

*ARIZONA HEALTH FUTURES
Policy Primers: a nonpartisan
guide to a better understanding
of key terms and issues in the
Arizona health policy landscape.*

Getting All the Cards on the Table

The Premise and Promise of Health Insurance Rate Review in Arizona

Ask Arizonans about their healthcare concerns and – overwhelmingly – they will say they are worried about how much their health insurance costs and whether they will continue to be able to afford it.

Although there are many reasons for the unsustainable rise in the cost of healthcare coverage (including the continual rise in healthcare costs), one important factor is that consumers often lack the information they need to make informed decisions about what plans are right for them. Few individuals or small businesses know how much of their premium dollar goes to health care versus administrative costs like paperwork, staff salaries or profits. Consumers also have a hard time discovering why their premiums are going up. Moreover, consumers often lack the bargaining power they need to drive insurers to deliver a better deal.

While there is no ace in the hole for solving these problems, states do have options to increase transparency so consumers have better information and are better protected against unreasonable rate increases. One



St. Luke's Health Initiatives

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important opportunity is through a process called *rate review*, which can potentially empower consumers by requiring insurers to make information on why rates are increasing publically available. Many states even have authority to reject unreasonable health insurance premium hikes.

With Arizona currently considering how best to strengthen its rate review process in response to the federal Affordable Care Act, this report aims to help consumers, regulators and advocates better understand the policy considerations central to setting up a strong rate review process for our state.

Rate Review Models and Successes

Rate review offers a way for states to oversee insurers' premium increases and provide better consumer protections. States generally adopt one or more of three strategies to strengthen their rate review processes: increasing the transparency of insurers' stated reasons for increasing rates, having regulators evaluate whether the proposed increases are reasonable, and requiring insurers to get approval before they raise premiums. These approaches are not mutually exclusive. In fact, states with the strongest rate review programs include all three. The track record of states that have adopted strong rate review processes shows that such processes meet a real need and deliver results for consumers.

Potentially Unjustified Rate-Setting Practices

While there are many reasons why insurers may be justified in raising health insurance rates, insurers sometimes engage in unscrupulous rate-setting practices that leave consumers paying an unfair premium. There are several ways a rate can be unreasonable: for example, it can be unjustified because the rate increase is not adequately supported by the data; or it can be based on unfair or incorrect rate-setting practices. This can result not only in consumers generally paying too much but in unfair discrimination because it leads to different classes of enrollees paying rates that do not reasonably reflect actual differences in medical costs.

Strengthening Rate Review in Arizona

To protect consumers from unjustified rating practices and ensure that consumers pay a fair premium for their coverage, Arizona should take a number of steps to strengthen its rate review process. These include giving regulators authority to reject unreasonable rate increases; improving transparency so the public has better knowledge about rate increases; and ensuring that consumers have a voice in the rate review process.

REVIEW AND PRIOR APPROVAL: Arizona should make its rate review process more effective in protecting consumers by strengthening the Arizona Department of Insurance's authority to prevent unreasonable rate increases from going into effect. Most consumers are ill-equipped to determine on their own whether premium increases are unreasonable or detect when insurers have used unjustified rate-setting practices.

Such a change may require changes in statutes and rules. Over thirty other states already have prior approval authority for at least some insurance products, including other western states like New Mexico (which last year passed a law strengthening its rate review process), Nevada and Colorado.¹

IMPROVING TRANSPARENCY: For all proposed rate increases or decreases, insurers should be required to file a full range of information with the Arizona Department of Insurance. In turn, the Department should make this information publicly accessible, allowing consumers to make judgments about the quality and cost of their care, and enabling advocates to more constructively engage in the Department’s rate review activities. Disclosure should include a short narrative (written in consumer-friendly language), including key reasons for the rate increase. It should also include information on the expected impact of the rate increase on consumers, the anticipated medical trend, level of administrative spending and profit margin, and full claims data and methodology details supporting these estimates. Consumers should also be informed of any rate increases that have been deemed to be unjustified.

CONSUMER INVOLVEMENT: Robust consumer participation can make a rate review program more useful to the public, and render regulatory deliberations better-informed. The Arizona Department of Insurance should post all rate increase information on a prominent and easy-to-use website in order for consumers to research rate filings. The Department should also develop easy ways for consumers to comment on pending filings and hold public hearings on rate filings that it determines are significant due to the size of the proposed increase, the scope of any proposed benefit changes and the number of consumers affected.

By making these changes, Arizona could make insurance coverage more affordable by providing consumers with needed information and protections.

More transparency and enhanced consumer protections could allow for a more competitive insurance marketplace, resulting in lower health insurance costs and improving coverage for individuals and small businesses in our state.



Introduction

Ask Arizonans about their healthcare concerns and – overwhelmingly – they will say the same thing: they are worried about how much their health insurance costs and whether they will continue to be able to afford it. And for good reason: overall, healthcare costs in Arizona increased 128 percent from 1999 to 2009.²

Although there are many reasons for the unsustainable rise in the cost of healthcare coverage (including the continual rise in healthcare costs), one important factor is that consumers lack the information they need to make informed decisions about what plan is right for them. Few individuals and small businesses know how much of their premium dollar pays for health care and how much pays for insurance company administrative costs and profits. Consumers also have a hard time discovering why their premiums are going up.

And the problems do not stop there: even if consumers are somehow able to learn these important details about their coverage, they often lack the bargaining power they need to drive insurers to deliver a better deal. This is especially true for consumers purchasing coverage on their own on the individual market, or for small businesses buying coverage in the small group market. With insurers offering take-it-or-leave-it deals, too many consumers can wind up paying unreasonable, unjustified rates that do not offer fair value.

Taken together, lack of information and limited bargaining power restrict the ability of consumers to shop for products offering the best value, making the health insurance marketplace work less efficiently. If an insurer engages in bad business practices or delivers lower value, it is hard for consumers to know and respond accordingly.

While there is no ace in the hole for solving these problems, states do have options to increase transparency so consumers have better information and are better protected against unreasonable rate increases. One important opportunity is through a process called *rate review*, which can empower consumers by requiring insurers to make information on why rates are increasing publically available. Many states even have authority to reject unreasonable health insurance premium hikes.

With Arizona currently considering how best to strengthen its own rate review system in response to the federal Affordable Care Act, this report aims to help consumers, regulators and advocates better understand the policy considerations central to setting up a strong rate review process for our state. After briefly describing elements of a rate review process, it explains how insurers set rates, the legitimate reasons why rates can increase and the potentially unjustified and unreasonable rate-setting practices some insurers may employ. Finally, it describes best practices for rate review and offers ideas on how they could be implemented in Arizona.

