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PRIVATE HEALTH INSURANCE

State Oversight of Premium Rates and Changes in Response to Federal Rate Review Grants

Statement of John E. Dicken
Director, Health Care

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Chairman Harkin, Ranking Member Enzi, and Members of the Committee:

I am pleased to be here today to discuss state oversight of health insurance premium rates in 2010 and changes that states that received Department of Health and Human Services (HHS) rate review grants have begun making to enhance their oversight of premium rates. In 2009, about 173 million nonelderly Americans, about 65 percent of the U.S. population under the age of 65, had private health insurance coverage, either through individually purchased or employer-based private health plans. The cost of this health insurance coverage continues to rise. In a 2010 survey, over three-quarters of U.S. consumers with individually purchased private health plans reported health insurance premium increases. Of those reporting increases, the average premium increase was 20 percent.¹ A separate survey found that premiums for employer-based coverage more than doubled from 2000 to 2010.² Policymakers have raised questions about the extent to which these increases in health insurance premiums are justified and could adversely affect consumers.

Oversight of the private health insurance industry is primarily the responsibility of individual states.³ This includes oversight of health insurance premium rates, which are actuarial estimates of the cost of providing coverage over a period of time to policyholders and enrollees in

¹The Kaiser Family Foundation, "Survey of People Who Purchase Their Own Insurance," (Menlo Park, CA, June 2010).

²The Kaiser Family Foundation and Health Research & Education Trust, "Employer Health Benefits 2010 Annual Survey," (Menlo Park, CA, September 2010).

³See Law of Mar. 9, 1945, ch. 20, 59 Stat. 33 (codified, as amended, at 15 U.S.C. ch. 20) (popularly known as the McCarran-Ferguson Act). The McCarran-Ferguson Act provides states with the authority to regulate the business of insurance, without interference from federal regulation, unless federal law specifically provides otherwise. Therefore, states are primarily responsible for overseeing private health insurance premium rates in the individual and group markets in their states. Through laws and regulations, states establish standards governing health insurance premium rates and define state insurance departments' authority to enforce these standards. In general, the standards are used to help ensure that premium rates are adequate, not excessive, reasonable in relation to the benefits provided, and not unfairly discriminatory.

a health plan.⁴ While oversight of private health insurance, including premium rates, is primarily a state responsibility, the 2010 Patient Protection and Affordable Care Act (PPACA) established a role for HHS by requiring the Secretary to work with states to establish a process for the annual review of unreasonable premium increases.⁵ In addition, PPACA required the Secretary to carry out a program to award grants to assist states in their review practices.⁶ Since the enactment of PPACA, members of Congress and others have continued to raise questions about rising health insurance premium rates and states' practices for overseeing them.

My statement will highlight key findings from a report we are publicly releasing today that describes state oversight of health insurance premium rates in 2010 and changes that states that received HHS rate review grants have begun making to enhance their oversight of health insurance premium rates.⁷ For that report, we surveyed officials from the insurance departments⁸ of all 50 states and the District of Columbia (collectively referred to as "states"). We received responses from all but one state.⁹ In order to obtain more detailed information about state oversight of health insurance premium rates in 2010, we also conducted

⁴To determine rates for a specific insurance product, carriers estimate future claims costs in connection with the product and then the revenue needed to pay anticipated claims and nonclaims expenses, such as administrative expenses. Premium rates are usually filed as a formula that describes how to calculate a premium for each person or family covered, based on information such as geographic location, underwriting class, coverage and co-payments, age, gender, and number of dependents.

⁵Pub. L. 111-148 §§ 1003, 10101(i), 124 Stat. 119, 139, 891 (adding and amending § 2794 to the Public Health Service Act (PHSA)).

⁶Pub. L. 111-148 § 1003, 124 Stat. 139, 140, 891 (adding and amending PHSA § 2794 (a)(1) and (c)).

⁷GAO, *Private Health Insurance: State Oversight of Premium Rates*, [GAO-11-701](#) (Washington, D.C.: July 29, 2011).

