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Report to Congressional Requesters

July 2011

PRIVATE HEALTH INSURANCE

State Oversight of Premium Rates

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GAO-11-701

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PRIVATE HEALTH INSURANCE

State Oversight of Premium Rates

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-11-701, a report to congressional requesters

Why GAO Did This Study

With premiums increasing for private health insurance, questions have been raised about the extent to which increases are justified. Oversight of the private health insurance industry is primarily the responsibility of states. In 2010, the Patient Protection and Affordable Care Act required the Department of Health and Human Services (HHS) to award grants to assist states in their oversight of premium rates. GAO was asked to provide information on state oversight of premium rates. In this report, GAO describes (1) states' practices for overseeing health insurance premium rates in 2010, including the outcomes of premium rate reviews; and (2) changes that states that received HHS rate review grants have begun making to enhance their oversight of premium rates.

GAO surveyed officials from insurance departments in 50 states and the District of Columbia (referred to as states) about their practices for overseeing premium rates in 2010 and changes they have begun making to enhance their oversight. GAO received responses from all but one state. GAO also interviewed officials from California, Illinois, Maine, Michigan, and Texas to gather additional information on state practices. GAO selected these states based on differences in their authority to oversee premium rates, and proposed changes to their oversight, their size, and their geographic location. GAO also interviewed officials from advocacy groups and two large carriers to obtain contextual information.

View GAO-11-701 or key components.
For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

GAO 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 GAO's 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 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.

GAO's 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. 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.

HHS and the National Association of Insurance Commissioners (NAIC) reviewed a draft of this report. In its written comments, HHS highlighted the steps it is taking to improve transparency, help states improve their health insurance rate review, and assure consumers that any premium increases are being spent on medical care. HHS and NAIC provided technical comments, which were incorporated as appropriate.

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Abbreviations

CRS	Congressional Research Service
HHS	Department of Health and Human Services
HMO	health maintenance organization
NAIC	National Association of Insurance Commissioners
PPACA	Patient Protection and Affordable Care Act
RBC	risk-based capital
SERFF	System for Electronic Rate and Form Filing

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

July 29, 2011

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Dianne Feinstein
United States Senate

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 a health plan. 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 the Department of Health and Human Services (HHS) by requiring the Secretary of HHS to work with states to establish a process for the annual

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

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

[3]*See* 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).

review of unreasonable premium increases.[4] In addition, PPACA required the Secretary of HHS to carry out a program to award grants to assist states in their review practices.[5] 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.

You asked us to review certain aspects of states' oversight of health insurance premium rates. This report describes (1) states' practices for overseeing health insurance premium rates in 2010, including the outcomes of premium rate reviews; and (2) changes that states that received HHS rate review grants have begun making to enhance their oversight of health insurance premium rates.

To describe states' practices for overseeing health insurance premium rates in 2010, including the outcomes of premium rate reviews, we surveyed officials from the insurance departments[6] of all 50 states and the District of Columbia (collectively referred to as "states"). We received responses from all but one state.[7] However, not all states responded to each question in the survey. Additionally, some survey respondents reported that they could not provide data for all questions. 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. In order to obtain more detailed information about state oversight of health insurance premium rates in 2010, we also conducted interviews with insurance department officials from five selected states. We 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

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

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

[6]For 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.

[7]Officials from the Indiana Department of Insurance declined to complete our survey.

premium rates, (2) proposed changes to their existing practices for overseeing premium rates, (3) size, and (4) geographic location.[8] Additionally, in order to obtain contextual information on states' practices for overseeing premium rates, we interviewed other experts and officials from relevant organizations, including 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,[9] NAIC consumer representatives (individuals who represent consumer interests at meetings with NAIC), and various advocacy groups such as Families USA and Consumers Union.

