



Keeping Insurers Honest: How California Can Stop Unreasonable Health Insurance Premium Hikes

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Introduction

Of all the problems affecting California's health care system, none is more immediate than the skyrocketing premiums consumers face year after year. Polls and surveys reliably show that the public's top priority for health care reform is policies to get costs under control.ⁱ Understandably, then, Anthem Blue Cross of California's recent proposal to hike rates on its customers by up to 39 percent galvanized an angry public. Anthem's rate proposal justly sparked outrage across the state – and even national attention from President Obama and U.S. Health and Human Services Secretary Kathleen Sebelius.ⁱⁱ

Anthem had to withdraw that proposal in disgrace when a special audit found that it was based on bad assumptions and mistaken math.ⁱⁱⁱ That brought important relief to 800,000 Californians. But egregious as the Anthem example is, it is only the tip of the iceberg. Across the state, families and businesses continue to face premium hikes, some as bad or worse than those proposed by Anthem.^{iv}

And the plain fact is, consumers got lucky. It took a perfect storm – a huge rate increase, media outlets primed to jump on health care stories, national attention primed by the fight over federal reform, an outraged public, and an insurer's sloppy math – to trigger the additional scrutiny that found Anthem's mistakes and reversed the hikes. California's families and businesses have absolutely no guarantee that something like

this won't happen again, because our laws don't do enough to protect against unjustified rate increases. After all, Anthem had submitted their proposal to regulators months before consumers got the notice that their rates were going up – it was only in the face of public pressure that action was taken. And absent flat-out errors like the ones Anthem made, the Department of Insurance has little power to rein in the insurance companies.^v

The bottom line is that with a weak watchdog and insurers facing no incentive to make sure they're not taking their customers for a ride, Californians can expect to see more big, unjustified rate hikes in the years to come.

Fortunately, our state has an opportunity to learn from this near-disaster and make sure it doesn't happen again. Legislation pending in Sacramento would protect consumers by empowering regulators to review premium increases before they went into effect. That means proposals based on bad math or that are otherwise unreasonable could be modified to a fairer level. The legislation would also open up these rate filings to public scrutiny, allowing consumers to know exactly where their money is going. Further, the recently-passed federal health reform law contains provisions helping states set up such review programs, including millions of dollars of grant aid.

This white paper examines the causes of unreasonable premium increases, including a focus on the recent Anthem Blue Cross hikes; it then looks at the proven track record of rate review in limiting such

increases, and makes recommendations for steps California should take to protect its consumers, businesses, and families.

The Problem of Rising Premiums

There are many causes of rising health care costs. Premiums go up for a variety of reasons that have little to do with the direct practices of insurance companies, from the marketing policies of drug companies to inadequate investment in primary and preventive care.^{vi} Because of this, even the most consumer-friendly insurer would have a hard time delivering quality, affordable coverage year after year.

Yet it is clear that too many of California's insurers too often fail to deliver on lower costs in the areas that are under their control, such as reducing health care paperwork and incentivizing high-quality care, preferring instead to manipulate their rates to evade regulatory scrutiny. And the case of Anthem Blue Cross' ill-fated rate proposal provides an important example of the ways insurance industry practices take advantage of families and businesses.

The substantial rate increases were concentrated on the individual market, where Anthem had the greatest freedom to set premiums. That's because those who don't have coverage through their employers must buy insurance on their own, without

the protection and bargaining power of a larger pool of customers. Further, individual market insurers are able to refuse a new applicant on the basis of a pre-existing health condition. That means that once a person buys a policy, if they get sick, they may be locked into continuing to buy it. The individual market also boasts higher administrative costs and overall lower-value care.^{vii}

In other words, these were Anthem's most vulnerable customers. Anthem's executives, including CEO Leslie Margolin, repeatedly promised that the rate increases they were trying to impose on these customers were sound.^{viii} But when California's Department of Insurance commissioned a closer study of their rate proposal, they found that Anthem's proposal was riddled with errors and mistakes. They double-counted the effect of aging on demand for medical services. They overstated cost growth rates. And they made other errors, that, when added all together, meant that Anthem was calling for rate increases that were on average 10 percentage points higher than was actuarially justified.^{ix}

It is difficult to write off these mistakes as random errors, however. A closer look at the environment that produced those increases suggests that similar mistakes are bound to happen again. Insurers face pressure from stock analysts and investors to reduce the amount they pay for medical care and to increase their profits.^x And under this pressure, there is every incentive to short-change consumers, and few safeguards to catch mistakes in the insurer's favor.