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Models of Rate Review

Rate review offers a way for states to oversee insurers' premium increases and provide better consumer protection. States generally adopt one or more of three strategies to increase the effectiveness of their rate review process: increasing the transparency of insurers' stated reasons for increasing rates, having regulators evaluate whether the proposed increases are reasonable, and requiring insurers to get approval before they raise premiums. These approaches are not mutually exclusive. In fact, states with the strongest rate review programs include all three.

TRANSPARENCY – Consumers do not always know why their rates are going up, only that they have received notice that they will soon have to pay more for their monthly premiums. Rates can go up for a number of reasons, including medical cost increases, benefit coverage expansion or an insurer's failure to keep administrative costs under control. Unfortunately, consumers often do not know which of these explanations are behind their rate increases. Without additional information, it is very difficult for consumers to determine whether it is better for them to pay the higher rates or change insurers.

States increase transparency by requiring insurers to file proposed rate increases with regulators and make the proposals available to the public via the Internet. This information is most useful to consumers if the proposals contain "plain language" summaries laying out the size and distribution of the rate change, as well as the reasons for the increases. For more sophisticated consumers and advocates, fuller details describing the basis for increases presented in a consistent and downloadable format allows deeper evaluation of whether insurers are providing good value.

Many states also inform consumers of proposed rate increases. In these states, rate increases can still go into effect, but insurers must tell consumers that regulators have determined that the rates they are charging may be unfair. Armed with this information, consumers can make better choices about their coverage.

RATE EVALUATION – Beyond transparency, many states have their own experts evaluate proposed increases to determine whether they are reasonable. By analyzing the assumptions and methodology that go into the proposal as well as the proposal's impact on enrollees, experts and actuaries can identify potentially unreasonable rate increases and label them as such. Rates can be unreasonable because they are based on errors or faulty assumptions, or because they lead to unjustifiable differences in the premiums paid by different consumers.

Many states also solicit public input on proposed increases. By allowing consumers to provide testimony or submit formal comments, regulators can better understand the impact of a rate increase on affordability.

PRIOR APPROVAL – At least thirty states require some or all insurers to get approval before a rate increase goes into effect in the individual or small group markets.³ If reviewers find that a rate increase is unreasonable, the insurer must lower or withdraw the rate increase.

Rates can go up for a number of reasons, including medical cost increases, benefit coverage expansion or an insurer's failure to keep administrative costs under control.

Why Rate Review?

Rate review is important for two reasons. First, with many insurers imposing double-digit rate increases in recent years, rate transparency and review can help consumers understand what their premium dollars are buying and better ensure that the rates they pay are fair. When it comes to health care, consumers overwhelmingly care about affordability. If consumers can examine a company's history of rate increases, they can better prepare for how their premiums might change in the future. Just because insurance coverage is affordable this year does not mean a family or business will be able to afford it next year.

Second, rate review can protect consumers from rate increases that are based on calculation mistakes or faulty assumptions, or increases that are unfairly discriminatory or otherwise unjustified. Recent years have shown several examples of insurers attempting to subject their enrollees to unjustified rate increases.⁴ On the individual and small group markets, consumers have little bargaining power and less ability to understand whether the sophisticated actuarial models insurers use are reasonable. A strong rate review process can thus help the insurance market work better by giving consumers confidence that the products they buy provide a fair value.

The track records of states that have adopted strong rate review processes show that they meet a real need and can deliver results for consumers:⁵

- Iowa regulators found that a third of filed rate proposals were unreasonable and lowered them, saving consumers an average of 40 percent off their premiums in these cases.
- In New Hampshire, rate review brought an insurer's proposed doubling of rates down to a 12.5 percent increase.
- Oregon consumers saved \$25 million in the first year after the state strengthened its rate review process in 2009, requiring greater transparency and consumer participation.
- Although California lacks prior approval authority, consumers saved over \$20 million after a new law increased transparency and required review of premium increases.

Rate review is not a panacea for addressing all of the needs of those who are trying to purchase health insurance. However, for those buying coverage on the individual and small group markets and who possess the least bargaining power in the health coverage marketplace, it is an important protection. By identifying or preventing unreasonable or unjustified rate increases, rate review can help ensure consumers get fair value for their healthcare dollar.



There is no better time for Arizona to adopt a strong health insurance rate review process.

Opportunities and the Federal Law

The federal Affordable Care Act includes two provisions that strengthen rate review:

- The Act offers grants to states to improve their rate review processes, providing additional resources to hire actuaries, enhance data collection and reporting and create websites for public disclosure.
- The Act requires review of any proposed rate increases that exceed 10 percent. Insurers must file information with the U.S. Department of Health and Human Services (HHS) and make that information public, and either the state or the federal government must determine whether the increases are justified or unjustified.⁶ As part of this process, the Act establishes minimum requirements for states to be able to deem rates as being justified or unjustified. In states without effective rate review processes (which include Arizona as of this writing), insurers will need to rely on federal regulators to review proposed rate increases. Given the preference of many states to have oversight occur at the state rather than federal level, this requirement provides an incentive for states to strengthen existing rate review processes.

These two provisions are already having an effect on how rate review is occurring in Arizona. The Arizona Department of Insurance was awarded a grant of \$1 million in 2010 which is currently being used to raise public awareness about rate review, improve the Department's procedures and increase their transparency.⁷ In addition, the Department is currently pursuing changes in its rules to enable it to become an effective rate review state, allowing Arizona rather than the federal government to make determinations on whether rate increases are justified.

These changes alone are likely to bolster Arizona's existing rate review process. Currently the state does not do enough to provide consumers with the information and protections they need. The Arizona Department of Insurance collects only incomplete rate information from insurers, and consumers can only access this limited information by filing a public records request or physically visiting the Department's office.⁸ And the Department does not currently have the authority to reject unreasonable or unjustified rate increases. Thus, these opportunities offer a chance for the state to make its rate review processes more transparent and consumer-friendly.

How Health Insurance Premiums and Increases are Determined

In theory, setting premiums and rates for health insurance is a straightforward process: insurers estimate enrollees' medical care costs and their own administrative costs, decide the target level of insurance company profit or, for nonprofit insurers, contribution to surplus, and set the overall rates accordingly.

In practice, however, the process can be very complex. For example, projecting medical costs is a difficult calculation that depends on understanding historical claims data and modeling how things might change in the future.

And beyond setting the overall rate structure, insurers also decide how to set premiums for their customers, deciding whether certain individuals or employers will pay more than others based on a number of demographic and other characteristics. Thus, different enrollees with the same insurance product can wind up paying very different premiums. To understand how a strong rate review process can help consumers, it is important to understand where premiums and rates come from and what they mean.

Where Does the Money Go?

Perhaps the most fundamental piece of information about a rate is where the money goes. The premiums consumers pay each month go primarily to three purposes: paying for medical claims, paying for the insurer's administrative costs and contributing to the insurer's profits.

