Trends Before and After the Start of "Unreasonable" Rate Review

As of September 1, 2011, rate increase requests of 10 percent or more are shared with the Center for Consumer Information and Insurance Oversight (CCIIO), which is a part of DHHS, as part of the "unreasonable" rate review program.[37] In addition to being reviewed by state or federal regulators, these filings are made available to the public through an online portal (healthcare.gov). We used the data collected from this study to compare rate increases and approval rates during the times periods before and immediately after the implementation of reasonable rate review.

We analyzed all the filings in our study that had rate modifications to see if filings that met the threshold for public disclosure, with a proposed rate increase of 10 percent or more, were subject to a larger percentage of modifications by state regulators than those that did not. While in general, larger requested rate increases should be more likely to be modified because they will draw greater scrutiny, the public disclosure of the larger-magnitude rate filings may cause carriers and regulators to treat publicly-disclosed filings differently. Of course an increase in reviews and modifications by state regulators may also be due to increased regulatory activity overall, as funded by the Cycle I and II rate review grants (also described in the Introduction) or by other factors not addressed in our analysis.

In the individual market (Table 36), filings with a requested increase of greater than 10 percent in both 2011 and 2012 were modified significantly more often than those with a requested rate increase of less than 10 percent. In 2011, 34.5 percent of filings with requested rates above 10 percent were modified, compared to only 18.3 percent of requested rates below 10 percent. This difference was even more apparent in 2012, with 42.1 percent of all requested rates above 10 percent modified, compared to only 20.2 percent of requested rates below 10 percent.

Table 36: Percentage of Filings with Rate Modifications, for Filings in which the Proposed Rate Increase was Greater than or Equal to 10%, Individual/Conversion

Requested Rate	SMR 2011	SMR 2012
Less Than 10%	18.3%	20.2%
Greater Than / Equal to 10%	34.5%*	42.1%*

* Estimate is significantly different from filings with a requested rate of less than 10% at $p < .05$.

Calculated based on the subset of filings with complete rate information – both proposed and approved premium increases

[37] As described in this report's Introduction section, reviewed filings are classified as "reasonable" or "unreasonable," although regulators' ability to deny or reduce proposed rates was not affected by the initiative – in some states, carriers may still implement "unreasonable" rate increases.

Limitations

This report presents descriptive analysis of the trends in rate increases in periods before and after ACA rate review, but there is no way of knowing what would happen absent the ACA, as its provisions apply to all states. NORC did not conduct multivariate analyses to test the impact of factors unrelated to the ACA that may affect premium increases.

In both the individual and small group markets, we cannot explain why the number of fillings sometimes fluctuates dramatically from year to year for a given state.

For some data fields in some filings, data were either missing or seemingly implausible. For example, some filings were missing either requested premium increases or approved rate increases; in these cases, we were unable to assess whether state regulators modified the rate originally proposed by the carrier, and so these observations had to be omitted from analysis of that question. In other instances, available data seemed implausible. For example, in some cases the total reported enrollment in multiple filings from the same year by a single carrier summed to a figure much greater than that carrier's entire enrollment listed in the NAIC April Supplemental Report, suggesting that some enrollees may have been double-counted in the filings. Where enrollment data is missing or implausible, the weighting methodology we use employs the data from NAIC on state insurer enrollment in the small group and individual markets to cap the maximum possible weight such filings can receive. From sensitivity testing conducted for a prior ASPE study of similar data, we believe that measures of central tendency in this report are robust to the particulars of the weighting method used.

Another limitation is the comparability of the current study's findings to the findings from the Trends study, as the study sample and data collection methods differed. The current study includes a modified panel of states, with six states that were included in the Trends study sample replaced by five states with publicly available websites. The six states replaced did not have public websites. For each state included in this study, NORC did not extract data for insurers outside of the carrier sample (sampled carriers were either those with at least one percent market share in the state or the five largest carriers, with the more inclusive rule applying, as described in this report's Methods section) for 2011 and 2012, unlike the Trends study. Some fluctuations in the number of filings for individual states may be attributable to the different sampling rules for the Trends study and "State Market Reforms." As a result, the number of fillings sometimes fluctuates dramatically from year to year for a given state, but differences in sampling methods only explain some of the results. For example, data collection efforts for Pennsylvania in the individual market from the Trends study resulted in 16 plan filings in 2008, 30 in 2009, 24 in 2010, and

35 in 2011, with 22 different insurance carriers represented. In comparison, for the current study there were 15 carriers in Pennsylvania's individual market included in the sample, yielding 10 filings in 2011, and 32 in 2012.

