private insurance system, by providing subsidies for low-income consumers, mandating that everyone purchase insurance, and reforming insurance industry practices. However, no provision of the federal law controls what health insurers can charge.

With federal health reform reliant on the ability of consumers to obtain private insurance, affordability is the key to successfully expanding access to care. The evidence in this report leads to the conclusion that direct, robust regulation of insurance rates, with a formal right of public intervention in rate proceedings, is necessary to ensure affordability and fairness while preserving a healthy, competitive health insurance market. The most comprehensive model for such regulation comes not from the world of health insurance, but from Proposition 103, a voter-passed law in California that requires prior review and approval of rates in the property and casualty markets.

The chief findings of the report are:

Premiums are rising in Massachusetts, despite the individual mandate
Massachusetts, the model for federal health reform, demonstrates the necessity of pairing health reform with strong rate regulation. Despite hopes that the individual mandate would, by itself, bring healthy people into the system and lower costs, Massachusetts is hard-pressed to maintain affordability. Premiums in the state remain the second-highest in the nation and rising costs are threatening to unbalance the state budget. Late in the game, Massachusetts is racing to strengthen rate regulation on the fly, while rate and cost increases threaten the viability of reform.

Tough regulation can bring down rates, if enforced

Industry self-regulation and lax oversight in many states has failed to contain premiums. Public outrage over recent hikes has exposed a pattern of unnecessary rate increases and manipulation of data by the insurance industry that highlights the need for greater scrutiny of rates. Independent examinations of health insurance rate hike requests have uncovered math errors favoring the insurers, indications that rates were deliberately padded, and exaggerated projections of future losses. State regulatory staff describe playing a "cat and mouse" game with insurers to find the bloat and eliminate it.

States that are moving to add or strengthen prior approval regulation are showing some success in reducing the rate of premium increases and keeping the insurance industry honest. Oregon and Maine have backed down insurer rate hikes in individual markets by taking overall corporate profitability and excessive surplus into account. New York is seeing smaller rate hike requests since restoring prior approval, and is reducing the requests further. Still, state enforcement is irregular—Connecticut provides a stark example, with a rate hike up of to 49% approved one month and a 20% rate hike sought by the same company denied in the next month, after a new insurance regulator was appointed.

California property insurance regulation shows keys to success

A stable and highly successful model for rate regulation exists in California's property and casualty insurance market. Proposition 103 has saved consumers billions, and maintained a profitable and competitive insurance market in the state.

Proposition 103's key components — a requirement that every rate be approved by the insurance commissioner before taking effect, detailed but flexible requirements that prevent insurers from passing on excessive administrative costs and profits to consumers, and a right for consumers to independently challenge rates and be reimbursed by the insurers for their time — provide the regulatory framework needed to protect health insurance consumers from unjustified rate hikes. Various states mirror elements of its regulatory framework, but none match all of its provisions.

States should regulate rates, with federal backup if they fail

Although the federal reform law encourages rate oversight, none of its provisions require effective prior approval of rates.

Insurance regulation should remain a state responsibility, with the Department of Health and Human Services encouraging prior approval regulation through its bully pulpit and grant-making powers. Congress should grant HHS the right to directly oversee rates only when states fail to enact or enforce prior approval laws and the right of consumer participation.

Whether the federal health insurance purchase mandate survives its current battle in the courts and in Congress, or alternatives are developed, this report concludes that states and federal officials must focus on developing more protective health insurance rate oversight. Without strong regulation, health insurance will become increasingly unaffordable and the federal reform law will fail in its primary goal of expanding access to health coverage.

Section 1. Massachusetts, Mandates and Rates

The health reform law enacted in Massachusetts in 2006, which included a mandate that every individual have health insurance, became the model for the federal reform law. It was also the go-to example for those who argue that the mandate will hold down insurance premiums by forcing the young and healthy into the insurance market. However Massachusetts' experience shows that the mandate alone will not control premiums.

Although the rate of uninsured has fallen to between 1.9% and 4.5%,[1] Massachusetts still has the second-highest health insurance premiums of any state in the nation.[2]

Mandate vs. Subsidies

An individual mandate may provide a small boost to unsubsidized health insurance enrollment, but subsidies were the biggest driver of new people into the ranks of the insured in Massachusetts'.

410,000 people have joined the ranks of the insured since Massachusetts' reform law passed in the summer of 2006.[3] Of Massachusetts' newly insured:

- 75% are enrolled in plans subsidized by the state[4]
- The majority of those enrolled in subsidized plans pay minimal or no premiums and copays[5]

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[1] Estimates of the numbers of uninsured in Massachusetts vary. The Massachusetts Division of Health Care Finance and Policy reports 98.1% insured in its survey released Dec. 2010, "Health Insurance Coverage in Massachusetts: 2008-2010."
http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf
The Centers for Disease Control and Prevention reports 95.5% insured in Massachusetts in the National Health Interview Survey released Jan. 2011.
http://www.cdc.gov/nchs/data/health_policy/StateTrendsinAccess04to10q1q2.pdf
Data for both surveys collected through June 2010.

[2] Kaiser Family Foundation, State Health Facts. Accessed on 3/2/2011
http://www.statehealthfacts.kff.org/

[3] Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," August 2010.
http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_august_2010.pdf

[4] Op. Cit., "Health Care in Massachusetts: Key Indicators."

[5] Health Connector Report to the Massachusetts Legislature, "Implementation of Health Care Reform Fiscal Year 2010," Nov. 2010.
https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.Content

That is to say: the vast majority of the newly insured in Massachusetts, healthy or not, are low-income consumers who signed up for insurance when they were offered subsidies to make it affordable – not simply because they were required to buy it.

Despite expanded enrollment, premiums and health care costs are still rising
Neither the mandate nor other provisions of the Massachusetts reform law have made a significant dent in rising premiums.

Health insurance premiums in Massachusetts have historically increased at a rate of growth faster than the national average. According to data reported to the Agency for Healthcare Research and Quality (AHRQ) on employer-based health insurance plans, this pattern continued after the Massachusetts reform law was enacted in 2006.[6] (See below)

Average Annual Premiums

	Single plan		Family plan	
	Mass.	National	Mass.	National
2003	$3,496	$3,481	$9,867	$9,249
2006	$4,448	$4,118	$12,290	$11,381
2009	$5,268	$4,669	$14,723	$13,027

Average Premium Rate of Increase Over Three- and Six-Year Periods

	Single plan		Family plan	
	Mass.	National	Mass.	National
2003-2006	27.2%	18.3%	24.6%	23.1%
2006-2009	18.4%	13.4%	19.8%	14.5%
2003-2009	50.7%	34.1%	49.2%	40.8%

Note: percentages for 3-year calculations do not add to equal 6-year calculation because of different starting bases.

Insurance premiums for a single plan increased 18.4% in Massachusetts since 2006,

DeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202010.pdf

[6] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Massachusetts and United States Tables
http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=35&year=-1

compared to 13.4% nationally. Premiums for a family plan increased 19.8%, compared to 14.5% nationally.

Massachusetts' Division of Health Care Finance and Policy notes a single exception, a one-year 13% drop in 2008 for non-employee new individual premiums, which occurred because of the introduction of cheaper, less comprehensive plans and (in part) the merger of the individual and small-business markets. The drop in new-policy individual premiums was countered by an increase in small-business premiums.[7]

More comprehensive data on individual insurance rates is not available because insurance companies generally protect the data as a competitive secret. The only source reporting an across-the-board decrease in premiums in Massachusetts' individual market is the trade and lobbying group America's Health Insurance Plans (AHIP). AHIP's numbers are not credible. (See footnote 8.)

Stretching state and consumer budgets

Massachusetts is now scrambling to keep costs from overwhelming its 4-year-old reforms.