One number, called the medical loss ratio, encapsulates this information. The medical loss ratio is the proportion of expenses that go to medical care. Thus, an insurer with a medical loss ratio of 80 percent spends 80 percent of its premium income on medical care, with the remaining 20 percent going to administrative costs and profits. All things being equal, this insurer is likely providing better value to consumers than one with a medical loss ratio of 70 percent. This second insurer is spending more on administrative costs and profits, which may provide no direct benefit to consumers. Disclosure of the medical loss ratio is one of the simplest ways rate transparency can help consumers make more informed decisions.⁹

Medical Costs

In most cases, the majority of a consumer's health insurance premium goes to medical costs. This, after all, is the purpose of health insurance; patients are treated by various providers, and while patients pay a share of the cost as deductibles, co-pays and co-insurance, the greater portion of the charge for the treatment is typically paid by the insurer.

Medical costs vary depending on whether the insurer has a contract with the providers delivering care, and changes in contracted providers occur over time for a variety of reasons. Sometimes insurers contract with providers, in which case claims are paid at contracted rates; in the absence of a contract, providers and insurers must come to an agreement on the level of reimbursement. Claims costs fluctuate over time as medical providers change their rates, patients alter the amount of treatment they seek and new procedures are substituted for old ones. Costs can also change if an insurer changes benefit packages to be more or less comprehensive.

Administrative Costs

The second-largest component of the health insurance premium is the insurer's administrative costs. Even the most efficient insurer has some overhead and must pay for expenses

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such as processing claims and enrolling new customers. Major categories of administrative costs generally include wages and salaries; equipment and occupancy costs; legal and compliance costs; taxes, fines, and regulatory fees; and the commissions insurers pay to brokers and agents for signing up new customers.

Profit or Contribution to Surplus and Reserves

The remainder of the premium amount consumers pay goes to insurance company profits, nonprofit insurers' contribution to surplus and reserves (the money insurers must set aside to pay future claims). The amount may differ depending on the insurer's overall financial position. If the insurer's surpluses or cash reserves are low, it is more likely to seek higher rates to build these amounts back up; an insurance company may also pursue higher profit margins to improve the rate of return for investors. Conversely, if the insurer is losing enrollment, it may lower its profit margin or spend down its surplus to keep rates low.

While an insurer has only limited control over medical and administrative costs, it generally has wide latitude to pursue whatever level of profit it chooses, especially in less competitive healthcare markets.

Setting the Rate

After summing up the total expected costs and establishing goals for profits or contributions to surplus and additions to cash reserves, the insurer comes up with a target for its total premium income. The insurer then sets rates for each of its insurance products, such as its HMO and PPO plans, to generate the target total.

This process is complicated by the fact that an insurer often offers many different versions of its products. For example, the insurer may offer versions with higher or lower deductibles; with or without prescription drug coverage; with different co-pays, co-insurance structures, out-of-pocket maximums, and annual or lifetime limits; and with larger or smaller provider networks. Each of these versions will cover a different share of an enrollee's medical costs. The more comprehensive the benefits and the lower the amount the enrollee pays for services, the higher the premium will be.

An insurer can implement these differences in one of two ways. Sometimes it will set a base rate for each different product, setting out the various monthly premiums a person would expect to pay for each. Other insurers set a single rate, then use plan relativities – a numerical measure of how comprehensive a given product is – to adjust this single rate according to plan variation. For example, a reference product might have a relativity of 1.00, while another, with richer benefits, would have a relativity of 1.10 – the second product would have rates 10 percent higher than the first.

An insurer often sets rates for multiple plans as a group or by an entire market segment – that is, for all the plans it offers on either the small group or individual markets rather than individually for each particular plan. This helps to avoid statistical issues with low sample sizes and addresses the fact that people may move from one product to another.

Premium Rating Factors

Once the insurer has set the overall rate for a particular product, it uses several rating factors to determine the premium a given enrollee will pay. In general, the more health care an enrollee is likely to use, the higher the premium the enrollee will pay. For individual families, these factors affect premiums in a straightforward way, but for a small business, the premium it pays usually depends on the average characteristics of its employees.

While an insurer has only limited control over medical and administrative costs, it generally has wide latitude to pursue whatever level of profit it chooses.

In Arizona, an insurer can vary its premiums depending on how sick or healthy the applicant.

Age

An insurer typically varies premiums based on the age of the enrollee. Thus, younger individuals and businesses with younger employees pay lower premiums, while older individuals and small businesses with older workforces pay more. Older enrollees in general need services more frequently and the treatments they need are often more expensive. For example, an insurer might use a rating factor of 1.5 for enrollees between the ages of 50 and 55, and 0.7 for those between 20 and 25; in the former case, the enrollee would pay 50 percent more than the base rate, while the younger enrollee would pay 30 percent less.

These price differences may correspond to the actual difference in expected costs for the different age groups, but an insurer may also use them to select for a healthier risk pool, for example by charging older individuals unrealistically high premiums to discourage them from enrolling.¹⁰

Health Status

In Arizona, an insurer can vary its premiums depending on how sick or healthy the applicant. State law sets some limits on this practice (called medical underwriting) in the small group market, but these protections do not exist for individuals buying coverage on their own.¹¹ As a result, if an enrollee currently has (or recently had) a health condition, the individual – and for those working for a small business, their fellow employees – can expect to pay a higher premium for their coverage.¹² A healthier enrollee with an identical plan pays less.

Geographic Area

An insurer may vary its premiums by geographic region. Often this is because the cost of medical care varies substantially from area to area within a state.¹³ Hospitals and other providers may charge very different rates in different regions, and insurers may have more or less bargaining power depending on the number of competing providers in an area, leading to variation in the contract rates the insurer pays for the same treatment.

In general, geographic rating is likely to be fairer and more accurate where rates are set for one or more counties at a time. Rating by smaller areas, like clusters of zip codes, may be statistically less reliable and may also disadvantage underserved communities.

Tobacco Use

Smokers and other users of tobacco are more likely to develop cancer, heart disease and other health problems. As a result, some insurers require them to pay a higher premium for their coverage.

Participation Rate

Many insurers use a “participation” factor when setting premiums for small businesses. If a higher percentage of a business’ employees participate in the healthcare plan, the insurer may provide a modest discount.

Duration

Similarly, for small businesses that have continued their coverage with the same employer for several years, some insurers may offer slightly lower premiums.

Family Size

Finally, a single individual will pay a lower premium than one who is seeking coverage for a spouse as well; premiums also increase if children are included on the policy.

