U.S. Department of Health and Human Services

Rate Review Annual Report

September 2014

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Rate Review Annual Report for Calendar Year 2013

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Background

Since its enactment in March 2010, the Affordable Care Act has resulted in the implementation of several critical protections for consumers who purchase health insurance coverage in the individual and small group markets. These protections have brought new levels of transparency and scrutiny to health insurance rates in the individual and small group markets. They include the Rate Review Program, the Rate Review Grant Program, the Medical Loss Ratio (MLR) requirement (also known as the "80/20 rule"), and provisions banning increased rates based on factors like pre-existing conditions or just being a woman. The Rate Review Program requires issuers to submit for review by HHS and/or the relevant state any proposed rate increase of 10 percent or more and to justify that increase. Through the Rate Review Grant Program, the Department of Health and Human Services (HHS) is providing $250 million in grants to states over 5 years to improve their rate review capabilities. The MLR provision requires insurance companies in the individual and small group markets to spend at least 80% of their collected premiums on claims payments and quality improvement activities or make rebates to consumers. The statutory provision addressing rating factors (section 2701 of the Public Health Service Act) prohibits the use of health status and gender as factors to set rates, and limits permissible rating factors to geographic location, single vs. family coverage, age (within a 3 to 1 band), and tobacco use (within a 1.5 to 1 band).

These provisions of the Affordable Care Act took effect at different times. The Rate Review Program began in September 2011. The Rate Review Grant Program runs for five years beginning in FY2010; the MLR requirements were effective beginning calendar year 2011; and section 2701 of the Public Health Service Act, as added by the Affordable Care Act, took effect January 1, 2014.

Rate Review Annual Reports: This is the third Rate Review Annual Report issued by HHS.[1] It is based on data for calendar year (CY) 2013 submitted by states receiving rate review grants ("grantee states"), supplemented by data that are available on these states' websites, and state website data for several non-grantee states. This report uses an analysis of data from 40 states in the individual market and 37 states in the small group market to estimate the impact of the Rate Review Program and the Rate Review Grant Program on premiums in the individual and small group markets. It focuses on the impact of these two provisions to assess trends in rate increases in the individual and small group markets. In addition the report uses data from the MLR Program to estimate consumer savings resulting from these provisions of the Affordable Care Act.

[1] The first Annual Rate Review Report can be accessed at http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html; and the second Annual Rate Review Report can be accessed at http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.pdf.

Beginning in September 2011, and continuing through April 2013, the Rate Review Program required insurance companies to document, submit for review, and publicly justify rate increases of 10 percent or more. Currently, HHS collects data on all rate increases, even those below 10 percent.[2] The Rate Review Grant Program, which is separate from the Rate Review Program, enhances state efforts to review proposed increases in health insurance rates and makes information and decisions about rate increases available to the public. Under this grant program, the Secretary of Health and Human Services is authorized to award grants to states for the purpose of improving their review of proposed rates in the individual and small group health insurance markets.[3] The law appropriated $250 million for rate review grants for a five year period comprising fiscal years 2010 through 2014. Each state receiving a grant is required to submit data to HHS documenting all rate increases requested by issuers for major medical policies in both the individual and small group health insurance markets of that state.[4]

2013 Findings

Key Findings:

- **Rate review reduced total premiums by an estimated $290 million in the individual market for all states.**

- **In the individual market, the average requested rate increase was reduced by 8 percent for the 40 states examined.**

- **Rate review reduced total premiums by an estimated $703 million in the small group market for all states.**

- **In the small group market, the average requested rate increase was reduced by 11 percent for the 37 states examined.**

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[2] Prior to the implementation of a rate increase, issuers must now submit to CMS a Rate Filing Justification for all rate increases that are filed on or after April 1, 2013, or that are effective on or after January 1, 2014 (45 CFR part 154.220 accessed at http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf) . This requirement is mandated by § 2794(a) of the Public Health Service Act, as added by § 1003 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

[3] § 2794(c) of the Public Health Service Act, as added by § 1003 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

[4] The Rate Review Grant Program awarded a total of $51 million to 45 states, 5 territories, and the District of Columbia in the first cycle of funding. Through the second cycle of funding, an additional $119 million was awarded to 30 states, three territories, and the District of Columbia. The third cycle of funding awarded $67 million to 20 states for rate review, data centers, and all payer claims databases. Details on state rate review grants can be accessed at: http://www.cms.gov/CCIIO/Resources/Rate-Review-Grants/index.html.