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[7] Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health Care Cost Trends Final Report," Appendices A.1a-A.3b, Apr. 2010. From the report: "The lowest-cost small group premium fell markedly in July 2007, when carriers introduced new low-cost products in the newly merged market (see Appendix, Figure C.2). These new products may have been introduced as Bronze coverage products made available to individuals through the Health Connector's Commonwealth Choice program (as many of the carriers in the study participate in Commonwealth Choice) or for other strategic reasons. … Overall, individual premiums declined significantly in 2008 [from $5,364 per year to $4,752] due to the shift in membership toward lower-premium products in the merged market. However, premiums for individuals in pre-merger products continued to increase."
http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/final_report_docs/health_care_cost_trends_2010_final_report.pdf

[8] Surveys by the trade and lobbying group America's Health Insurance Plans reports a 40% decrease in premiums in Massachusetts' non-group market. AHIP reports premiums of over $8500 in the Massachusetts individual market in 2006. Although no other source specifically identifies yearly premiums in the individual market, every other report of premiums for individuals in Massachusetts in 2006, including that from AHRQ, is dramatically lower, in the $4400-$4800 range. Furthermore, the individual market was merged with the small group market by Massachusetts' reform law, so any comparison between pre- and post-2006 individual premiums is an apples to oranges assessment. Finally, AHIP's annual reports themselves are not credible: they are voluntary surveys of corporate members, with admittedly incomplete responses; the same companies may not report in consecutive years; no adjustment for missing data is mentioned; the numbers may not be weighted by plan size and there is no way to determine if the numbers reported are for comparable coverage. AHIP does not make available any underlying individual plan data.
http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf
http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf

Rising costs are threatening to unbalance the state budget: Massachusetts faces a $1 billion increase in health care spending in the 2012 fiscal year.[9] Health care costs account for 40% of state spending and have grown by nearly 8% annually in the past three years while other areas of the budget have been flat or declining.[10]

Consumer budgets are stretched as well. Massachusetts grants waivers to the individual mandate requirement for those uninsured consumers who cannot afford to purchase insurance, similar to provisions in the federal Affordable Care Act. The state had to grant 63% of requests in 2010, compared to just 44% of requests the previous year.[11]

Consumers are responding to cost pressures by reducing coverage. The number of Massachusetts residents enrolled in high-deductible health plans doubled in 2010.[12]

Belated effort at regulation

The only significant premium curbs that have been documented in Massachusetts are due to increased activity by state insurance regulators who have begun demanding that insurers justify rate hikes and lower costs, or a competitive bidding process the state exchange uses to negotiate rates for subsidized plans.

In spring of 2010, Massachusetts insurance regulators invoked a state law that was on the books but had never been used, giving the state insurance commissioner the power to disapprove "excessive, inadequate or unfairly discriminatory" rates.

The Division of Insurance issued emergency prior approval regulations in February 2010 that required health insurance companies to submit justifications and obtain approval for small business rate increases before they took effect. Health insurers filed small business rate hikes of up to 32% that were scheduled to take effect April 1, 2010. The Division of Insurance disapproved 235 of 274 rate hikes.

As Governor Deval Patrick told Politico:

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[9] Massachusetts Budget and Policy Center, "Preliminary Analysis: The Governor's Fiscal Year 2012 Budget." Accessed on 2/10/2011
http://www.massbudget.org/documentsearch/findDocument?doc_id=774&dse_id=1444

[10] Governor Deval Patrick, Speech to Massachusetts Chamber of Commerce, Feb. 17, 2011.
http://www.mass.gov/?pageID=gov3terminal&L=3&L0=Home&L1=Media+Center&L2=Speeches&sid=Agov3&b=terminalcontent&f=text_2011-02-17-healthcare&csid=Agov3

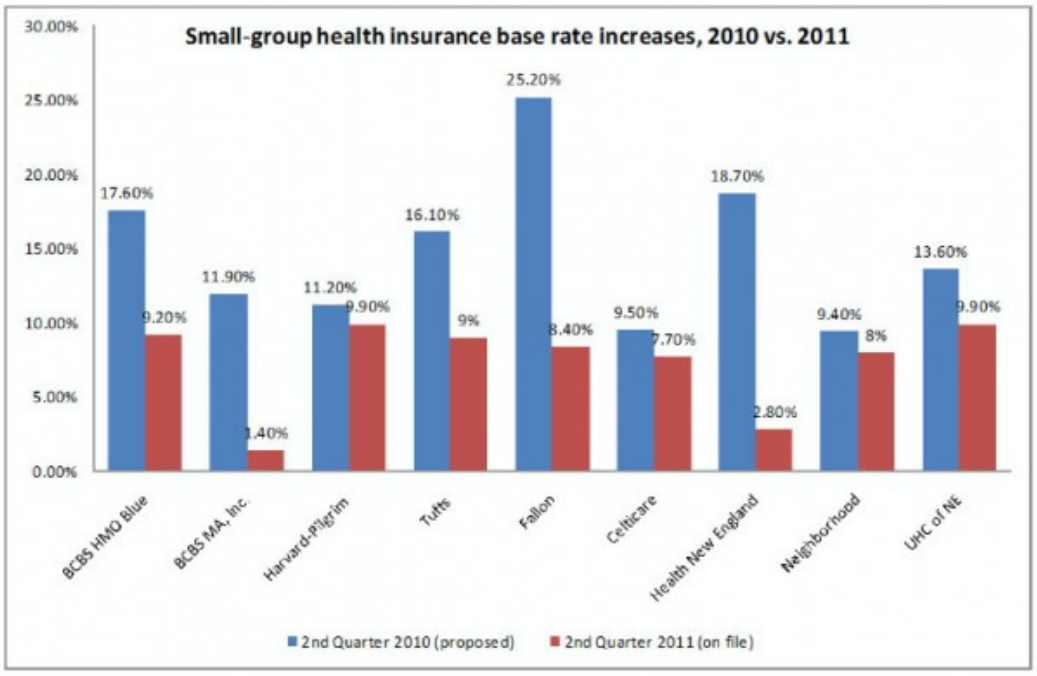
[11] Kay Lazar, "More get waivers of health insurance," *Boston Globe*, Feb. 7, 2011.
http://www.boston.com/news/local/massachusetts/articles/2011/02/07/more_get_waivers_of_health_insurance/?page=full

[12] Kay Lazar, "More opt for low-cost coverage," *Boston Globe*, Mar. 25, 2011.
http://www.boston.com/news/local/massachusetts/articles/2011/03/25/more_opt_for_low_cost_health_coverage/

> "Our message to insurers and providers is clear: Come to the table and work with us on solving this economic emergency for small businesses and working families. We have made progress on providing short-term relief from double-digit premium increases and will continue to closely monitor rates to ensure they are fair."[13]

Insurance companies challenged the basis for the denials, but set aside their objections in settlements with the Division that agreed to hold most rates to single-digit increases.[14,15]

A year later, Massachusetts approved small business rate increases from the same insurers of just eight percent to nine percent. (See below)



Source: Massachusetts Division of Insurance
Credit: WBUR

[13] Sarah Kliff, "It's coverage vs. costs in Mass.," *Politico*, June 15, 2010. http://www.politico.com/news/stories/0610/38512.html

[14] Robert Weisman, "Insurer, state in surprise accord," *Boston Globe*, July 3, 2010. http://www.boston.com/business/healthcare/articles/2010/07/03/harvard_pilgrim_reaches_settlement_with_state_to_limit_rate_hikes/

[15] An insurance division appeals board ruled in favor of several insurance companies against the denials. The Division of Insurance indicated it would challenge the decisions. Settlement agreements on rate increases between the Division and insurance companies preempted those appeals.

The Division has successfully used prior approval regulation to leverage reductions in health care spending. Insurance companies have the incentive to lower costs because they cannot pass on every spending increase to the consumer. As the Boston Globe reported, "insurers have been taking a harder line in contract talks with hospitals and other medical care providers, offering incentives for them to limit the scope of physician networks and provide care in community settings."[16]

Proposals signed into law at the end of last year strengthened the Division's authority to oversee rates and set standards for determining if a rate is excessive or unreasonable.[17]

- Rate increases must be filed at least 90 days prior to implementation in order to give the Division adequate time for review
- Insurers are prohibited from setting aside excessive surplus
- Increases in administrative costs are limited to the rate of medical inflation
- Insurers must spend at least 88% of premiums on medical care

For consumers, unaffordable is synonymous with inaccessible. In a system based on individuals' ability to pay for private insurance, the state's gains in access will quickly erode if it does not also address what health insurers charge.