Internal documents from Anthem's corporate parent, insurance giant WellPoint, dramatize this dynamic. Concerned about the impact of increased medical costs, company officers fretted about the fact that new California regulations prevented them from retroactively cancelling the coverage of sick enrollees. They also bemoaned the fact that while before, only half of the premiums paid by certain first-year enrollees went to health benefits, now the percentage had crept up above 65%, leaving less for administrative overhead, executive compensation, and profits.^{xi}

To try to please investors, they identified ways to reduce the amount they spent on care – but none of them had to do with actually lowering costs. Instead, the 12 strategies they identified centered for the most part on identifying high-risk, sick consumers, and then trying to avoid having to pay for their care – either by refusing to cover them in the first place or instituting waiting periods or other devices to reduce their financial exposure.^{xii}

Meanwhile, WellPoint employees also spoke of creating “filing cushions” in their rates that would allow them to reduce initially-high premium increases in order to make them seem more reasonable. Similarly, company emails appear to suggest that one consideration in setting rates was tweaking key indicators that could trigger regulatory oversight. Despite all of this effort to ensure their rates appeared reasonable, there is no indication that they considered slowing their spending on executive compensation or lavish retreats.^{xiii}

From these documents, it is hard to trust that WellPoint's rate increases simply reflected rising medical costs. Significant pressure existed to deliver rates that would please investors and avoid scrutiny from the public and from government watchdogs – and when such rates were proposed, there was little incentive to ask the pointed questions necessary to make sure that they had not been gamed, and were not based on flat-out actuarial errors.

Ultimately, the picture that emerges is of insurers who, in the absence of oversight and accountability, have the ability to manipulate premiums and ignore the best interests of their customers. Without transparency and oversight, it is impossible for families and businesses to truly know where their premiums are going – in fact, they might not even be aware that they are being ripped off. While getting insurers' behavior under control, by itself, will not be enough to make the rise in health care costs more sustainable, it is clearly an important first step.

How Reviewing Rate Increases Can Help

As the mistakes in Anthem’s filing demonstrate, even transparency alone can make a noticeable difference – just looking over an insurer’s shoulder can do wonders to keep them honest. But more than this is needed to protect consumers from these rate hikes. While there are many causes of rising health care costs, California is wasting an opportunity that most other states have taken to protect its families and businesses: creating a strong watchdog on insurers, by requiring them to file their rate increases for a review that would make sure that their premium increases are justified before allowing them to go into effect.

A majority of states – at least 30 – have some form of this protection, called “rate review.”^{xiv} And their experience proves that giving regulators the power to reject proposed premium increases that cannot be justified on the facts helps police insurer behavior and lowers costs.

Oregon, our neighbor to the north, provides an especially important example. Oregon strengthened its existing rate review process in 2009 to prohibit excessive rate increases, taking aim at unreasonable administrative costs, opening insurers’ rate filings to public scrutiny, and empowering consumers to take part in the process.^{xv} And these new measures have worked. The 25.3% rate hike recently requested by Regence Blue Cross Blue Shield was instead downgraded to a 16% rise, realizing significant savings for consumers. The new review process also

appears to be encouraging insurers to adopt reforms to lower medical costs.^{xvi}

And looking at other states, it is clear that Oregon’s success is not an isolated incident:^{xvii}

- Colorado has seen nearly half of proposed increases lowered since it instituted rate review.
- Indiana and Maryland have both been able to negotiate lower premiums for consumers in half of all increases.
- Iowa regulators have reduced a third of filed proposals, saving consumers an average of 40% off of their premiums in these cases.
- In New Hampshire, an insurer proposed to flat-out double its rates, but rate review helped bring it down to a 12.5% increase.
- Vermont’s rate review system has allowed it to lower or deny 75% of proposed rate increases.

Taken together, the picture is clear – strong rate review systems have a proven track record of lowering costs for consumers. Against this, insurers may object that it is difficult to compare rate increases between states, because different insurance markets often face significantly different pressures. The importance of strong rate review policies, however, is confirmed by the experience of states that have opted to repeal their rate review systems, and seen costs increase for consumers:

- When New York repealed its strong rate review law, the result was that health plans were able to overcharge customers by more than \$100 million. Meanwhile, the amount of money the insurers gave to investors as dividends more than tripled, and their surpluses almost doubled.^{xviii}
- Washington state also saw premiums race up after it deregulated insurance premiums by repealing their rate review law. They have since reinstated rate review, which has resulted in a slowing of premium growth.^{xix}