- **For both markets, the total estimated reduction in premiums for 2013 was approximately $1 billion ($993 million).**

- **Together with the 2013 MLR rebates of $250 million for the individual and small group markets, this estimated reduction in premiums amounts to $1.2 billion of savings to consumers in 2013 due to the Affordable Care Act's rate review and MLR provisions.**

- **In 2012 the Affordable Care Act's MLR and rate review provisions accounted for $1.6 billion in rebates and premium reductions. The combined amount of rebates and reduction in premium amounts for 2013 and 2012 was $2.8 billion.[5]**

Individual Market

Estimated Reduction in Premiums: For these 40 states in 2013, 23.7 percent of total covered lives were in policies that had rate change requests reduced or denied. We used this percentage to make an estimate for all 50 states and the District of Columbia by applying it to 2013 Medical Loss Ratio (MLR) data for covered lives in the individual market in all 51 jurisdictions. The MLR data for the individual market in 2013 shows 10.9 million covered lives and total premiums of $32.3 billion. An estimated 2.6 million covered lives (or 23.7 percent of the nationwide total), had rate change requests reduced or denied. Based on 2013 MLR data for total individual market premiums in all states, rate review caused total premiums in the individual market to be reduced by approximately $290 million. We calculated this estimated 8 percent reduction by multiplying the difference between the average rate increase initially requested (11.2 percent) and the average rate increase implemented (10.3 percent) in those 40 states by the nationwide total 2013 premiums of $32.3 billion.[6]

Requested Rate Increases of 10 Percent or More: One quarter (25 percent) of rate filings in the individual market in 2013 contained requested rate increases of 10 percent or more and 23.1 percent of rate filings contained implemented rate increases of 10 percent or more. Rate increases of 10 percent or more affected a larger share of covered lives in the individual market

[5] It is not possible to give cumulative totals from all 3 rate review reports (2012 report, 2013 report, and this 2014 report) because both the 2012 and the 2013 report used data from CY 2012. The 2012 data reported in the 2012 report were not complete and were updated in the 2013 report.

[6] Premium and covered lives data are based on the 2013 Medical Loss Ratio (MLR) data submitted by issuers to CCIIO (available at http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html) for all 50 states and the District of Columbia, whereas the average rate increase is based on ASPE's analysis of 40 states using Rate Review Grants (RRG) Program data and/or state website data for 38 grantee states and state website data for two non-grantee states (Florida and Oklahoma). RRG Program data was supplemented by state website data whenever such data was publicly available. Ten grantee states that submitted limited RRG Program data for 2013 were not included in the analysis. Taking the average difference between rate changes requested and rate changes implemented, weighted by the number of covered lives, and multiplied by the estimated total U.S. premiums, this report extrapolates an estimated total reduction in premiums in the individual market resulting from rate review, assuming that states without available data are similar to states that reported data.

than in the small group market. In the individual market, 42 percent of covered lives had an average requested rate increase of 10 percent or more and 41 percent had an implemented rate increase of 10 percent or more. Table 1 summarizes the results for the individual health insurance market.