⁸For the purposes of this report, we refer to the entities responsible for the oversight of premium rates as insurance departments, even though the entity responsible for oversight of premium rates in each state was not always called the Department of Insurance. For example, in Minnesota, the Department of Commerce is responsible for the oversight of health insurance premium rates.

⁹Officials from the Indiana Department of Insurance declined to complete our survey. In addition, not all states responded to each question in the survey. We conducted the survey from February 25, 2011, through April 4, 2011, collecting information primarily on state practices for overseeing premium rates in calendar year 2010.

interviews with insurance department officials from five selected states.¹⁰ Additionally, we interviewed other experts and officials from relevant organizations, including the Center for Consumer Information and Insurance Oversight within the Centers for Medicare & Medicaid Services, the National Association of Insurance Commissioners (NAIC), the American Academy of Actuaries, America's Health Insurance Plans, two large carriers based on their number of covered lives,¹¹ NAIC consumer representatives (individuals who represent consumer interests at meetings with NAIC), and various advocacy groups such as Families USA and Consumers Union. We also reviewed portions of the states' Cycle I rate review grant applications submitted to HHS and other relevant HHS documents. Our work was performed from September 2010 through July 2011 in accordance with generally accepted government auditing standards.

In brief, we found that oversight of health insurance premium rates—primarily reviewing and approving or disapproving rate filings submitted by carriers—varied across states in 2010. While nearly all—48 out of 50—of the state officials who responded to our survey reported that they reviewed rate filings in 2010, the practices reported by state insurance officials varied in terms of the timing of rate filing reviews, the information considered in reviews, and opportunities for consumer involvement in rate reviews. Specifically, respondents from 38 states reported that all rate filings reviewed were reviewed before the rates took effect, while other respondents reported reviewing at least some rate filings after they went into effect. Survey respondents also varied in the types of information they reported reviewing. While nearly all survey respondents reported reviewing information such as trends in medical costs and services, fewer than half of respondents reported reviewing carrier capital levels compared with state minimums. Some survey respondents also reported conducting comprehensive reviews of rate filings, while others reported reviewing little information or conducting cursory reviews. In addition, while 14 survey respondents reported providing consumers with opportunities to be involved in premium rate oversight, such as

¹⁰We selected these states—California, Illinois, Maine, Michigan, and Texas—based on differences among the five states in terms of their (1) state insurance departments' authority to oversee premium rates, (2) proposed changes to their existing practices for overseeing premium rates, (3) size, and (4) geographic location.

¹¹A carrier is generally an entity—either an insurer or managed health care plan—that bears the risk for and administers a range of health benefit offerings.

participation in rate review hearings or public comment periods, most did not. Finally, the outcomes of states' reviews of rate filings varied across states in 2010. Specifically, survey respondents from 5 states reported that over 50 percent of the rate filings they reviewed in 2010 were disapproved, withdrawn, or resulted in rates lower than originally proposed, while survey respondents from 19 states reported that these outcomes occurred from their rate reviews less than 10 percent of the time.

Our survey of state insurance department officials found that 41 respondents from states that were awarded HHS rate review grants reported that they have begun making changes in order to enhance their states' abilities to oversee health insurance premium rates. For example, about half of these respondents reported taking steps to either review their existing rate review processes or develop new processes. Other states reported that they were changing information that carriers are required to submit with rate filings, incorporating additional data or analyses in rate filings, or taking steps to involve consumers in the rate review process. In addition, over two-thirds reported that they have begun to make changes to increase their capacity to oversee premium rates, including hiring staff or outside actuaries, and improving the information technology systems used to collect and analyze rate filing data. Finally, more than a third reported that their states have taken steps—such as introducing or passing legislation—in order to obtain additional legislative authority for overseeing health insurance premium rates.

Chairman Harkin, Ranking Member Enzi, this concludes my prepared remarks. I would be pleased to respond to any questions you or other members of the committee may have at this time.

For questions about this statement, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Kristi Peterson, Assistant Director; Kelly DeMots; Linda Galib; and Peter Mangano.

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