Understanding Rate Changes

Changes to any of the factors discussed in the previous section can lead to a person or business paying a higher or lower premium. This is not a rate increase. The premium change is a result of applying the same rating factors and base rates in effect when the enrollee signed up. For example, even if an insurer keeps its rates unchanged over time, as people grow older, they may find themselves paying higher premiums as they enter a more expensive age bracket. Similarly, they might decide to change to a more expensive plan with broader benefits, or a less expensive product with less comprehensive coverage.

A rate change is when an insurer changes its rates by altering its base rates and/or its rating factors. It is important to note that a rate increase can affect enrollees differently, depending on how it is structured. An average 8 percent increase, for example, could include a rate increase of only 3 percent for enrollees in some geographical areas and double-digit increases for enrollees in other areas.

To understand a rate increase and whether it is reasonable and justified, it is therefore important to know the reasons for the increase and how enrollees will experience the increase.

Common Factors in Rate Increases

Medical Trend

Typically, the most significant component of an insurer's proposed rate increase is rising medical costs. Medical costs go up primarily for three reasons: (1) increased unit cost of treatment because providers are charging more; (2) increased utilization, meaning that enrollees are using more medical care; and (3) change in the mix of services, meaning that enrollees are using more high-cost treatments such as brand-name drugs.

An insurer may calculate its expected medical trend in several ways. The simplest is to look at historical claims data and extrapolate from there. By examining how much it has paid in claims each month over the past one or two years and calculating the average rise in those costs, the insurer can project forward that rate of increase and derive how much it should expect to pay in medical costs over the next year. This approach can be affected by economic factors. For example, over the past few years during the economic downturn, many consumers have decided to postpone or forego treatment due to cost. As a result, utilization has been low, and recent medical trends for most insurers have generally been lower than historical averages.¹⁴

Some insurers do not use this methodology, but instead calculate a "normalized" medical trend. This involves applying a series of mathematical corrections to each month's claims data to remove the impact of certain factors such as changes in benefits or enrollees' ages. For example, claims costs might increase by 20 percent in a single month, but if the increase results from enrollees switching to products with more comprehensive benefits, it does not represent a true increase in medical costs. While normalization makes sense in theory, insurers should use it with caution. By relying on a series of mathematical models and calculations rather than actual experience, the approach is more subject to error, and comparatively small differences in assumptions and methodology can lead consumers to pay very different rates.



One category of administrative costs frequently goes up much faster, namely the commissions paid to brokers and agents for enrolling consumers.

Leveraging

One fairly technical reason that rates can increase is the interaction between healthcare costs and the cost-sharing structure that defines enrollees' deductibles, co-pays and co-insurance. The way costs are allocated between insurers and enrollees affects the way medical cost changes translate into changes in insurers' expected claims costs.

To illustrate, consider the example of a person whose insurance product has a two-tiered cost-sharing structure where the person pays all costs up to a deductible of \$500 and the insurer covers all costs over the deductible amount. Thus, if the person has a treatment costing \$1,000, they would pay \$500, and the insurer would pay \$500. If medical costs go up at a rate of 10 percent, the next year that same treatment would cost \$1,100 – but if the deductible stays the same, the enrollee would pay the same \$500, while the insurer would now pay \$600. Thus, while overall medical costs have increased by 10 percent, the insurer's claims costs have gone up by 20 percent. (This example is only illustrative; these corrections typically do not change an insurer's expected claims costs by nearly this large an amount.)

An insurer uses actuarial models to determine how these interactions will play out for its enrollees, depending on the particular details of their insurance products, to come up with a correction to their medical trend. This correction due to cost-sharing is called deductible leveraging (or sometimes simply leveraging). Leveraging is often included as an element of an insurer's projected medical trend. Even though it is not truly part of an estimate of how much overall medical costs will increase, it does contribute to the expected increase in the claims costs that an insurer will pay.

Benefit Changes

Rates may change because an insurer is changing the benefits it offers. For example, a plan may add new benefits that it did not previously cover (like an annual eye exam), or it may restrict them, for example by lowering the number of office visits covered by the plan. More subtle changes also have an impact on rates. Lowering co-pays or deductibles for certain treatments will increase the insurer's expected claims costs and therefore lead to increased rates. Similarly, for products that have lower deductibles, co-pays and co-insurance for preferred providers, expanding the pool of preferred providers can also change costs.

Typically, insurers use actuarial models to predict how their claims costs will change after the benefit change.

Changes in Administrative Costs

In addition to changes in medical costs as a result of medical trends, leveraging and benefit changes, an insurer's administrative costs can also change, going up or going down. Because enrollees ultimately pay for administrative costs, these changes also have a rate impact. These types of costs include many different kinds of expenses, from the computer systems that enroll consumers and process claims to the salaries of the insurer's staff. Generally speaking, most administrative costs should increase more slowly than medical costs, which historically have gone up much faster than inflation.

However, one category of administrative costs frequently goes up much faster, namely the commissions paid to brokers and agents for enrolling consumers. Typically, such commissions are paid on a percent of premium basis. For example, in the first year of an enrollee's



coverage, 25 percent of their premium might go to commissions. Commissions paid on a percent of premium basis will increase at the same rate as the overall premium. As a result, the portion of total premiums that goes to administrative costs instead of medical care grows as these commissions increase. Some insurers pay brokers a fixed commission as an alternative, which can help deliver better value for consumers.

Changing enrollment can have an impact on how much each enrollee must pay in administrative costs. Some administrative costs, such as salaries of the staff that process claims and payments to providers, depend on the number of enrollees and the volume of claims. But others, such as rent and computer hardware, are relatively fixed. If enrollment increases, these fixed costs can be spread out over a larger number of policyholders, while if enrollment decreases, each enrollee must pay a higher share of the administrative costs.

Changes in Target Profit/Contribution to Surplus

Another factor that can cause rate increases is the insurance company's decision to increase its targeted profit margin – or the nonprofit insurer's decision to increase its goal for contribution to surplus – for a given product. As discussed above, this decision is often based on the insurer's financial position, which may include making sure it remains fiscally solvent, or may reflect a desire to pay higher dividends and increase its attractiveness to investors.

Premium Rating Factor Changes

Any of the premium rating factors discussed above – the factors insurers use to set premiums for enrollees based on their age, geographical area and so on – can be changed in a rate filing. These changes can be made in a revenue-neutral fashion, such that any premium increases experienced by some enrollees are balanced by premium reductions for others, or they can amount to an overall rate increase or decrease.

Changes in Risk Pool

Changes in the demographic profile of the insurer's enrollees can also lead to rate changes. An insurer's "risk pool" is the sum of all the risk it has taken on. Thus, for a health insurer, the risk pool equates to the overall health of its enrollees. If the demographic profile of the insurer's enrollees is changing, so too is the profile of the risk pool, which will have an effect on claims costs and thus on rates. In general, if enrollees are growing older or less healthy, costs will increase.

