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Arbitrary Rate Review Threshold to Increase Health Costs

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PPACA's New Rate Review Rule

Beginning September 1, 2011, health insurers must submit requests to state or federal reviewers if they wish to increase insurance rates by 10 percent or more. This "rate review" process is required by Section 2794 of the Public Health Service Act (PHSA), which was added to Section 1003 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148.[i]

The final rule was introduced by the Center for Consumer Information and Insurance Oversight (CCIIO), within the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). Specifically, it mandates that "all rate increases that meet or exceed a specified threshold are reviewed by a state or by CMS to determine whether they are unreasonable and that certain rate information be made public."[ii]

The goal of this mandate is to reduce health care costs by addressing the asymmetry of information in the health insurance market between consumers, providers and industry actors. However, despite the stated goals of the mandate, it fails to ultimately address the underlying issues accelerating health care costs.

Key Takeaways

PPACA's Arbitrary Rate Review Threshold

- Health insurers must now submit requests to state or federal reviewers if they wish to increase insurance rates by 10 percent or more.
- Rate Review was designed to reduce health care costs by addressing asymmetry of information in the health insurance market.
- Despite mandate goals, rate review fails to address underlying drivers of health care costs.

Increasing Costs and Limiting Plan Choice

- The 10 percent rate review threshold is expected to activate reviews of one half to three quarters of all rate increases filed.
- The Federal register estimates that the total cost for states and insurers, including paperwork, will exceed $23 million.
- CMS evaluations conclude that 34.8 million enrollees will be subjected to reviews, with approximately 10.6 million in the individual and 24.2 million in the small group markets.
- New personnel, filing and compliance costs, will force health plans to leave the market.

Rate Review Background

Historically, costs associated with US health insurance represent only about four percent of all health care expenditures, including both administrative costs and plan profits.[iii] Therefore, insurance rates are not themselves real determinants of health related costs, but instead reflect other pressures and the underlying cost drivers in the health care sector. Given that total health care expenditures have increased more than the general inflation rate for the past four decades, there is no argument that consumers and policymakers are looking for drastic change.[iv] However, until core causes of higher expenditures are addressed, insurance rate review will not prove to be an effective, long-term tool to lower premiums for individuals and their employers.

Currently, 44 states have some type of state-level rate review process using formulas that account for insurance product category, then adjusted for specific benefit levels, claims experience, contracting costs, individual health status and claims history using actuarial-based science. Despite these well-established review processes, the new 10 percent threshold will automatically subject double-digit increases to additional state or HHS reviews. This not

only removes some state-level autonomy, but unnecessarily adds burdens on the regulatory system that is unwarranted. The new regulation implies that increases in premiums are directly and ultimately tied to a company's desire to maximize profits instead of simply reflecting fundamental health care costs. However, greater transparency and justification for rate increases on company websites will not affect the calculations used, as they are constructed around actuarial science pertaining to a myriad of state-level factors and existing regulation, nor will it change the insurance products chosen by most employers and individuals.

Additionally, by creating an arbitrary threshold that triggers state or federal review, HHS produces an environment that will decrease market competition due to new barriers to entry with increased compliance costs, prompting higher insurance rates for lower quality health insurance plans. The 10 percent threshold implies that larger increases in rates are inappropriate and disregards the uniqueness of each state market; putting health care plans in a position where they must prove their innocence. Moreover, the threshold chosen could lead to a review of the majority of rate increases in the individual market and about 40 percent in the small group market because the threshold was based on inaccurate metrics that often account for measurements that do not directly influence insurance premiums. In contrast to the metrics used by HHS to establish the threshold, a recently published Segal survey that looks at per capita claims (taking price inflation, utilization and new technology into account) estimates that in 2011, trends will show a 12.7 percent increase for fee-for-service, 11.7 percent for high deductible health plans, 11 percent for preferred provider organizations and 10.2 percent for health maintenance organizations.[v] As demonstrated by these average increases, transparency and justification for health-related cost drivers does need to be addressed, but this problem will not be resolved by regulation of insurance rates.

Regulatory Impact on States, Health Plans, and Consumers

The 2010 health reform bill saw significant changes to its statutory language when the PHSA was included. While PPACA vaguely references creating barriers against "excessive or unjustified premium increases," the Public Health Service Act attempts to outline the process that reviews insurance rate increases.[vi] However, even Section 2794 does not actually specify the responsibilities that fall on either HHS or state governments. It briefly, and vaguely, states that HHS will review premium increases "in conjunction with the states" for individual and small group markets. Until now, 14 of the 44 states who have a state review process use a model known as "file and use".[vii] This system requires insurance companies to file their proposed rate increases before the next insurance cycle so that they are posted well before they go into effect. Additionally, 34 states have a "prior approval" process in place that requires insurance companies to file their proposed increases before the increases go into effect.[viii] Furthermore, forcing rate regulation is not necessary in states that have competitive markets, those where no single insurance carrier has a large portion of the market. Therefore, the new legislation does nothing but add red tape and excessive costs to all but six states.