Massachusetts has recognized this and shifted attention to controlling costs. Governor Patrick's latest cost initiative includes new authority for the Insurance Division to scrutinize insurers' contracts with hospitals, doctors, and other medical providers and compare them with underlying medical inflation and GDP growth as part of the rate review process. Insurers will be required to pass on savings achieved through alternative payment systems, or other methods, to consumers.[18]

The Governor advised Congress in March: "The next frontier for Massachusetts and for America is cost control. The framers of our Massachusetts reform purposefully addressed access first and put cost control off. We can wait no longer."[19]

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[16] Robert Weisman, "Insurers seeking smaller rate hikes," *Boston Globe*, Feb. 15, 2011. http://articles.boston.com/2011-02-15/business/29335693_1_health-insurers-rate-increases-rate-requests

[17] http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288

[18] Liz Kowalczyk and Noah Bierman, "Patrick unveils health overhaul," *Boston Globe*, Feb. 18, 2011. http://articles.boston.com/2011-02-18/news/29347715_1_health-care-health-overhaul-health-insurance

[19] Governor Deval Patrick, Written testimony to the U.S. House Energy and Commerce Committee, Mar. 1, 2011. http://republicans.energycommerce.house.gov/Media/file/Hearings/FullCmte/030111/Deval%20Patrick.pdf

Section 2. The Insurance Industry's Honesty Problem and State Efforts to Regulate Rates

A June 2010 survey by the Kaiser Family Foundation found recent premium increases in the individual market averaging 20%, far above the declining rate of medical inflation, which averaged just 2.9% in 2010.[20] An annual Kaiser Family Foundation survey of employer-sponsored health benefits shows a 138% increase in premiums between 1999 and 2010, a period when the overall rate of inflation increased just 31%.[21] At the same time, after public outcry and increased regulator scrutiny in some of the hardest-hit states, evidence has begun to pile up of unjustified pricing and manipulation of the data used by insurance companies to determine rates.

We've learned through hard example that the insurance industry can't be taken at its word in states with weak or cursorily enforced regulation.

The attempt last spring by Anthem Blue Cross of California to raise rates by up to 39% is widely credited with reviving a federal health reform bill that was on life support after Democrats lost Ted Kennedy's Massachusetts Senate seat. It is also illustrative of how health insurers manipulate the data to overcharge consumers when they are not required to publicly justify and get rates approved.

Health insurance regulation is weak in California and the insurance commissioner does not have the power to reject excessive rate increases. However, the storm of public criticism generated by Anthem's proposed 39% increase went as high as the White House, and gave the insurance commissioner enough leverage to pressure Anthem to delay the increase. The insurer agreed to submit data supporting the rate for independent analysis, and a Congressional subcommittee investigated the increase.

The reviews uncovered questionable data and practices by Anthem Blue Cross, and exposed the profit motive behind the increase:

- Independent actuarial analysis of the rate submission found substantive mathematical errors and even double-counting of some projected expenses

[20] Bureau of Labor Statistics, news release, CPI-U, US city average, medical care, Jan - Dec 2010. http://www.bls.gov/news.release/archives/cpi_02172011.htm

[21] Kaiser Family Foundation/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010. And associated chart pack. http://facts.kff.org/chart.aspx?ch=707

that materially increased some rates.[22]

- The House Energy and Commerce Subcommittee on Oversight's March 2010 inquiry into the Blue Cross rate hike obtained internal e-mails between Blue Cross actuaries and executives indicating the company added a 5% "cushion" to the rate, in the expectation that regulators would question the rate and seek a reduction.

- Another internal company email showed that the increase was intended to "return CA to target profit of 7 percent (vs 5 percent this year)."

- In discussions with subcommittee staff, Anthem said that as much as 7% of the average 25% rate increase was based on adverse selection – the company's projection that healthy individuals would drop coverage, resulting in a higher ratio of spending on medical care. In fact, documents provided by the insurer to the National Association of Insurance Commissioners and released by the subcommittee showed that 2009 enrollment *rose* by 7 %.

- The hearing also exposed the use of premium increases to pay high executive salaries – the company paid 39 executives over $1 million in 2009 – and $27 million over two years spent on executive retreats in often luxury resorts.[23]

After these details were revealed, Anthem "voluntarily" cut its requested increase to a maximum of 20% and average of 14%.[24]

This finding of substantial errors, misrepresentation and excessive spending was a clear indicator of the need for more thorough rate review. The next round of rate filings by Anthem and other insurers in California repeated the cycle. Only unrelenting scrutiny by California's insurance commissioner, and a public angry enough to take their outrage to the streets, created enough public pressure to reduce or delay some increases. Still, health insurers are refusing to budge on most increases. The California Department of Managed Health Care, which is responsible for regulating HMOs, found a May 1, 2011 Anthem Blue Cross rate hike to be "unreasonable" but could only "express our

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[22] Axene Health Partners, "Review Of Anthem Blue Cross 2010 Rate Increases" for California Department of Insurance, Apr. 4, 2010. http://www.insurance.ca.gov/0400-news/0100-press-releases/2010/upload/AnthemActuarialReview.pdf

[23] Consumer Watchdog letter to Insurance Commissioner Steve Poizner, Apr. 19, 2010. http://www.consumerwatchdog.org/resources/PoiznerAnthemRateLetter.pdf
Copies of the e-mails: http://democrats.energycommerce.house.gov/index.php?q=hearing/premium-increases-by-anthem-blue-cross-in-the-individual-health-insurance-market

[24] Tom Murphy, "Health Insurer Now Seeks 14 Pct Calif. Rate Hike," *Associated Press*, July 1, 2010. http://www.consumerwatchdog.org/story/health-insurer-now-seeks-14-pct-calif-rate-hike

disappointment that Anthem Blue Cross didn't lower the rates as we requested."[25] Health insurers will remain free to refuse regulators' requests for delay or review until regulators have full legal authority, and not just a bully pulpit, to require insurers to modify or deny excessive increases.

California's experience, and that of the other states outlined below, makes clear that regulators should be asking more questions about health insurers' claims.

Prior approval in the states

Pennsylvania regulators, who have more authority than those in California, report that they analyze insurers' assumptions about future losses and often dispute them. As described in a 2010 survey of state health insurance regulation by the Kaiser Family Foundation:

> "In Pennsylvania, if a carrier proposes a rate increase of any kind, particularly if it is over 10%, actuaries on staff reportedly 'pore through the data, and often request additional data.' According to the staff, more often than not, the Department's actuaries come to different conclusions than the plan's actuaries. The staff noted, *'insurers usually pad what they're asking for. We know it and they know we know it.'* [emphasis added] Thus, when the Department demands a reduction, the carriers generally don't dispute the state's conclusions."[26]

A combination of tough prior approval laws, expert analysis, and the will to act is necessary to keep health insurers fully honest in their rate filings. No state is there yet. The states have widely differing laws regarding health insurance rate review and regulation.

The Kaiser Family Foundation reports that 34 states and the District of Columbia have prior approval authority over some portion of the individual and small group markets.[27] The National Conference of State Legislatures, however, reports that there are 26 states with prior approval laws.[28] The lack of agreement seems to be primarily in how prior approval is defined, but indicates the range of strength in state regulation.

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[25] California Department of Managed Health Care, news release, Apr. 29, 2011. http://www.dmhc.ca.gov/library/reports/news/prabcrates042911.pdf

[26] Prof. Sabrina Corlette, Georgetown University Health Policy Institute, and Janet Lundy, Kaiser Family Foundation, "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable." Dec. 2, 2010. Accessed via KFF website: http://www.kff.org/healthreform/8122.cfm

[27] Ibid.

[28] National Conference of State Legislatures, "State Approval of Health Insurance Increases," Mar. 2011 online update. Accessed on 4/25/2011. http://ncsl.org/default.aspx?tabid=19787

Adding further confusion, even nominal authority to regulate rates does not necessarily produce meaningful oversight.

Many states are limited to regulating only the individual or small business market, or oversight may be limited by type of company, for instance just HMOs or just nonprofit insurers such as Blue Shield and some Blue Cross companies.

Many states suffer from a lack of resources, staff, or political inclination to conduct strong oversight. In 2009, 22 states had just one licensed life and health insurance actuary or a part-timer, on staff or under contract, according to the National Association of Insurance Commissioners.[29] These numbers have likely increased somewhat since enactment of the Affordable Care Act, and distribution of grants by the Department of Health and Human Services to reinforce state regulators.