Generally, when an insurer has stable enrollment, it is unlikely that significant shifts in its risk pool are taking place. Where enrollment is dropping or increasing, however, there may be a noticeable effect on costs. This is because the healthiest individuals are more apt to drop coverage when costs go up, since they have the least need for insurance and will have the easiest time getting alternate coverage. The sickest enrollees, on the other hand, will be very unlikely to want to disrupt their care by shifting insurers, and may not be able to get different coverage if they have developed a pre-existing condition. As a result, falling enrollment often means that an insurer's risk pool is getting less healthy, which can drive up rates further, leading to even larger enrollment losses. If such a trend is left unchecked, the stability of the insurer may be jeopardized.

How a Rate Increase is Implemented

After an insurer decides to change rates, it has many options on how to implement the increase across its products and enrollees. The simplest approach would be to increase all enrollees' premiums by the percentage of the increase. However, few if any insurers take this course. Instead, they allocate rate increases so that some enrollees see higher rate increases than others.

Sometimes these allocations are easy to understand. For example, if the insurer changes its premium rating factors for age or geographic area, it is simple to see who will pay more and who will pay comparatively less. Benefit changes also affect different plans differently: if some plans already include a benefit being added to others, those plans that already had the benefit will generally not see a rate increase.

Sometimes, however, an insurer makes changes that are less clear, increasing base rates for some products more than others. The overall impact, variation and distribution of the rate change may be confusing and opaque, providing little help to consumers unless additional information is provided.

Potentially Deceptive or Unjustified Rate-Setting Practices

Thus far, this section has discussed the many legitimate reasons why an insurer can change the rates it charges. However, insurers sometimes engage in unscrupulous rate-setting practices that leave consumers paying an unfair premium. There are several ways a rate can be unreasonable: for example, it can be unjustified because the rate increase is not adequately supported by the data; or it can be based on unfair or incorrect premium rate-setting practices. This can result not only in consumers generally paying too much but in unfair discrimination because it leads to different classes of enrollees paying rates that do not reasonably reflect actual differences in medical costs.

Relying on Outdated or Incomplete Data

Using old or insufficient data to project future costs can result in an insurer developing unjustified rate increases. The best guide to whether a rate increase is reasonable is if the insurer's projections line up with their historical experience. If the insurer's medical costs have been increasing by 10 percent each year for the past three years, it is likely that that trend will continue. However, an insurer may use only a few months of data, which is insufficient for evaluating the need for a rate increase. An insurer may also rely on outdated information, using claims data from several years ago without adjusting it for current conditions. For example, an insurer may not recognize that because of the recession medical costs have been growing at historically low rates. An insurer setting rates based on the growth of medical costs in 2007 or 2008 would therefore project an unrealistically high growth trend.

Unjustifiably High Increases in Administrative Costs

An insurer can also develop unjustified rate increases when it includes higher than necessary administrative costs. Rates will always contain a certain level of administrative costs, since insurance companies do not run themselves. But in general, these costs should make up a small portion of the premium and rise at a rate slower than overall medical inflation. Medical cost inflation reliably runs several percentage points higher than overall inflation, and there is no reason that an insurer's costs to process claims and pay its employees should go up at the same rate as the cost of medical treatments.



If administrative costs rise more quickly, it may be because the insurer pays brokers and agents on a commission basis, as discussed above. This practice can lead to consumers paying an unjustifiably high amount in administrative costs.

Hidden Profits and Inflated Medical Trend

Some insurers include superfluous factors in their medical trend calculations that go beyond the unit cost, utilization and service mix factors discussed above. For example, an insurer may include an amount labeled “provision for adverse deviation.” This technical language conceals more than it reveals. Such a provision is meant to account for the risk that medical costs may be higher than the insurer expects. However, it is just as likely that medical costs will be lower than expected if the insurer has performed an unbiased forecast. As a result, such a provision amounts to nothing but a hidden profit margin. An insurer may pursue whatever level of profit it prefers, but consumers deserve to know what that level is, rather than having some of it be concealed and inaccurately labeled as a medical cost.

Medical trend calculations may also be inflated by calculations and assumptions that are not justified by the data. As discussed in the previous section, some insurers rely not on their actual claims data in setting rates, but rather on “normalized” values that are arrived at after complex mathematical and actuarial calculations. These calculations may be based on flawed assumptions or may magnify small errors into large ones. For example, Blue Cross of California in 2010 attempted to raise rates on its customers based on a model that erroneously double-counted the effect of enrollee aging.¹⁵ Full disclosure of the methodology being used and the data it is being applied to are necessary to evaluate whether the medical trend calculations are reasonable.

Rates Unreasonable in Relation to Benefits

Perhaps the most egregious rating practice is when insurers charge a premium that is too high for the benefit packages they offer. In markets for most other products, consumers can make clear comparisons on what they get for various costs, and make decisions accordingly; however, because insurance is a complex product and consumers have little bargaining power, these market dynamics generally do not hold. The medical loss ratio often offers the clearest point of comparison to determine whether an insurer is providing adequate value.

Unjustified Variations in Rates

As discussed in detail above, an insurer uses rating factors to determine the different premium rates it charges to different types of enrollees. These variations may be justified by actual differences in the medical services consumed by various populations. However, an insurer sometimes uses rating factors that are unfairly discriminatory, charging enrollees different rates in a manner that is not supported by the data. This may occur if an insurer considers certain people to be undesirable customers. For example, the insurer may expect that some enrollees will not pay their premiums or co-pays, so they set higher rates to discourage them from enrolling.

Alternately, insurers may use rating factors to try to affect the composition of their risk pool. If it wants to bring in younger, healthier enrollees and drop older, more expensive ones, the insurer may shift its age ratings so that younger people pay dramatically lower rates and older people dramatically higher ones. Once the risk pool has shifted to the extent the insurer deems sufficient, it can reinstitute the old rating factors.

An insurer may pursue whatever level of profit it prefers, but consumers deserve to know what that level is.

Informing and Involving Consumers

Because of the complexity of insurance rate calculations and the risk of companies using unjustified or deceptive practices, a strong rate review program can be a great boon to consumers. Rate review programs in turn benefit from consumer involvement.

At the simplest level, consumers benefit from the information provided by rate transparency initiatives because it helps them to shop around and choose plans that work well for them. If an insurer whose product they are considering is known to have a history of high rate increases, the consumer will be forewarned that their current low premium might soon be a thing of the past. Comparing medical loss ratios and profit margins can help consumers determine how much value they are getting for their premium dollars. When rate increases are filed, consumers can also assess whether the increases are reasonable by looking at the causes of the increases. For example, when benefit changes lead to a rate increase, this information allows consumers to decide whether the additional benefits are worth the added costs.