Finally, it is important to note that state procedures for posting filings in their public portal and their process for reviewing filings vary, even among states that have the same regulatory authority (file and use or prior approval). For example as noted previously, in some states files on proposed rate increases that are rejected by the regulator are kept open until a compromise rate increase can be arrived at while in other states in response to a rejection from the regulator the carrier may re-file a new rate at a at a later date under a separate tracking number. Although use of the SERFF portal and the SERFF file template did improve the consistency of the information presented in filings, in some cases sections of the template were left blank or could only be found in the correspondence attached to the filing. As such, while the completeness of the filing documentation submitted by carriers has improved since the beginning of the Trends study, the data presented in this report is subject to the limitations of its sources.

Conclusion

In 2011, two provisions of the ACA that relate to the review of health care insurance policy rates went into effect. First, starting at the beginning of the plan year, if carriers in the small group and individual markets had medical loss ratios below 0.80, a provision required carriers to rebate the "excess" to subscribers. Second, beginning on September 1, carriers with premium increases of 10 percent or more in 2011 and 2012 were to submit justification for those increases to state and/or federal regulators. In addition, 35 and 30 states now have prior approval authority in the individual and small group insurance markets, respectively. Prior approval requires insurance department approval before new premium rates go into effect.

To analyze trends in pre- and post-ACA premiums, this study examined publicly available data from 2011 and 2012 and presented findings alongside findings from NORC's earlier study for ASPE, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011." NORC extracted data from 24 states that were included in the Trends study that had public websites, and five additional states that were not included in the Trends study but that had public websites.

In calculating state and national averages, we have used separate weights for the small group and individual markets that reflect enrollment in the plan and carrier. Composite weights for each state are based on the estimated number of persons with coverage in the small group and individual market. Our analyses examine trends in two critical measures – premium increases and approval of rates by state regulators -- in the periods before and after the ACA rate review provisions went into effect.

Our major finding is that premium increases slowed substantially since the time that ACA rate regulations went into effect in 2011 compared to the prior period in the states included in this research. In the Individual market, premium increases fell from 11.7 percent in 2010 to 7.1 percent in 2012. In the small group market, premium increases declined from 8.8 percent in 2010 to 4.8 percent in 2012. In both the individual and small group markets, premium increases for each post-rate review period were lower than for any pre-rate review period.

The slowing of premium increases has two dimensions. First, insurers' requested smaller premium rate increases in both individual and small group markets. Second, regulators reduced requested premiums of insurers more extensively after ACA rate review provisions went into effect. In 2012 state regulators approved about 83.6 percent of rate requests in the individual and 73.2 percent in the small group market, but the average reduction in requested premiums was 12.7 and 23.9 percent respectively. In the pre-rate

review years, data from the Trends study shows rate reductions were never as much as 10 percent in the small group market. In the individual market, rate reductions of 10 percent or more occurred only in 2010. Over the period of the two studies, the number of filings in the study sample grew continuously in the small group market from 124 in 2008 to 569 in 2012. In the individual market the number of filings collected varied significantly from year to year, with 395 found for 2012; these fluctuations occurred on the level of individual states.

Appendix A: Large Carriers and Market Concentration in Each State

Table A1: Market Concentration and Number of Carriers for the Individual Health Insurance Market, by State

State	Number of Carriers in Sample	Largest Carrier (by market share, as a % of premiums)	Market Share - Largest Carrier	Market Share - Top 3 Carriers
High Market Concentration (80% or More of Market Share by Largest Carrier)				
Alabama	5	BCBS of Alabama	88.67%	95.03%
Iowa	5	Wellmark, Inc.	83.23%	91.65%
North Carolina	6	BCBS of North Carolina	82.85%	89.86%
Rhode Island	5	BCBS of Rhode Island	94.71%	98.48%
Medium Market Concentration (50-<80% of Market Share by Largest Carrier)				
Arkansas	6	USAble Mutual Insurance Co. (Arkansas BCBS)	79.07%	91.21%
District of Columbia	8	Group Hospitalization and Med. Svc. (CareFirst, Inc.)	51.06%	78.02%
Illinois	10	Health Care Service Corporation	65.77%	78.17%
Indiana	10	Anthem Insurance Companies, Inc. (WellPoint)	53.57%	78.47%
Kentucky	5	Anthem Health Plans of Kentucky (WellPoint)	79.11%	95.92%
Michigan	11	BCBS of Michigan	53.68%	73.78%
Minnesota	7	BCBS of Minnesota	62.68%	84.37%
Nebraska	6	BCBS of Nebraska	65.56%	87.02%
New Jersey	8	Horizon Healthcare Services, Inc. (BCBS of NJ)	54.86%	80.10%
Oklahoma	9	Health Care Service Corporation	58.64%	75.91%
Virginia	7	Anthem Health Plans of Virginia (WellPoint)	74.73%	86.05%
Low Market Concentration (<50% of Market Share by Largest Carrier)				
California**	9	Anthem Blue Cross (WellPoint)*	48.22%	82.13%
Colorado	12	Rocky Mountain Hosp. and Med. Serv., Inc (WellPoint)	32.01%	52.62%
Connecticut	8	Anthem Health Plans, Inc. (WellPoint)	48.54%	84.17%
Delaware	9	Highmark BCBS of Delaware	46.85%	82.10%
Florida	11	BCBS of Florida	49.20%	70.02%
Kansas	9	BCBS of Kansas	43.76%	75.56%
Maine	5	Anthem Health Plans of Maine (WellPoint)	44.86%	92.45%
Nevada	10	Rocky Mountain Hosp. and Med. Serv., Inc. (WellPoint)	33.57%	67.81%
New York	15	Empire HealthChoice HMO (WellPoint)	17.08%	43.81%
Oregon	9	Regence BCBS of Oregon	35.28%	64.82%
Pennsylvania	15	Highmark, Inc.	31.59%	55.15%
Tennessee	7	TRH Health Insurance Group	36.69%	79.77%
Washington	11	LifeWise Health Plan (Premera Blue Cross)	33.80%	83.04%
Wisconsin	14	Wisconsin Physician Services Ins. Corp.	18.43%	46.14%