Caveats and loopholes may also allow major insurers to escape oversight. Maine, for instance, exercises strong prior approval regulation in the individual market, but state law allows any company that agrees to meet a target 78% medical loss ratio to avoid prior approval of small group rate filings.[30] If rates are later found to have missed the target, refunds are ordered. However, the lack of prior review and approval means that assumptions made by insurers about future costs do not get the same scrutiny as other rate filings, and refunds come too late for those forced to drop their insurance because of a substantial premium increase.

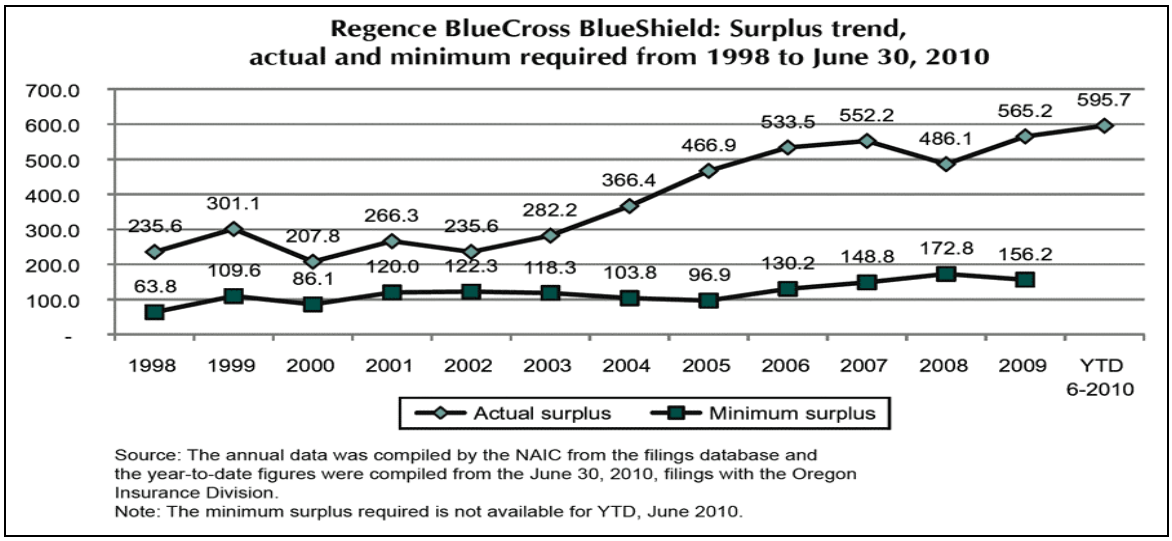
In a promising trend for consumers, several states are moving to improve their laws, their enforcement, or both.

Oregon: **Bolstering Prior Approval.** Insurance Division Administrator Teresa Miller rolled back increases by Regence BlueCross BlueShield in the individual market from 16% to 12%, in December 2010, ordering the insurer to dip into its surplus if needed. Her department had already reduced four other proposed rate requests since September, wielding new prior approval tools approved by the state legislature in 2009 that allow consideration of excess surplus and overall corporate profit. Since 2008, Oregon has reduced requested rate increases by BlueCross BlueShield, the largest insurer in the state's individual market, by an average of more than 25%.[31] Miller stated of the BCBS

[29] National Association of Insurance Commissioners, "2009 Insurance Department Resource Report."
[30] Maine Office of Policy and Legal Analysis, "Overview of Maine Health Care Laws," May 20, 2010, slide 7. www.maine.gov/legis/opla/OverviewofMaineHealthCoverLaws.ppt
[31] Chart prepared by Consumer Watchdog from data provided by the Oregon Insurance Division. http://www.consumerwatchdog.org/resources/regenceor.pdf

order: "[B]ecause you have a surplus and because you are more profitable overall, we're going to give consumers a little break in these markets."[32]

Oregon insurers warned that if they took losses in their individual policies, no matter how flush the company is overall, it could put their stability at risk. Insurers must maintain a mandatory surplus in every state. Regence's surplus is, at $594.7 million, nearly four times the state requirement and continuing to rise, even as the mandatory minimum has decreased due to the insurer's shrinking customer base. (See below)



Credit: Oregon Insurance Division, 2011 health insurer report

Miller stated:

> "During this tough economy, we pared back some rate requests knowing that insurers were losing money and would be relying on surplus to cover the losses. However, I think insurer surplus levels show that we have done so without undermining any company's stability."[33]

Maine: Attention To Insurers' Overall Financial Strength. Maine regulators also consider insurers' overall financial strength as they examine rate increases, including contributions to surplus and profit.

[32] Brent Huntsberger, "Oregon pushes back on insurance rate increases," *The Oregonian* newspaper and website, as modified Dec. 11, 2010.
http://www.oregonlive.com/business/index.ssf/2010/12/oregon_pushes_back_on_insuranc.html
[33] Statement by Teresa Miller to Consumer Watchdog, Feb. 1, 2010

Maine Insurance Superintendent Mila Kofman required Anthem Blue Cross to reduce a proposed 2009 rate increase from an average 18.5% to an average 10.9%, saving over 12,000 individual policyholders approximately $5.4 million on a year's premium.[34]

Kofman found that Anthem's projected claims trend was inflated, and that the "extreme financial health of the company" and the severe state of the economy merited a rate with a profit margin of zero and no contribution to surplus:

> "The large number of policyholders who testified at the public hearings and sent written comments provides ample evidence of the first point and Anthem's financial statements provide ample evidence of the second. Under these circumstances, it is reasonable to allow no profit and risk margin this year. While a break-even rate would not contribute further to the company's surplus, it would not be a drain either."[35]

Maine law prohibits a rate that is excessive, inadequate or unfairly discriminatory. Anthem appealed the decision, arguing that that a profit margin of zero was inadequate, and that the superintendent was not allowed to consider the company's overall financial health when reviewing individual market rates. The court rejected Anthem's arguments, finding that the law's requirement that rates be adequate: "relates to the ability of a rate to sustain projected losses and expenses such that the insurer can meet its obligations vis-à-vis its insureds. It does not, however, expressly entitle insurers to a mandated profit margin."[36]

New York: **Restoring Regulations That Work**. After a decade and a half of insurer self-regulation with no prior review or approval of rates, New York was experiencing crushing rates and increases.[37] In June 2010, at the request of the governor, the state legislature restored the prior review and approval law. Prior to its repeal in 1995, the law had trimmed requested rates by an average of 25%. While the current prior approval regime is quite new, it is already having a significant impact. In a statement issued Oct. 21, 2010, state Insurance Superintendent James Wrynn stated that new rate

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[34] Calculation by Maine Bureau of Insurance life and health actuary Richard Diamond.

[35] Maine Bureau of Insurance Decision and Order, May 18, 2009. http://www.maine.gov/pfr/insurance/hearing_decisions/09-1000.htm

[36] Maine Superior Court Order on Appeal, Apr. 21, 2010. http://www.maine.gov/pfr/insurance/bluecross_anthem/2009_rate_filing/pdf/saufley_appeal_dismissed_04212011.pdf

[37] New York State Insurance Department report, "The Price of Deregulation," June 8, 2009. http://www.ins.state.ny.us/press/2009/p0906081.htm

requests were reduced by an average 2.5 percentage points—roughly a one-fourth average cut, potentially saving New Yorkers hundreds of millions of dollars.[38]

Even the requested rate increases in New York were well below the double-digit rate spikes seen in states like less-regulated California, according to a chart of requested and approved rates issued by the New York superintendent's office. Most of the 33 requested increases listed were in the single digits, with only three over 20%. The highest of the approved increases was 20%, reduced from 34.5% and affecting less than 2% of members in one HMO plan type.[39]

New York is also a state with a "take-all-comers" law that prohibits insurance companies from denying coverage or charging patients more on the basis of health. The state is often invoked to make the case that an insurance mandate is necessary to lower premiums by bringing healthier people into the system and countering the influx of unhealthy patients that a take-all-comers law is supposed to attract. Instead, Massachusetts, with both a take-all-comers law *and* an individual mandate, has higher premiums than New York State.[40] Mandate or no, New York and Massachusetts have experienced escalating premiums and health care costs, and both states have turned to rate regulation to help rein these costs in.