As for added costs, even the Congressional Budget Office (CBO) estimated in 2010 that premiums in the individual and group markets will increase by an average of 10 to 13 percent, solely as a result of new PPACA mandates, regulations and taxes.[ix] Additionally, a Kaiser Family Foundation survey released in June 2010 found that national insurance premium increases in the individual market averaged 20 percent.[x] These data indicate that the 10 percent threshold actually falls below national level trends, bringing into question the meaning of "unreasonable" and why there is no standard stated in PPACA. Additionally, given significant state differences, the justification for a transparent "apples-to-apples" comparison is highly unlikely.

Furthermore, the onerous regulations associated with this law raise issues concerning the federal government's ability to overrule states' rights with regards to the 10th Amendment. Almost all states currently have a rate review process, many of which have been in place for decades. Although many of these processes are not perfect, the federal government, and HHS in particular, should not force a one-size-fits-all policy on all 50 states. States have expertise and experience with their own regulatory environment, insurance market and consumers. Institutional knowledge and reporting ensures that insurance providers are accountable to the state's governors, commissioners and communities. In contrast, PPACA regulations ignore the local market conditions, unique characteristics of the states and local health care utilization patterns that drive rate increases. For example, the average annual premiums in the individual market in Iowa are $2,606 a year, while in New York they are $6,630 a year.[xi] Instead of taking this variation into account or controlling the real cost producers, PPACA regulations will place unnecessary and costly encumbrances on insurers, state governments, the federal government and eventually, consumers.

The 10 percent threshold is expected to activate reviews for one half to three quarters of all rate increases filed.[xii] In addition to burdening the health insurance industry with new federal regulation, the mandate further adds many new administrative costs and responsibilities to states and insurers. Expanding the review process will require states to hire additional specially-trained personnel and outside actuarial professionals or cede their authority to the federal government. This increase in input costs and outsourcing expenses will certainly influence plans willingness to join or remain in the market while new barriers to entry and meeting regulatory compliance standards will eventually decrease the number of firms. This chain of events will prove to negatively impact consumers while failing to address the real drivers of rising health care costs.

Insurance plans, and eventually consumers, will be hit hardest by rate review associated costs. PPACA stipulates that plans must spend at least 80 percent of their premium income for payment of claims for "clinical services" and for activities to improve the quality of care in the small group or individual market.[xiii] The new administrative costs will have to come out of the insurer's pockets, forcing insurers to find additional money previously unbudgeted, affecting all other aspects of the organization and leading to more cost-sharing with consumers and fewer plan choices.

Insurers will also have to face the possibility of leaving the market altogether if the federal government regulations interfere with their ability to innovate and make profits. In 2010 alone Iowa saw a 30 percent reduction in market plan choice due to withdrawal of products. This indicates that current state-imposed regulations are in many cases successfully deterring large price increases, and also that when faced with insolvency, insurance companies will voluntarily leave the market, reducing choices for consumers. A similar rate review process that denied actuarially developed rates has left only two insurers remaining in Maine's individual market, with one insurer having two-thirds of the market share.[xiv]

Figure 1: Estimated Number of Issuers Subject to the Rate Review Requirements by Market

Description	Issuers (Companies) Offering Coverage	Percent of Total	Enrollees (Numbers in Thousands)	Percent of Total
Individual Market	311	74.6	10,603	30.5
Small Group Market	342	82.0	24,189	69.5
Total	417	100	34,792	100

State governments will also see an increase in costs due to the new insurance rate review methods, as most of the 311 insurers in the individual market and 342 insurers in the small group market are highly concentrated in a few states. For states and insurance companies, paperwork alone is projected to add 11,902 hours of work at a cost of $2.3 million. More comprehensive estimates provided by the federal register estimate that the total cost for states and insurers, including paperwork, will be about $23.8 million.[xv] Additionally, CMS evaluations conclude that 34.8 million enrollees will be subjected to reviews, including approximately 10.6 million in the individual markets and 24.2 million in the small group market.[xvi]

The costs associated with rate review regulation for the federal government are estimated to be smaller than those to the states or individual insurers. Nevertheless, the federal register projects the regulation to cost between $0.7 million and $5.9 million.[xvii] In addition to these costs, PPACA has already provided $250 million in federal grants from fiscal years 2010 to 2015 to support expansion of rate review. Given the uncertain language in PPACA and PHSA, no one knows exactly what role the federal government, or more specifically CMS within HHS, will play in the review process. One assured outcome is that administrative costs will come with any involvement, oversight or monitoring. The estimate presently includes paperwork, man hours and additional experts to reevaluate what the companies and states have already reviewed.

Conclusion

State insurance markets are driven by a variety of state-level factors that make a one-size-fits-all federal threshold incapable of evaluating or regulating insurance rate increases. This approach will decrease state autonomy while increasing health insurance related costs for plans, including the state and federal government. Ultimately, though, it is the health care consumers who will suffer most. The federal government's actions of impeding on states' rights will lead to fewer insurance choices in the marketplace, decreased competition and eventually lower quality plans with higher rates without correcting the real price forces in health care.

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