Table 1: Rate Change Requested Versus Rate Change Implemented in the Individual Market (Based on Analysis of 40 States)

Individual Market Rate Change, 2013	Requested	Implemented[7]
Number of rate filings in 40 states	647	647
Filings with rate change requested≥ 10% for 40 states (%)	25.0%	23.1%
Average rate change:		
For 40 states	11.2%	10.3%
When request ≥10% for 40 states	18.4%	16.9%
Covered Lives:		
Number of covered lives affected by these rate filings	6,918,000	6,918,000
Covered lives with rate change requested≥10% for 40 states (%)	42.0%	41.0%
Covered lives with rate change request reduced or denied (%)		23.7%
Total covered lives with rate request change reduced or denied based on 10.9 million total covered lives for all states		2.6 million
Total U.S. estimated reduction in premiums based on $32.3 billion total premiums in the individual market for all states		**$290 million**
Sources: Revised State Rate Review Grant (RRG) data and data from state websites[8]		

Small Group Market

Estimated Reduction in Premiums: For these 37 states, 20.5 percent of total covered lives were in policies that had rate change requests reduced or denied. We used this percentage to make an estimate for all 50 states and the District of Columbia by applying it to 2013 MLR data

[7] Rate Change Implemented includes modifications (increases and decreases) and denials.

[8] The individual market data are based on MLR data from 50 states and the District of Columbia (accessed at http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html), whereas the average difference between rate changes requested and rate changes implemented is taken from ASPE's analysis of 40 states using Rate Review Grants (RRG) Program data and/or state website data for 38 grantee states and state website data for two non-grantee states (Florida and Oklahoma). The results were extrapolated to approximate a national total premium reduction for the individual market as a result of rate review. See footnote 7 for more detail.

for covered lives in the small group market in all 51 jurisdictions. The MLR data for the 2013 small group market shows 17.3 million covered lives and $78.2 total premiums. Of the 17.3 million covered lives in the small group market nationwide, 20.5 percent, or an estimated 3.6 million covered lives, had rate change requests reduced or denied. Based on 2013 MLR data for total small group market premiums in all states, rate review resulted in a reduction in total premiums of approximately $703 million. We calculated this estimated 11 percent reduction by multiplying the difference between the rate increase initially requested (8.0 percent) and the rate increase implemented (7.1 percent) by the total 2013 premiums of $78.2 billion. [9]

Requested Rate Increases of 10 Percent or More: Compared to the individual market, a smaller share of small group rate filings requested rate increases of 10 percent or more in 2013 (20.7 percent of small group rate filings compared to 25 percent of individual market rate filings). Overall, 18.1 percent of small group rate filings and 23.3 percent of small group covered lives experienced an implemented rate increase of 10 percent or more. Approximately one-fifth (20.5 percent) of total covered lives in small group policies had a rate change request reduced or denied through rate review in the small group market. Table 2 summarizes the results for the small group insurance market.

[9] This estimate uses information submitted by 36 states through the Rate Review Grant Program and/or grantee state websites, plus state website data from Florida, a non-grantee state, and is based on the average difference between rate changes requested and rate changes implemented, weighted by the number of covered lives. RRG Program data were supplemented by state website data whenever such data was publicly available. Eight states submitted limited RRG Program data in the small group market and were therefore not included in the analysis. As with the individual market analysis, the small group estimates includes data from the reporting states on all rate increases, even those below 10 percent, in the small group market and assumes that the difference will be similar in the states that did not report data.

Table 2: Rate Change Requested Versus Rate Change Implemented in the Small Group Market (Based on Analysis of 37 States)

Small Group Market Rate Change, 2013	Requested	Implemented[10]
Number of rate filings in 37 states	1,099	1,099
Filings with rate change requested ≥10% for 37 states (%)	20.7%	18.1%
Average rate change:		
For 37 states	8.0%	7.1%
When request ≥10% for 37 states	14.4%	11.6%
Covered Lives:		
Number of covered lives affected by these rate filings	10,424,000	10,424,000
Covered lives with rate change requested≥10% for 37 states (%)	29.7%	23.3%
Covered lives with rate change request reduced or denied (%)		20.5%
Total covered lives with rate request change reduced or denied based on 17.3 million total covered lives in the small group market for all states		3.6 million
Total U.S. estimated reduction in premiums based on $78.2 billion total premiums in the small group market for all states		**$703 million**

Sources: Revised State Rate Review Grant (RRG) data and data from state websites[11]

ACA Insurance Reforms and Rate Trends in the Individual and Small Group Markets

Individual Market Trends

Before the enactment of the Affordable Care Act, annual premium increases were highly variable and increases averaged 10 percent or more at the state-level. From 2008 to 2010, the average annual rates of premium increases in the individual market ranged from 9.9 percent to 11.7 percent. In 2010, many increases were in the range of 9 to 15 percent, but a full quarter of issuers increased premiums by 15 percent or more. The average annual state-level increase was 10 percent or higher.[12]

[10] Rate Change Implemented includes modifications (increases and decreases) and denials.