Connecticut: Without Public Participation, Regulators May Shirk. Even in states with prior approval capacity, regulators do not always exercise their full powers to protect consumers. The disparate treatment of two recent rate increases by the same company in Connecticut illustrates the variability of enforcement, due to resource shortages, political pressure or both.

Connecticut's insurance regulations include prior review and approval of rate increases in the individual market and for some small groups. That regulation was in force when Anthem Blue Cross tried to hike rates twice in late 2010 for different policy groups.

Connecticut Anthem Blue Cross Rate Hike No. 1

The company proposed a rate hike of up to 47% on individual plans meeting all requirements of the Affordable Care Act for coverage. The Connecticut insurance commissioner approved the request in mid-October 2010 without a public hearing and over the strong objections of then-Attorney General Richard Blumenthal, who said Anthem failed to justify the increase.

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[38] News release, New York State Insurance Department, Oct. 21, 2010. http://www.ins.state.ny.us/press/2010/p1010211.htm

[39] New York state Department of Insurance, chart of requested and approved rates through September 2010. http://www.ins.state.ny.us/press/2010/p101021rates.pdf

[40] Kaiser Family Foundation, StateHealthFacts.org, Average Premiums by State as accessed Feb. 8, 2011: http://statehealthfacts.org/comparetable.jsp?typ=4&ind=270&cat=5&sub=67

Blumenthal had found that:[41]

- Anthem submitted no documentation explaining its cost projections;
- The Insurance Department failed to examine Anthem's profitability;
- Anthem refused to report or document its medical loss ratio.

The insurance commissioner refused to revisit the rate, accepting Anthem's argument that the increases were largely due to new protections in the federal health reform law, despite much lower cost estimates for those requirements by both government and most of the health insurance industry.

In early November the insurance commissioner – a longtime former insurance industry executive – resigned in the face of stiff criticism and was replaced by an interim commissioner from the office's professional staff.

Connecticut Anthem Blue Cross Rate Hike No. 2

In November, under the interim commissioner, Anthem Blue Cross proposed a rate increase of up to 20% on individual plans that were "grandfathered in" after passage of the Affordable Care Act, despite not meeting all coverage requirements.

The Insurance Department held public hearings, examined the rate filing and rejected the entire rate increase. The commissioner found that Anthem's projected claims-cost trend was excessive, and that no increase was justified, saying "…the current rates are actuarially sound, and are adequate, not excessive and not unfairly discriminatory in accordance with [the law]."[42]

Just one change, a new commissioner, made a major difference in the manner in which the two rate requests were examined. Since this episode, some state legislators have come out in favor of electing the insurance commissioner, who is currently appointed by the governor, and other proposals to strengthen rate regulation.

These greatly different outcomes illustrate that simple prior approval authority isn't enough to ensure consumers are protected. States also need detailed standards that regulators must follow when determining whether a rate is excessive; and consumers must have the right to act when regulators do not. Both are hallmarks of California's model prior approval insurance regulation law, Proposition 103.

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[41] Letter from Attorney General Richard Blumenthal to Insurance Commissioner Thomas Sullivan, Oct. 6, 2010.
http://blogs.courant.com/connecticut_insurance/Blumenthal%20Letter%20To%20Sullivan%2C%20Rate%20Hikes%2C%20Oct.%206%2C%202010.pdf

[42] State of Connecticut Insurance Department, Order In the Matter of: The Proposed Rate Increase Application of Anthem Blue Cross and Blue Shield, Dec. 3, 2010.

Section 3. A Model for Health Insurance Regulation

While Massachusetts scrambles to strengthen rate regulation and other states seek to bolster both regulatory laws and enforcement, a model that comes from outside the health insurance market may provide the most effective framework for both protecting consumers and preserving competitive markets. The framework of California's Proposition 103 can be translated by the states to provide the same protection for health insurance consumers it has given drivers, homeowners and doctors in California.

Part I. History of Proposition 103

California's rate regulation law for the property and casualty insurance markets was enacted in circumstances very similar to those we find in the national health insurance market today. It was 1988, and California had substantially toughened its mandatory auto insurance law without requiring that premiums be affordable. Rates were rising painfully every year.[43] Consumer advocate Harvey Rosenfield presented rebellion-minded voters with a ballot measure known as Proposition 103 to lower their premiums. It passed in November despite a then-record $80-million industry campaign in opposition, and went into effect in 1989.

The new law covered most property and casualty insurance and:

- Called for an immediate 20% rollback of unjustified rate increases;
- Required the state insurance commissioner to review all rate increases (or decreases) and prohibited any rate change without Commissioner approval;
- Allowed the commissioner to modify or deny a rate change altogether if it did not comply with Proposition 103;
- Funded consumer challenges to rates when regulatory enforcement fell short.[44]

Insurers threatened to flee the California market if Proposition 103 passed, and opponents warned that a 20% rate cut would be economically crippling (similar to the complaints expressed today by health insurers who assert that they cannot meet new medical loss ratio requirements without the collapse of the individual insurance market).[45] Of course, the sky did not fall. Instead, California's auto insurance market

[43] Between 1985 and 1986, auto insurance premiums in California increased by 22%. See Harvey Rosenfield, "Auto Insurance: Crisis and Reform," *University of Memphis Law Review*, Fall 1998.
[44] The text of Proposition 103 as passed and later amended is at http://www.consumerwatchdog.org/resources/prop103.pdf
[45] "Prop 103 is built on the notion that the price of auto insurance can be rolled back by a third or more without taking any steps to reduce the cost of providing it. It starts with a decree that rates be cut to a level 20 percent below that of November 1987. … If the rollbacks take effect, the California Insurance

became more competitive and more profitable than the national average, while saving consumers billions on their insurance premiums.

Part II. Success of Proposition 103

A 2008 study by the Consumer Federation of America found that:

- California is the fourth most competitive auto insurance market in the nation, as measured by the widely used Herfindahl-Hirshman Index;
- California auto insurers retained healthy profitability, averaging 10.1% net profit over 10 years ending in 2006. [46]

Yet consumers also benefited dramatically from Proposition 103:

- California drivers saved $61.8 billion in auto insurance rates between 1989 and 2006, an average of $1670 per Californian;
- California is first among all states in holding down auto insurance premiums, with a 3.8% increase compared to an average national increase of 42.9% through 2008;[47] and,
- While California auto insurance premiums were the third highest in the nation and far above the national average premium in 1989, the state fell to the 20th ranking by 2008 with premiums below the national average.

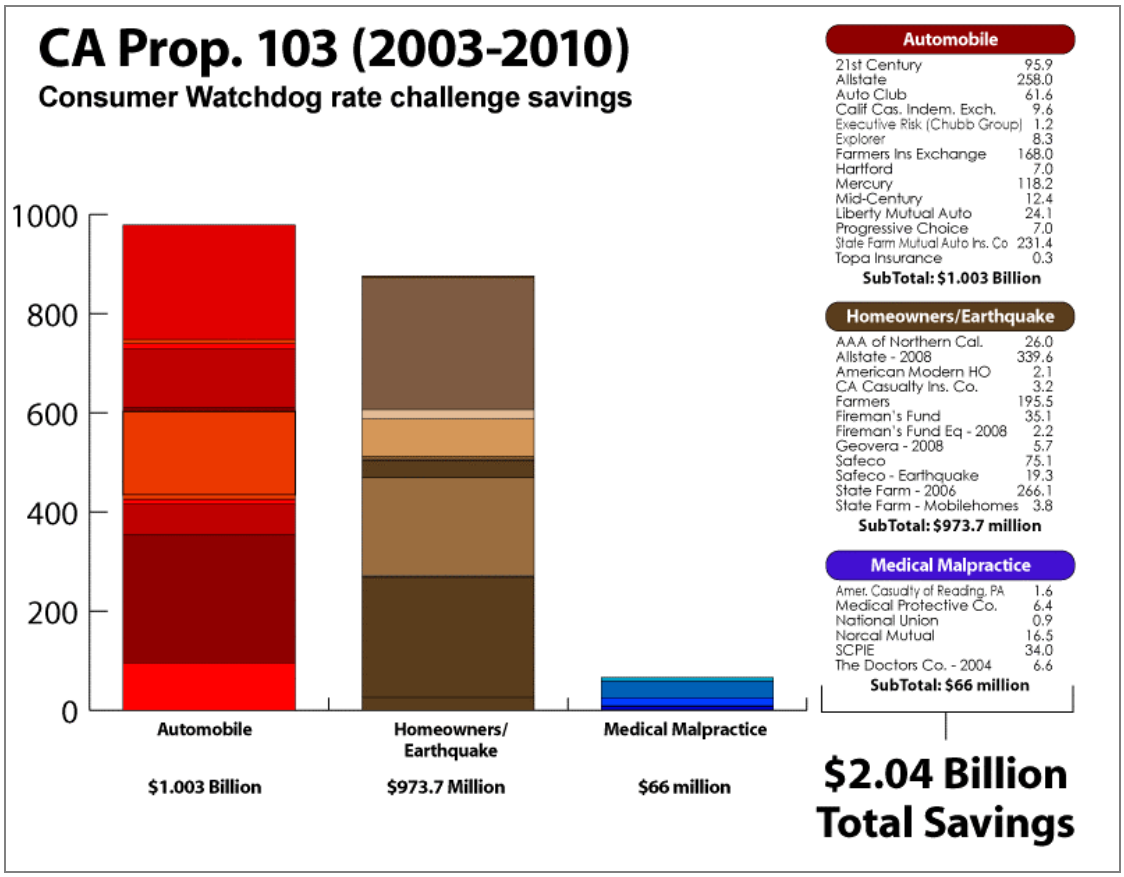
Consumer Watchdog's rate challenges using Proposition 103's public participation process resulted in more than $2 billion in savings for auto, homeowners and medical malpractice policyholders from 2003 to 2010.[48] (See below)