Not only can rate review rein in unreasonable premium increases, it can also be used to help drive quality-increasing, cost-saving innovations through the health system. For example, Rhode Island law now looks beyond the customary criteria of fiscal soundness and consumer protection, to examine whether insurers are adequately compensating providers and encouraging accessibility, quality and affordability. The state has used this new leverage to put in place a series of standards that include increased payment for primary care providers, coordinated preventive care, and incentives for the adoption of health information technology.^{xx}

Rate Review Done Right

It's long past time that California joined the majority of other states by instituting a rate review process to protect its consumers. And as mentioned above, the recently-passed federal health care law allows states to apply for grants to create and run rate review systems – California, as one of the largest states, could expect to win up to \$5 million under this provision.^{xxi} As a result, there has never been a better time to take this step.

However, not all rate review systems are created equal. There are certain key policies California should be sure to adopt, in order to ensure the maximum possible protection

for consumers, and deliver the greatest possible reductions in health care costs.

Set a Comprehensive Framework

The single most important step to take is requiring the review of all premium increases, not just a subset. This means giving the same authority to both of California's regulators of health insurers, the Department of Managed Health Care and the Department of Insurance, to review rates, and creating airtight rules sorting all rate filings into the jurisdiction of one agency or the other. Further, the same rules should apply to all plans, regardless of how comprehensive or new they are. Allowing

loopholes will only allow insurers to manipulate their products in order to escape scrutiny, and leave consumers no better off than they are now. To be sure, there are “special” products like high-deductible plans and newly-offered plans that may behave differently in some respects (for example, by shifting more of the cost pressure to deductibles, rather than premiums). But these considerations are less important to consumers than the fundamental question of whether the rate increase is justified and transparent.

Providing Strong Negotiating Authority and Setting Robust Standards

Regulators should have the power and the mandate to stand up for consumers in reviewing whether a proposed rate increase is justified. That means creating broad authority to reject a proposal, which is not limited only to a narrow set of circumstances. If regulators can only reject a rate if it violates particular criteria – for example, if the insurer devotes an insufficient portion of premium income to medical care – this will only invite insurers to attempt to game the system.

In deciding whether to approve or reject an application, regulators should take all of the considerations listed above into account and make a holistic determination. In particular, insurers who repeatedly fail to adopt reforms to lower costs should not be allowed to pass the costs of their inaction to consumers. Given the current broken incentives and skyrocketing costs of our medical system, an insurer who is not taking action to make care

more affordable is by definition subjecting its customers to unreasonable rates.

With that said, legislation should lay out certain guidelines to easily identify rate proposals that are likely to be problematic. For example, while medical costs continue to skyrocket, there is little reason why administrative costs should increase faster than the Consumer Price Index – if a proposal does include administrative costs that are rising more quickly, it should be presumed unreasonable in the absence of adequate justification explaining the discrepancy. Similarly, if an insurer has had to pay out significant regulatory fines or legal damages due to bad practices, these financial losses should come out of its profits, rather than providing an excuse for the insurer to raise its rates.

Require Transparency

California should make sure that rate filing proposals are comprehensive. Insurers should be required to make a full statement of all information relevant to their premium increase proposal. This includes the proportion of premiums they currently spend on care, as against administration and executive compensation; their full financial position, including investment income and reserves; the specific cost-saving, quality-enhancing reforms they have adopted to lower the costs of care; their history of legal violations, consumer lawsuits, fines paid, and other regulatory action; and their track record of premium increases.

Further, all the information an insurer submits should be made publically available – a secret justification is no justification at all. The rate filing should be made available in its entirety for consumers to inspect on the Internet, with exclusions for “trade secrets” determined by regulators and kept to a minimum, if not eliminated entirely. The public availability of rate filings will help to promote consumer confidence in the insurance products they buy, as well as helping to weed out mistakes, errors, and bad practices that can inflate premiums.

The information should be easy for consumers to look up, allowing them to quickly use the information on the insurance card or other plan information they receive from their insurer to determine which plan

to look at. And the filings should be easy to search and sort, so that consumers can make comparisons between different plans and see which have a history of performing well and lowering costs, and which do not have a strong track record.

Creating a Role for Consumers

Finally, both the DOI and DMHC should offer robust opportunities for consumer involvement, to comment on the impact of rising rates and to trigger increased scrutiny of a particular plan. Consumers should also be allowed to submit comments on particular rate proposals, so that regulators have information on the likely effect of the premium increase.

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