However, the information insurers provide can be technical and hard for consumers to understand. The disclosure forms used in the federal rate review program, for example, can often be opaque to ordinary consumers. The forms include several pieces of important information, such as the level of profit, the medical loss ratio and the reasons for the rate increases. Unfortunately, this information is sometimes written in technical language and includes complex numerical formulas. While this data is very useful for more sophisticated consumers such as companies' benefits experts and consumer advocates, it has limited usefulness for most consumers.

FIGURE 1: **Claim Projections**

B. Claim Projections

B1. Adjustment to the Current Rate

Start Period:

End Period:

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient				
Outpatient				
Professional				
Prescription Drugs				
Other				
Capitation				
Total				

B3. Medical Trend Breakout

Factor	Impact
Utilization	
Unit Cost	
Other Factors	

Note: The federal disclosure forms require insurers to report important information about proposed rate increases. This portion of the sample form lists the reporting requirements related to insurers' projections of expected claims, and the medical trends they propose to use. While useful to advocates, this information may be difficult for many consumers to understand without an accompanying "plain language" summary.¹⁶

Fortunately, for large rate increases, the U.S. Department of Health and Human Services requires insurers to include a “plain language” narrative of the reasons for rate increases, which is intended to be more comprehensible to consumers. This approach means that full data is provided for more sophisticated consumers, but consumer-friendly summaries are also made available to allow less-expert consumers to make informed decisions.

Plain language summaries should include the overall average rate increase, the maximum and minimum rate increases consumers could experience under the proposal depending on the rating factors used, the percent of expenditures going to medical care, administrative costs and profits, and an explanation of any changes to rating factors or benefits.

FIGURE 2: CIGNA’s Explanation of the Rate Increase

CIGNA HealthCare of Arizona, Inc has prepared the following written explanation of this rate increase.

Insurer’s explanation of the rate increase:

Scope and range of the rate increase:

Cigna’s average new average rate for a small group HMO plan offered through the association will be \$1,272.41 PMPM. This is an increase of \$389.22 from the average current rate. There are estimated to be 90 customers impacted by this rate increase over the course of the next year. The increase all customers will receive is 44%.

Financial Experience of Cigna Healthcare of Arizona, Inc. SG Association HMO-Small Group

This product has experienced higher than expected claims and claims have been so high that they have exceeded the revenue collected since 2010. This means that the revenue received has not been sufficient to pay for all claims and administrative expenses. Of the 44% rate increase requested in this filing, 28% is intended to generate additional revenue to decrease losses from their current level.

Changes in Medical Service Costs:

The cost of medical services makes up the majority of a premium rate. These medical costs are increasing due to the costs of services and how often customers use medical services. The annual medical trend of 12.25% is caused by increasing doctor’s and hospital’s costs and more frequent use of medical services.

How Legally Required Benefit Changes contribute to the rate increase:

There have been no premium changes due to benefit changes in this filing. However, since enactment of PPACA, the premium rates have increased by an average of 1.75% in order to cover additional costs and higher use of medical services driven by the mandated benefit changes. These changes include covering preventive services at no cost share to the customer, removing lifetime and annual maximums from the benefits, covering dependents to age 26 and removing pre-existing condition exclusions on children.

How administrative costs & anticipated profits contribute to the rate increase:

In addition to the cost of medical services, there are a number of indirect medical and non-medical costs that an insurance company has to pay. These costs include things like programs that promote the best level of care and health for a patient, payments that must be made to federal, state or local government authorities in the form of taxes or fees, assessments or subsidies that states charge to pay for public health programs, e.g. childhood vaccines, financial examinations by the government, prevention of healthcare fraud, payments to agents or brokers who help customers enroll in a health plan and other costs that all business have such as employees’ salaries, building upkeep, utilities, etc.

Historically, the premium rate has not been sufficient to cover these administrative costs, although we anticipate the requested rate increase will be sufficient to cover all of these administrative costs in 2012.

Note: Plain language narrative submitted by Cigna HealthCare of Arizona explaining a proposed rate increase for some of its small group HMO products.¹⁷

FIGURE 2: Oregon's Rate Review Options



Welcome. You can use this page to view rate request documents, comment on specific rate requests and view the comments of others.

You do not have to fill in all the blanks to find a specific request. Select the company, type, and/or status of filings you are interested in. Select "Pending" to see the most recent rate requests. From the resulting list, you can view or make comments.

If you need help, call Jenni Bertels at 503-947-7081.

Company Name:

Insurance Type:

SERFF Tracking #:

State Tracking #:

Status: Pending Approved Disapproved Withdrawn Closed** All

Sort:

Note: Oregon's search page for insurer rate information allows the public to look for rate filings from particular companies, in particular market segments, and differentiate between pending and already-reviewed rate filings. It also allows for easy sorting of results by a variety of different criteria.¹⁸

Consumers also need the ability to easily find and compare rate information to be able to comparison shop. Robust, easy-to-use search tools with downloadable data (in easy-to-use formats like tab- or comma-delimited text files) in state rate review websites such as the Oregon Health Insurance Rate Review site allow users to sort insurers by the size of their rate increases.

Beyond being savvy shoppers by reading available information on rate increases, consumers can also play a valuable role in the rate review process by providing input to inform regulators' assessments of whether rate increases are justified. By submitting comments or testifying at hearings, consumers can provide a valuable perspective on what the likely impact of rate increases will be and when it becomes simply unaffordable. Significant rate increases may undermine the stability of an insurer – but it is sometimes difficult for regulators or the insurer to recognize whether a proposed increase may result in a dramatic drop in enrollment. These comments can help determine whether consumers are likely to drop coverage and move to another insurer, move to a different product with reduced benefits or simply pay the proposed increase.

The federal rules require state rate review programs to take consumer comments on pending, significant rate increases and that the state should make it as easy as possible for consumers to submit their views.

Experience shows that the informed comments of consumer advocates can also be valuable to regulators as they deliberate on the reasonableness of a rate increase. For example, when Oregon held its first public hearing in years on a health insurance rate increase, the head of the state's Insurance Division was initially skeptical of the value of the hearing, but was ultimately "incredibly impressed by the level of comments."¹⁹

Building a Strong Rate Review Process for Arizona

At present, Arizona’s rate review processes do not do enough to provide consumers with the information and protections they need. The Arizona Department of Insurance collects only incomplete rate information from insurers and lacks the power to disapprove unreasonable rate increases; consumers can only access even this limited information about their rates by filing a public records request or physically visiting the Department’s office.²⁰

As discussed in earlier sections of this report, there is no better time for Arizona to create a strong rate review program. Federal dollars can help to defray the start-up costs, and by making sure that the state’s rate review program counts as “effective” under the federal rules, improving the program could also allow Arizona to take primary responsibility for reviewing significant rate increases, rather than relying on the U.S. Department of Health and Human Services (HHS) to review insurers’ proposals.