Department has estimated that five of the state's ten biggest property/casualty insurers will become insolvent, with 35 firms underwater by the end of the first two years." Scott Harrington, U. of South Carolina; Walter Olson, Manhattan Institute, for Manhattan Institute, Feb. 13, 1989. http://www.manhattan-institute.org/html/cjm_13.htm#canute

[46] J. Robert Hunter for the Consumer Federation of America, "State Automobile Insurance Regulation: A National Quality Assessment and In-Depth Review of California's Uniquely Effective Regulatory System," Apr. 2008. http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/state_auto_insurance_report.pdf

[47] Consumer Federation, op.cit., updated with NAIC Auto Insurance Database Report 2007/2008, "Average Premiums and Expenditures," p.26.

[48] Consumer Watchdog, "Rate Proceedings Pending and Completed." Accessed on 2/8/2011. http://www.consumerwatchdog.org/feature/rate-proceedings-chart-pending-and-completed



A sample public rate challenge

Allstate Insurance was required to reduce rates by 28.5% for 1.1 million homeowners in July 2008.[49] The decrease was ordered after the company's initial request for a 12.2% *rate increase*, despite years in which the company paid out less than 50 cents on the premium dollar in claims.[50] Consumer Watchdog used Proposition 103's consumer intervention provisions to join in challenging the request.

Allstate's case for the rate increase included a request for an exception to the Proposition 103 regulation that includes an allowable maximum rate of return. The company argued it would suffer deep financial hardship if required to limit its profits. Consumer Watchdog argued that Allstate's claim of financial hardship was unsubstantiated and improper. The company was required to use the standard ratemaking formula used to calculate rates in California, instead of substituting Allstate's preferred higher rate of return.

[49] News release, California Department of Insurance, July 10, 2008. http://www.insurance.ca.gov/0400-news/0100-press-releases/0070-2008/release070-08.cfm

[50] Dean Calbreath, "Allstate must slash homeowner rates," *San Diego Union-Tribune*, July 11, 2008. http://www.signonsandiego.com/uniontrib/20080711/news_1b11insure.html

The 28.5% rate reduction – an overall 40.7% rate change from the requested 12.2% increase – resulted in $339.6 million in annual savings for affected homeowners.

Exterior cost-control benefits of Proposition 103
While making insurance affordable is a chief goal of prior approval regulation, Proposition 103 also triggered tougher moves by insurance companies to control the root causes of high insurance premiums.

In a poorly regulated environment, the more insurers charge, the more they can invest. There is no incentive to control expenses. Regulation under Proposition 103 ended the cost pass-through mentality pervasive in the insurance industry. Under this 'cost-plus' model of insurance pricing, insurance companies added up their expenses, whatever they were, and tacked on a percentage profit to set the premium. By limiting premiums, Proposition 103 gave insurers a financial incentive to reduce expenses in order to keep as much of the premium in the form of profit as they can.

In particular, insurance companies stepped up anti-fraud efforts and joined consumers and government in more robust highway and auto safety campaigns. Such reforms, aside from their social benefits, helped the insurers retain more profit while reducing premiums.

As the Consumer Federation's 2008 study of the results of Proposition 103 stated:

> "Proposition 103 … renewed insurer efforts to prevent losses. It directly prompted the insurance industry to work with consumer groups in 1989 and 1990 to establish the Advocates for Auto and Highway Safety and the Coalition Against Insurance Fraud. In fact, the establishment of ongoing, institutionalized efforts to hold down loss costs throughout the nation, and particularly in California, is an important legacy of Proposition 103 that has helped insurers maintain profits. …
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> "Two years after Proposition 103 passed, the Los Angeles District Attorney noted that, "until coming under pressure to lower rates under Proposition 103, [insurance] carriers simply settled claims and passed the cost to consumers in the form of higher premiums. 'That has begun to change,' he said. 'Insurance companies are getting serious about fraud.'" A trade publication observed that "low expense ratios [are] a common factor among many of [the] auto insurers that posted underwriting profits. They have avoided expense-hungry products, out-

sourced functions or eliminated the middle man from their operations."[51]

A 2001 study by Dwight Jaffee of the Haas School of Business and Thomas Russell of the Leavey School of Business finds a similar cost-reduction effect from Proposition 103, while acknowledging the scarcity of hard data:

> "At this time, we can only rely on anecdotal evidence, but it is strongly suggestive that auto anti-fraud activities in California have significantly reduced the amount of auto insurance fraud in the last ten years. For example, the largest category of press releases on the web page of California's Department of Insurance refer to cases of auto insurance fraud that have been apprehended. … [I]t is certainly plausible that Proposition 103 may have played a role here.
>
> "In addition to the possible effect in controlling fraud, Proposition 103 may also have contributed to an across the board cost cutting exercise within the insurance industry. Faced with a *de facto* freeze on premiums, the control of costs became essential to the preservation of profits. As Table 5 shows, underwriting expenses decline sharply in relative terms between 1990 and 1998."[52]

Similar efforts to control costs and external fraud would be expected from health insurers under regulation based on Proposition 103. Massachusetts, which has begun strengthening prior review of health insurance rates, is already seeing stronger, broader efforts by insurers to hold down hospital and health services provider costs.[53]

Part III. Proposition 103 methods and their application to health insurance

California's Proposition 103 is the strongest example of prior approval rate regulation in the nation, employing every key consumer safeguard while encouraging a profitable and competitive insurance market.

The success of prior approval under Proposition 103 stems from the clear standards regulators and insurers must follow when setting rates, and the ability of consumers to

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[51] Op.Cit., Consumer Federation, page 48. Original citations: Lois Timnick, "51 to Face Charges in Auto Insurance Fraud Roundup," L.A. Times, Oct. 18, 1990, at B4. Richard Yingling, "Rebuilding Crumbling Loyalties," Best's Review., Sept. 1, 1990, at 57, 59.

[52] Dwight M. Jaffee, Haas School of Business, University of California; and Thomas Russell, Leavey School of Business, Santa Clara University. "The regulation of Auto Insurance in California," April 2001, pp33, 49 (table). The authors also note that while auto premium costs cooled under regulation, insurers' rate of return was stable or rising over the 10 years after Proposition 103 went into effect (p. 31). http://faculty.haas.berkeley.edu/jaffee/Papers/Auto2.pdf

[53] Op.Cit., "Patrick unveils health overhaul," *Boston Globe*.

ensure both regulators and insurers hold to those standards. Many of these provisions have been proposed in various states where regulators, faced with spiraling health insurance premiums, are seeking new tools to examine and evaluate rates.

The provisions of Proposition 103's prior approval law follow, with bullet points to highlight their applicability to health insurance and moves by states to implement similar provisions.