Table A2: Market Concentration and Number of Carriers for the Small Group Health Insurance Market, by State

State	Number of licensed carriers	Largest Carrier (by market share, as a % of premiums)	Market Share - Largest Carrier	Market Share - Top 3 Carriers
High Market Concentration (80% or More of Market Share by Largest Carrier)				
Alabama	5	BCBS of Alabama	97.21%	99.58%
Medium Market Concentration (50-<80% of Market Share by Largest Carrier)				
Delaware	5	Highmark BCBS of Delaware	57.11%	87.31%
Illinois	10	Healthcare Service Corporation	54.29%	75.64%
Iowa	10	Wellmark, Inc.	51.77%	77.16%
Kansas	10	BCBS of Kansas	59.23%	74.83%
Kentucky	5	Anthem Health Plans of Kentucky (WellPoint)	71.77%	93.57%
North Carolina	7	BCBS of North Carolina	63.33%	87.68%
Oklahoma	8	HealthCare Services Insurance Corp.	51.76%	73.29%
Rhode Island	5	BCBS of Rhode Island	73.75%	98.16%
Tennessee	7	BCBS of Tennessee	69.37%	84.82%
Low Market Concentration (<50% of Market Share by Largest Carrier)				
California**	12	Kaiser Foundation Health Plan	25.51%	55.79%
Colorado	8	UnitedHealthcare Ins. Co.	29.23%	77.37%
Connecticut	7	Anthem Health Plans,Inc. (WellPoint)	31.00%	70.31%
District of Columbia	8	Group Hosp. and Med. Serv., Inc. (CareFirst)	47.04%	86.91%
Florida	12	UnitedHealthcare Ins. Co.	27.42%	67.97%
Maine	6	Anthem Health Plans of Maine (WellPoint)	49.88%	91.11%
Michigan	14	BCBS of Michigan	38.18%	70.91%
Minnesota	8	BCBS of Minnesota	36.40%	82.39%
Nebraska	9	BCBS of Nebraska	43.07%	80.98%
Nevada	14	Rocky Mountain Hosp. and Med. Serv., Inc. (WellPoint)	23.38%	56.98%
New Jersey	8	Horizon Healthcare (BCBS of New Jersey)	31.00%	69.76%
New York	15	Oxford Health Insurance (UnitedHealth)	22.91%	49.18%
Oregon	8	Regence BCBS of Oregon	21.41%	60.31%
Pennsylvania	11	HM Health Ins. Co. (Highmark)	19.30%	44.09%
Virginia	13	Anthem Health Plans of Virginia (WellPoint)	32.58%	59.38%
Washington	11	Premera Blue Cross	33.15%	68.39%
Wisconsin	21	UnitedHealthcare Ins. Co.	26.85%	46.09%

Appendix B: Number of Filings with a Given Characteristic, by Year and Market

Table B1: Number of Filings by Independent Variable, by Year - Individual/Conversion

Characteristic	SMR 2011	SMR 2012	SMR Total
Total	363	395	758
File and Use	88	62	150
Prior Approval	248	282	530
Other	27	51	78
HMO	82	79	161
PPO/HDP	209	249	458
Indemnity	24	29	53
No Product Type Available	48	38	86
Top 3 Carrier	146	179	325
Other Carrier	217	216	433
Low Concentration States	269	257	526
Medium Concentration States	72	115	187
High Concentration States	22	23	45

Table B2: Number of Filings by Independent Variable, by Year – Small Group

Characteristic	SMR 2011	SMR 2012	SMR Total
Total	327	569	896
File and Use	76	197	273
Prior Approval	209	273	482
Other	42	99	141
HMO	169	246	415
PPO/HDP	122	271	393
Indemnity	9	23	32
No Product Type Available	27	29	56
Top 3 Carrier	143	239	382
Other Carrier	184	330	514
Low Concentration States	253	445	698
Medium Concentration States	69	122	191
High Concentration States	5	2	7