The federal requirements for effective rate review programs are a good starting point for crafting this improved process. However, simply adopting the federal requirements would be a missed opportunity for Arizona to craft a rate review process that is responsive to the particular needs of consumers in our state and tailored to our insurance market. This section includes recommendations on policies the state should adopt in order to have a leading rate review process. All these recommendations apply equally to the small group and individual markets.

Review and Prior Approval

Perhaps the most important thing Arizona can do to make its rate review process effective in protecting consumers is to strengthen the authority of the Arizona Department of Insurance to prevent unreasonable rate increases from going into effect.

The recent federal rules already require states to analyze the information insurers submit to determine whether significant rate increases are reasonable in order for the state’s rate review process to qualify as effective. For rate filings that are significant due to the size of the proposed increase, the scope of the proposed changes to benefits, and/or the number of Arizonans affected, the Department’s review should be as thorough as possible, although a full actuarial analysis may not be required for all proposed increases.

When a state reviews significant rate increases, it can identify potentially unjustified rate-setting practices that insurers have employed. While federal law only currently requires that these unjustified rate increases be deemed as “unreasonable” in an effort to better inform consumers, it is common for states to go another step to better protect consumers by disallowing unjustified rate increases.

This key consumer protection may require changes to Arizona statutes and rules. Over thirty other states already have prior approval authority for at least some insurance products, including other western states like New Mexico (which last year passed a law strengthening its rate review process), Nevada and Colorado.²¹

Instituting such a requirement would better protect consumers. In many instances, small business and individual consumers may have few options for coverage and limited ability to comparison shop for coverage. For example, if consumers are purchasing coverage in the individual market and have developed a pre-existing condition that prevents them from obtaining other coverage, they may have few insurance options available. Consumers should not be forced to pay an unreasonable rate for the coverage they need.

Perhaps the most important thing Arizona can do is to strengthen the authority of the Arizona Department of Insurance.

Required Disclosures

For all proposed rate increases or decreases, the insurer should be required to file a full range of information with the Arizona Department of Insurance. The Department should in turn make this information publically accessible, allowing consumers to make judgments about the quality and cost of their care, and enabling advocates to more constructively engage with the Department's rate review activities.

All individual and small business health insurers should be required to submit the following information related to any rate increase that they propose to implement:

Basic Facts:

- A short narrative, written in consumer-friendly language, explaining the key reasons for the rate increase and summarizing the other information in this subsection.
- The average yearly increase – that is, how much the average enrollee will see their monthly premium increase if the rate is approved.
- The medical loss ratio, including a breakdown of what percentage is going to profit versus administrative costs. The loss ratios for the past five years should also be provided.
- Allocation of the rate increase to claims and non-claims costs – that is, how much is due to the increase in medical costs (claims costs) and how much is due to increases in administrative costs, profits and so on (non-claims costs).
- A five-year history of the insurer's rate increases in this market segment.
- The number of enrollees and total premiums received by the insurer, with data on both going back five years.

Medical Costs and Trends:

- Medical trend projections, including a breakdown of the proposed trend into unit cost, utilization and mix of services and any other factors being used.
- Monthly historical and projected claims experience going back at least three years, provided on a per-member-per-month basis to allow for apples-to-apples comparisons. (If aggregate claims costs are listed instead of per-member-per-month, changes in enrollment may overwhelm actual changes in the cost of medical care.)
- Methodological details of how the insurer calculated their medical trend, including the underlying data and assumptions if a normalization approach was taken.

Administrative Costs:

- A full historical disclosure of administrative costs for the last five years, broken down by different categories including wages and salaries; broker commissions; equipment; rent and occupancy; and taxes, fines and fees. All of these costs should be further classified according to whether or not they are directly related to processing and paying claims. An estimate of expected administrative costs over the next year, similarly broken down by categories, should also be provided.



Benefit and Rating Factor Changes:

- Any changes to benefits and the impact these changes will have on projected claims and rates.
- The rating factors currently in effect including factors for age, geography and health status, and whether they are being changed in the filing. If there are changes proposed, claims data for the different demographic groups involved should also be provided to permit an assessment of whether the proposed change bears a reasonable relationship to the actual difference in costs.

Other Information:

- Comparison of the projections the insurer made in previous years of medical trend, enrollment and so on to the actual values observed. If an insurer has a history of over- or under-estimating its medical costs, regulators and consumers should know that its current estimates may similarly be less reliable.
- Details on the insurer's financial status, including its reserves, surplus and investment income. Data going back five years can help provide a broader understanding of trends, for example revealing whether a higher-than-usual rate increase is necessary to make up for years of declining surpluses.
- How the rate increase is distributed across the enrollee population, and the maximum and minimum possible rate increases.
- Projected enrollment if the rate increase is approved. Dropping enrollment can undermine the stability of an insurer's risk pool, as healthier enrollees are the ones most likely to drop coverage first. Knowing what the insurer's enrollment is projected to be can help reveal if this is occurring, and what the insurer is doing to reverse this trend.
- A description of what the insurer is doing to reduce costs and improve quality, and an estimate of how much each of their initiatives is saving. With medical costs continuing to increase, the insurers who invest in programs to reduce unneeded treatments and promote evidence-based care will provide a better long-term deal to consumers. Enrollees need to know this information to make better decisions, and regulators must have this information to know whether the increased investment of administrative costs entailed in creating them will ultimately help consumers.

The federal rules require information to be disclosed only for proposed rate increases above 10 percent, or a state-specific threshold that may be identified in the future. This threshold was selected due in part to concerns about administering rate review at the federal level and the complexities of gathering rate information from every state.²² However, there is no reason Arizona should similarly limit the information available to consumers. If some insurers are raising rates by 2 percent while others are raising rates by 9 percent, consumers will better be able to shop around if they know that fact.

Complying with the above recommendations would not be especially onerous for insurers, since almost all of the information listed must be compiled as they calculate their rate increases. Our recommendations closely track the requirements currently used in the federal rate review program, and compliance with those rules is expected to take twelve hours or less of staff time per filing.²³

If some insurers are raising rates by 2 percent while others are raising rates by 9 percent, consumers will better be able to shop around if they know that fact.

Consumer Involvement

As discussed earlier in this report, robust consumer participation can make a rate review process more useful to the public and render regulatory deliberations better-informed. Arizona should:

- Post all rate information on a prominent and easy-to-use website, so that consumers can quickly and simply research rate filings for all insurers.
- Develop easy ways for consumers and advocates to comment on rate increases before regulators begin their review.
- Hold hearings on significant rate increases and take testimony from affected consumers and their advocates.