Prior Approval

Insurance commissioner must approve rates before they take effect. A rate may not take effect or remain in effect that is excessive, inadequate or unfairly discriminatory.

- This most basic standard for prior approval is already found in the health insurance regulations of many states including Connecticut, Indiana, Minnesota, New York and New Jersey.
- However, a regulator with the statutory authority to reject excessive rates may not necessarily exercise that authority. Proposition 103's other requirements make it hard for regulators to avoid that responsibility.

Insurer must submit rate proposal for review at least 60 days in advance. A minimum 60-day period is necessary to ensure regulators have adequate time to review rate filings.

- A 60- to 90-day review period is already the standard for health insurance rate filings in several states.

Standards for Setting Rates

An overall goal for administrative expenses is set at the industry average, rewarding insurers that operate more efficiently with a higher rate of return. Expenses in excess of the average cannot be included in the rate, giving insurers an incentive to reduce costs.

- The federal Affordable Care Act includes a related "medical loss ratio" rule that requires health insurers to limit non-health care spending to 15% - 20% of premiums. However, in the absence of prior approval, the rule creates a reverse incentive for insurance companies to *increase* health spending, in order to increase the dollar value of the percentage they are able to keep in profits. By directly examining administrative and overhead costs, the Proposition 103 model provides the correct incentive—it rewards proven efficiency.

Amount of executive salaries that insurers can include in a rate is limited by a formula based on company size. The law puts no numeric or percentage cap on top salaries, but prohibits using consumer premiums to pay salaries in excess of the formula.

- The total CEO compensation for 10 health insurers came to $228 million in 2009, excluding stock options. Most of that amount went to the CEOs of Aetna, Cigna, Conventry Health Care, Humana, United Health Group and Wellpoint. The CEO of United Health Group also reaped more than $100 million from the sale of stock options. From 2000 to 2009, total CEO compensation for the same top 10 insurers totaled nearly $1 billion.[54] While regulation would not directly prohibit this sort of executive bloat, insurance companies that chose to continue offering such outsized salaries would have to pay out of their regulated profit instead of passing the whole cost on to ratepayers.

Limits the rate of return. The insurer's rate of return on premiums is capped at the rate paid by certain federal bonds plus a percentage. California auto insurers' profitability from 1997 to 2006 averaged 10.1%, above the national average.

Insurers are forbidden from passing on to consumers any of the costs of:
Lobbying expenditures
Political contributions

- Lobbying and political contributions by the health insurance industry also have grown exponentially during the last decade, making them a more prominent expense item.[55]

Fines or penalties, and bad faith damage awards

- For example, this would prohibit health insurers from passing on the cost of judgments in cases where the insurer is found to have wrongfully denied a covered treatment or benefit.

Some advertising and marketing

Such exclusions increase consumers' perception of fairness.

Funded Public Participation

The public has the right to challenge any rate.

The Insurance Commissioner must hold a hearing when a member of the public files a formal petition and the rate change is 7% or more for personal insurance or 15% or more for commercial insurance. Mandatory hearings when the rate change meets a certain threshold are important to keep regulators accountable, even if they are not

[54] Health Care for America Now, "Breaking the Bank," April 2010. http://healthcareforamericanow.org/ceosbreakbanks

[55] Data on OpenSecrets.org, maintained by the Center for Responsive Politics, show that the insurance industry as a whole more than doubled lobbying expenses since 2000, from $75.7 in 2000 to $164.4 million in 2009. Blue Cross Blue Shield alone spent $15.1 million on lobbying in 2009, double its spending in 2000. http://www.opensecrets.org/lobby/indusclient.php?year=2000&lname=F09&id

inclined to challenge the insurance industry.

- Mandatory hearings on health insurance rates, often triggered by a certain percentage increase, are already required in some states including Iowa,[56] Maine, and Rhode Island.[57] Others hold hearings on a voluntary basis or at the request of policyholders.

While transparency and voluntary public participation are highly desirable, it is the *funded* public intervention authorized by Proposition 103 that makes it steadily effective. The intervenor serves as a counterbalance on state regulators, when insurance departments have few resources or fail to adequately scrutinize insurers' claims. Funding for public intervenors ensures consumers have professional actuaries and experts to represent their interests.

Any member of the public who participates in a rate challenge may seek compensation for reasonable advocacy and witness fees.
Fees are awarded if the person represents the interests of consumers and makes a substantial contribution to the resulting rate order. In such cases, fees are paid by the insurance company whose rates are at issue.

Few intervenors in other states
No state other than California has a stably funded system for consumer intervention in property and casualty insurance rate proceedings, allowing the public to initiate a rate challenge on behalf of consumers. (Several states allow public intervention in utility rate proceedings.)

Just one state has established an official consumer intervention system for health insurance rate proceedings.

- Maine allows consumer advocates to apply for full intervenor status in rate hearings. Such participation was first funded in 2010, when the state announced it would make $200,000 in federal rate review grant funds available to qualified consumer groups or other potential public intervenors.[58] The status of funding in future years is undetermined.

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[56] Hawkeye.org, "Public invited to weigh in on health insurance rate increases," Jan. 6, 2011. http://www.thehawkeye.com/story/insurance-hearing-010611

[57] Lund Report, Legislators Hear From Other States on Regulating Insurance Rates, Feb. 10, 2011. http://www.thelundreport.com/resource/legislators_hear_from_other_states_on_regulating_insurance_rates?quicktabs_1=1

[58] Maine Bureau of Insurance, "A Consumer Advocate's Guide to the Rate Review Process," Jan. 2011. Accessed on 3/2/2011. http://www.maine.gov/pfr/insurance/consumer/Consumer_Advocate_guide_to_rate_review_Jan2011.htm

- Other states limit consumer participation to varying degrees of public comment. Oregon, for example, awarded a single consumer advocacy organization a one-year $100,000 grant of federal funds in 2010 to provide expert analysis of rate filings and increase consumer participation. The organization, however, will have no legal standing in rate proceedings. In other states, public participation amounts to little more than an email address where consumers may complain about rate hikes.

As noted above, public interventions by Consumer Watchdog alone have saved California property and casualty insurance customers more than $2 billion since 2003. Public intervention is the single feature of insurance regulation that ensures the effectiveness of regulators in varying political climates. While public hearings and appointed consumer advocates are helpful to regulators, only intervenors who have the opportunity to be reimbursed can afford the time, and hire the experts necessary, to ensure enforcement of health insurance regulation. The mere presence of public interest experts who can take a second look at insurers' rate filings is likely to result in more reasonable rate requests in the first place.

Many of the above elements have been tried individually in various states. However, no state has implemented comprehensive rate oversight on the Proposition 103 model for health insurance.

Section 4. Federal Health Reform Does Not Regulate Rates

The federal health reform law's only two provisions addressing what health insurers may charge are: A requirement for states or the Department of Health and Human Services (HHS) to review, not approve, "unreasonable" rate increases; and, A rule that health insurers spend 80% or 85% of premiums on medical care and health quality improvements rather than administrative costs or profits.

The Affordable Care Act contains no authority for the states or HHS to modify or deny rate changes, and creates no formal role for consumers to participate in the rate review process. Its provisions fall far short of the strong oversight necessary to keep insurance companies honest and premium increases fair.

Review of "unreasonable" rates

The federal law requires states or HHS to review "unreasonable" rate increases, and requires health insurance companies to publicly justify these increases. Draft regulations issued by HHS in December 2010 would require any increase of 10% or greater to be reviewed, and would require each of these increases be publicly justified by the insurer.

In theory, review and justification of rates would allow the public and regulators to scrutinize any questionable increase, and the specter of public embarrassment would pressure insurers to lower unjustified rate hikes. The draft regulation issued by HHS in December falls short of this mark. The regulation limits review to increases of 10% or higher. Any increase of 9.9% or less would not be reviewed (unless state law otherwise requires review), in effect certifying any increase below 10% as reasonable. Importantly, in cases where a review is conducted by HHS, the department would disclose the detailed rate data necessary for the public to determine if rates are fair. However, if states conduct the review, the regulation allows states to choose to keep detailed rate data confidential. This lack of transparency, and a too-narrow scope for review, will diminish any pressure insurers might otherwise feel to modify unreasonable rates. In any case, shame is not sufficient to modify even egregious rate increases. For instance, California's Department of Managed Health Care has asked Blue Shield to "explain" two recent successive rate increases totaling 37.5%, but the rates are already in effect and the department has no power to modify them.[59]

The federal law also gives HHS the authority to issue grants to the states to develop stronger rate review and regulation. Most states have already received $1 million to begin to increase scrutiny of rates and expand consumer participation.