[11] As with the individual market data, the small group premium data are based on MLR data from 50 states and the District of Columbia (accessed at http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html), whereas the average difference between rate changes requested and rate changes implemented is taken from ASPE's analysis of 37 states in the small group market using Rate Review Grant Program data and/or state website data for 36 grantee states and data from Florida, a non-grantee state. Again, the results were extrapolated to estimate a total national reduction in premiums for the small group market as a result of rate review.

[12] To gather baseline premium information, ASPE commissioned NORC, at the University of Chicago, to collect data from a sample of state insurance departments for the period 2008-2011 (the number of states grows from 16 to 21 states over those years) (accessed at http://www.aspe.hhs.gov/health/reports/2014/Premiums/20121119%20PremTrendsRptFnl.pdf). In addition, ASPE analyzed available data from individual market rate filings submitted for 2012 (39 states) and 2013 (40 states) from

After the enactment of the Affordable Care Act in 2010, average rate increases moderated to 7.0 percent in 2011 and 7.1 percent in 2012. The average rate increase was 10.3 percent in 2013, but would have been 8.7 percent if the high increases in one state, California, were excluded.

Small Group Market Trends

In the period immediately preceding the Affordable Care Act (2008-2010), the average annual rates of increase in premiums in the small group market were 11.2 percent in 2008 and 2009, and 8.8 percent in 2010, with substantial variability by state. After the law's enactment, the average annual rates of increase declined to 6.1 percent in 2011 and 4.7 percent in 2012. In 2013, the average rate of increase was 7.1 percent.

Conclusion

The rate review provisions of the Affordable Care Act enhance transparency in the health insurance market and hold insurance companies accountable for rate increases. Rate changes are now public information, and issuers must provide data on requested increases of any size. While the average premium increased more in 2013 than in prior years, it was still less than typical growth prior to the Affordable Care Act. Consumers nevertheless benefited from an estimated reduction in premiums of nearly $1.0 billion ($290 million in the individual market and $703 million in the small group market). When added to the $250 million in MLR rebates that consumers received for CY 2013, the Affordable Care Act's rate review and MLR provisions have, together, accounted for approximately $1.2 billion in premium reductions and rebates for consumers. In 2012 the total combined effect of these two provisions was $1.6 billion. For 2012 and 2013 the total combined effect of these two provisions was $2.8 billion.

For rate filings for plan years 2014 and later, issuers must submit data for all of the plans in their risk pools in a single rate filing to both their state and CMS.[13] This data will substantially improve the ability to review rate impacts on the market as a whole, compare rates across issuers, and monitor changes over time. Using both historic and new filing and review methods, HHS will continue to monitor the long-term trend of requested and implemented rate increases in the health insurance market.

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rate grant states, publicly available state data, and data from several non-grantee states. ACA rate review grants significantly increased the number of states posting their rate filings on websites, making data collection easier. However, these data should be used with caution because there was no national source of comparable data, plans varied in what services were covered, applicants could be medically underwritten in most states, and the available data has significant limitations and omissions.

[13] An issuer must submit data to HHS if the issuer has a rate increase of any size for any plan; if the issuer has a Qualified Health Plan in its single risk pool; or if the state Department of Insurance requires the issuer to submit the federal template when submitting rate filings. Although a tiny fraction of issuers may not meet any of these requirements, the vast majority of issuers will meet one or more of these requirements and therefore be required to submit data to HHS.