If a significant rate increase is found to be unjustified or unreasonable but allowed to go into effect, an insurer should be required to affirmatively inform its customers of this fact – simply putting a note on the insurer’s website is unlikely to do enough to inform the public about this important finding. For example, an insurer could be required to include such a notice along with the mailing informing consumers of their new rate.

Conclusion

By making these changes, Arizona can create a nation-leading rate review program that brings transparency to the often-cryptic process of setting rates, giving consumers a voice in the process and protecting the public from unjustified, unreasonable rate increases that would otherwise drive up healthcare costs.

With the price of coverage continuing to increase and affordability growing more and more important for healthcare consumers, strong rate review would provide consumers with needed information and protections.

More transparency and increased consumer protections would allow for a more competitive marketplace, resulting in lower costs and higher quality coverage for individuals and small businesses in Arizona.

Endnotes

- 1 See Kaiser Family Foundation, State Health Facts – Rate Review, Small Group, and Rate Review, Individual, at <http://www.statehealthfacts.org/comparetable.jsp?ind=888&cat=7> and <http://www.statehealthfacts.org/comparetable.jsp?ind=887&cat=7>; for the New Mexico law, see SB 208 (Feldman), Health Insurance Rate Increase Review, 2011 Regular Session, at http://www.nmlegis.gov/lcs/_session.aspx?chamber=S&legtype=B&legno=208&year=11.
- 2 CMS Office of the Actuary, Total All Payers State Estimates by State of Residence – Personal Health Care, Dec. 2011, at <https://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf>.
- 3 See Kaiser Family Foundation, State Health Facts – Rate Review, Small Group, and Rate Review, Individual, at <http://www.statehealthfacts.org/comparetable.jsp?ind=888&cat=7> and <http://www.statehealthfacts.org/comparetable.jsp?ind=887&cat=7>.
- 4 See, e.g., California Department of Insurance, *California Department of Insurance Uncovers Substantial Errors in Anthem Blue Cross Rate Filing; Anthem Withdraws Rate Application*, Apr. 29, 2010, at <http://www.insurance.ca.gov/0400-news/0100-press-releases/2010/release058-10.cfm>; Oregon Department of Consumer and Business Services, *State Lowers Regence Rate Increase to 12.8 Percent*, July 19, 2011, at http://www.insurance.oregon.gov/news_releases/2011/071911-regence-decision.pdf; Maine Department of Professional and Financial Regulation, Bureau of Insurance, *Decision and Order in re Anthem Blue Cross and Blue Shield 2011 Individual Rate Filing*, May 12, 2011, available at http://www.maine.gov/pfr/insurance/hearing_decisions/11-1000.htm.
- 5 See CALPIRG, *Keeping Insurers Honest*, May 2010, at <http://www.calpirg.org/reports/caf/keeping-insurers-honest>.
- 6 The final federal rules may be found at 45 CFR Part 154. Notably, the nationwide 10 percent threshold is meant to be temporary, to be replaced in future years by state-specific thresholds set by the Secretary of HHS in consultation with each state. 45 CFR § 154.200.
- 7 See Arizona Department of Insurance, Application: Grants to States for Health Insurance Premium Review – Cycle 1, July 2010 at http://www.id.state.az.us/RateReview/AZ_Rate_Review_Grant_Application_20100816.pdf; U.S. Department of Health and Human Services, Notice of Grant Award, Grant No. 1 IPRPR100014-01-00, August 2010, at http://www.id.state.az.us/RateReview/AZ_Rate_Review_Grant_Award.pdf.
- 8 See Arizona Department of Insurance, Frequently Asked Questions and Key Facts about Health Insurance Rate Review, at <http://www.id.state.az.us/publications/FAQsfinal26ap11.pdf>.
- 9 A provision included in 2010's Affordable Care Act requires individual market and small group insurers to maintain medical loss ratios of at least 80%, or pay rebates to their customers. See Patient Protection and Affordable Care Act of 2010 ("ACA"), §§ 1001 (amending § 2718 of the Public Health Services Act) and 10101(f).
- 10 In 2014, the ACA will set "age band" limits, restricting the ability of insurers to vary premiums based on enrollee age. ACA § 1201 (adding §2701 of the Public Health Service Act).
- 11 In effect, insurers cannot increase a business' premiums for more than 15 percent per year based on changes in health status. ARS §20-2311.
- 12 It is also the case that on the individual market, insurers can refuse to offer coverage to consumers – and so they frequently decline coverage to those who are sick or are more likely to become sick, or insist on excluding treatments for certain pre-existing conditions from the coverage. However, provisions of the ACA, set to go into effect in 2014, will require insurers to offer coverage to all, without pre-existing condition exclusions, and also prohibit rating on health status, on both the individual and small group markets. ACA §1201.
- 13 See, e.g., Dartmouth Atlas of Health Care, Price-Adjusted Medicare Reimbursements per Enrollee Data for Arizona, at <http://www.dartmouthatlas.org/data/region/>.
- 14 See, e.g., Aon Hewitt, 2011 Health Care Trend Survey – Summer, at http://www.aon.com/attachments/thought-leadership/2011_Health_Care_Trends_Survey_Final_FINAL.pdf.
- 15 See Axene Health Partners for the California Department of Insurance, Review of Anthem Blue Cross 2010 Rate Increases, April 28, 2010, at http://www.naic.org/documents/index_health_reform_rate_review_ca_review_anthem_rate.pdf.
- 16 Excerpt of CMS Form 10379, Rate Increase Disclosure and Rate Review Reporting Requirements, available at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp>.
- 17 Healthcare.gov, CIGNA HealthCare of Arizona, Inc. Rate Review for AZ SG Association HMO-HMO-Small Group-97667AZo13, at http://companyprofiles.healthcare.gov/states/AZ/companies/97667/products/97667AZo13/rate_reviews/309.
- 18 Oregon Health Insurance Rate Review Search Tool, at http://www.oregonhealthrates.org/?fuseaction=home.show_search.
- 19 See, e.g., The Oregonian, *An Insurance Regulator's Aha Moment*, July 21, 2011, at http://www.oregonlive.com/opinion/index.ssf/2011/07/an_insurance_regulators_aha_mo.html.
- 20 See Arizona Department of Insurance, Frequently Asked Questions and Key Facts about Health Insurance Rate Review, at <http://www.id.state.az.us/publications/FAQsfinal26ap11.pdf>.
- 21 For the New Mexico law, see SB 208 (Feldman), Health Insurance Rate Increase Review, 2011 Regular Session, at http://www.nmlegis.gov/lcs/_session.aspx?chamber=S&legtype=B&legno=208&year=11.
- 22 See Federal Register, Vol. 76, No. 99, pp. 29967-68.
- 23 Id., pp. 29975-76.



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