[59] J. Jeffrey, Insurance News Net, April 21, 2011 http://insurancenewsnet.com/article.aspx?id=257162

At least 12 states said in their initial grant applications that they intended to seek new or expanded authority for prior approval rate regulation from state legislatures.[60] These steps toward more robust regulation indicate that some insurance commissioners are stepping up to the plate to protect consumers. At the same time, the politics surrounding the uncertain legal status of the reform law have already led at least one of these states, Florida, to return its rate review grant and announce it is placing all implementation activity, including an expansion of prior approval authority, on hold.

A second round of up to $200 million in rate review grant funding was announced by HHS in February. HHS provides an incentive for states to obtain the power to approve or disapprove rate hikes by setting aside $27.5 million in extra funding for those states.

Medical loss ratio

In an attempt to require health insurers to become more efficient, the health reform law requires insurers to spend 80% to 85% of customers' premiums on medical care or health quality improvements—a percentage known as the "medical loss ratio," or MLR.

Absent strict rate regulation, the medical loss ratio requirement contains a significant flaw: It will perversely encourage insurers to raise their premium rates. In the same way that a Hollywood agent who gets a 20% cut of an actor's salary has an incentive to seek the highest salary, insurers will have a financial incentive to increase health care costs and raise premiums so that their 15% or 20% cut is a larger dollar amount. The medical loss ratio must be applied in conjunction with effective regulation in order to ensure that insurance companies do not unnecessarily raise rates in order to boost profits.

Even then, how effective the regulation is will depend upon how narrowly regulators hold insurers to the requirement that only "clinical services" and "health care quality activities" be considered health care. In the interim final regulation on medical loss ratios issued by HHS, insurers were able to successfully redefine as health quality improvements some costs that are traditionally considered administrative, claims adjustment or cost-reduction activities, including: advertising that purports to have a public health purpose but is primarily marketing; accreditation fees that primarily assess the quality of a health plan, not health care; prospective utilization review that insurers may use to pay bureaucrats to deny treatment; and, hotlines that may mix basic medical advice with measures to restrict or delay doctor visits.[61]

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[60] Survey of final grant applications to HHS by Carmen Balber, Washington director of Consumer Watchdog.

[61] Consumer Watchdog, "HHS Final Rules on Medical Loss Ratio Remain Tilted in Insurers' Favor," news release, Nov. 22, 2210. http://www.consumerwatchdog.org/newsrelease/hhs-final-rules-medical-loss-ratio-remain-tilted-insurers-favor-says-consumer-watchdog

Insurers also gained the right to exclude most state and federal tax payments from the MLR calculation, a victory that allows them to spend more on the administrative and profit side of the equation. This allowance was included in the interim final regulation despite objections by members of Congress who said it was not the intended outcome of the law. According to a report for Anthem Blue Cross of California by an outside actuary, the combined effect of the tax deduction and new "quality improvements" in the medical spending category will be a four percent boost in the medical loss ratio. So an insurance company that previously had a 76% MLR on individual policies (and would owe policyholders a 4% premium rebate) would magically jump to an 80% MLR and owe no rebate.[62]

An ongoing threat to the rule is an effort by insurance brokers and independent agents to remove their fees from the administrative portion of the medical loss ratio calculation. The plan could add several more "free" percentage points to the MLR for most insurers. This would demolish the provision's limit on insurance company administrative costs, raise health insurance premiums, and eliminate millions in rebates insurers would otherwise owe to consumers.

[62] Report Prepared By Actuarial Services & Financial Modeling, Inc. As Requested By Anthem Blue Cross Life and Health Insurance Company Regarding Individual Rates to be Filed with the California Department of Insurance For April 1, 2011 Effective Dates (delayed to June 1, 2011), Feb. 23, 2011.. page 50. Retrieved via California Department of Insurance., www.insurance.ca.gov/0250-insurers/HlthRateFilings/upload/PF00002OAR.pdf

CONCLUSION

Neither consumers, who will soon be required to prove they have health insurance, nor the government, which will be on the hook to subsidize ever-increasing premiums, will be able to keep up with the rate of premium growth that is occurring in the private insurance market. Therefore, the key to the success of federal health reform is ensuring health insurance premiums are affordable.

Massachusetts tells us that an individual purchase mandate alone will not lower premiums. This report has shown that effective prior approval regulation of rates can successfully hold insurance companies accountable and prevent excessive premium increases.

States should enact, and Congress and HHS should encourage, stronger rate regulation
The states have long been responsible for insurance regulation. State regulators are more in touch with conditions and benefit guarantees in their own states and can be far more responsive to consumer complaints and changes in local markets than a federal regulator could be.

Aside from the difficulty of developing federal regulation applicable to states as different as North Dakota and New York, any federal scheme carries a strong risk of ending up as a lowest common denominator that drives down stronger state protections, or at best an average of the current level of regulation.

A thorough analysis from the Georgetown University Health Policy Institute of three bills introduced in Congress in 2005 found that federal regulatory proposals would cut back or eliminate benefit guarantees, cause economic distortions and adverse selection in insurance markets and leave consumers with little or no recourse in the event of abuses and treatment denials by insurers headquartered in a distant state.[63] The study focused on states' benefit requirements, however its conclusion that federal regulation would tend to be distant and downgrade consumer protections applies equally to rate regulation.

While far from perfect, state control remains a more practical and flexible system of health insurance regulation.

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[63] Mila Kofman, J.D. and Karen Pollitz, M.P.P, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," April 2006 for Georgetown University Health Policy Institute.
http://www.consumerwatchdog.org/resources/healthinsurancereportkofmanandpollitz-95.pdf

Skyrocketing premium increases have prompted an outpouring of consumer complaints to state insurance departments. These complaints have inspired state regulators to strengthen rate review, some of whom have invoked regulatory powers that have been on the books but dormant for decades. Other state legislatures have approved laws to expand regulation and consumer participation, including New Mexico and New York, or are considering legislation, including California and Connecticut.

The federal health reform law's requirement that every individual have health insurance is certain to add to the public pressure for states to develop prior approval laws and strengthen enforcement of existing statutes. The law's rate review requirement may also spur stronger state regulation because it allows the Department of Health and Human Services (HHS) to take over review of unreasonable rates in those states with minimal or no oversight. HHS can use the grant process today to encourage prior review and approval of rates, and reward states that implement an effective public intervention and participation process.

Still, some state regulators lack the tools or interest necessary to enact and enforce strong rate regulation. Congress can further encourage this move by directing HHS to intervene in states that fail to institute a minimum level of prior review, authority to modify or reject rate changes, and consumer participation in the rate review process. The White House backed a similar proposal as an amendment to the federal health reform law and should champion such efforts today.

Legislation introduced by Sen. Dianne Feinstein and Rep. Jan Schakowsky in the 112th Congress would give HHS backup authority to reject "excessive, unjustified or unfairly discriminatory" rates in states where insurance commissioners do not have, or are not exercising, that authority.[64] The bill moves regulation in the right direction by pressing states to create their own effective prior approval rate regulation, and creating a system to protect consumers from excessive rates if states fail to act. The bill should also require prior review and approval of all rates, and give consumers the ability to participate in the process.

Finally, if state legislatures and Congress both fail to strengthen rate oversight, citizens in 24 states have the power to take health insurance regulation to the ballot. Proposition 103 was enacted after the state legislature, beholden to the insurance

[64] News release, office of Sen. Feinstein, Jan. 25, 2011. http://feinstein.senate.gov/public/index.cfm?FuseAction=NewsRoom.PressReleases&ContentRecord_id=bf4100ff-5056-8059-765d-85e216cca6d0

industry and its campaign contributions, refused to act on legislative proposals to protect consumers from skyrocketing auto insurance rates. California voters revolted, and Proposition 103 was the result. Citizens in half the nation's states can take the same fight to the ballot to rein in excessive health insurance premium increases.