To describe changes that states that received HHS rate review grants have begun making to enhance their oversight of health insurance premium rates, we collected information about state changes in our survey described above from the 45 state survey respondents that were awarded HHS rate review grants in 2010 entitled, "Grants to States for Health Insurance Premium Review-Cycle I" (referred to as Cycle I rate review grants).[10] We also asked about these changes in oversight during our interviews with state insurance department officials from the five selected states and in other interviews with experts and relevant organizations described above. Additionally, we interviewed officials from the Center for Consumer Information and Insurance Oversight within the Centers for Medicare & Medicaid Services. We also reviewed portions of the states' Cycle I rate review grant applications submitted to HHS and other relevant HHS documents. See appendix I for a more detailed description of our methodology.

[8]We obtained information on states' authorities to oversee premium rates from the National Association of Insurance Commissioners. We obtained information on states' proposed changes to their rate oversight practices from states' Cycle I rate review grant applications that were submitted to HHS between June and July of 2010.

[9]A 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.

[10]Forty-five of our 50 state survey respondents reported that they applied for an HHS Cycle I rate review grant. Survey respondents from five states—Alaska, Georgia, Iowa, Minnesota, and Wyoming—did not apply for an HHS rate review grant and therefore did not indicate in our survey if they had taken steps to make changes to rate oversight as described in rate review grant applications to HHS. One state—Indiana—applied for a Cycle I rate review grant but did not complete our survey.

We conducted this performance audit from September 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The majority of Americans receive their health coverage through private health insurance, either by purchasing coverage directly or receiving coverage through their employer, and many of those with private coverage are enrolled in plans purchased from state-licensed or regulated carriers. An estimated 173 million nonelderly Americans, 65 percent, received health coverage through private insurance in 2009. The remainder of Americans either received their health coverage through government health insurance, such as Medicare and Medicaid, or were uninsured.[11]

In general, those who obtain private health insurance do so in one of three market segments: individual, small-group, and large-group. Policyholders in the individual market purchase private health insurance plans directly from a carrier—not in connection with a group health plan. In 2009 an estimated 17 million nonelderly Americans obtained individual private health insurance coverage.[12] In the small-group market, enrollees generally obtain health insurance coverage through a group health plan offered by a small employer, and in the large-group market, enrollees generally obtain coverage through a group health plan offered by a large

[11]Medicare is the federal health insurance program for people age 65 or over, certain disabled individuals under age 65, and individuals diagnosed with end-stage renal disease. Medicaid is the federal-state program that finances health care for certain low-income individuals and families.

[12]Carmen DeNevas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," *U.S. Census Bureau* (September 2010).

employer.[13] In 2009, an estimated 156 million nonelderly Americans obtained private health insurance through employer-based group plans offered by either small or large employers. While most small-group coverage is purchased from state-licensed or regulated plans, most large-group coverage is purchased from employer self-funded plans not subject to state licensing or regulation. However, there are some fully-insured large-group plans, which are subject to state regulation.

Premium rates are actuarial estimates of the cost of providing coverage over a period of time to policyholders and enrollees in a health plan. To 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.

States' Roles in Oversight of Health Insurance Premium Rates

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.

[13]States generally define a small employer as an employer with at least 2 but not more than 50 employees, and a large employer as an employer with at least 51 employees. PPACA redefined a small employer as an employer with an average of 1 to 100 employees, and a large employer as an employer with an average of at least 101 employees. For plan years beginning before January 1, 2016, a state has the option to define small employers as having employed an average of 1 to 50 employees during the preceding calendar year and to define large employers as having employed an average of at least 51 employees during the preceding calendar year. *See* Pub. L. No. 111-148, § 1304(b), 124 Stat. 172.

In overseeing health insurance premium rates, state insurance departments may review rate filings submitted by carriers. A rate filing may include information on premium rates a carrier proposes to establish, as well as documentation justifying the proposed rates, such as actuarial or other assumptions and calculations performed to set the rate. According to the Congressional Research Service (CRS) and others, most states require carriers to submit rate filings to state departments of insurance prior to implementation of new rates or rate changes.

The authority of state insurance departments to review rate filings can vary. Some insurance departments have the authority to approve or disapprove all rate filings before they go into effect, while others do not have any authority to approve or disapprove rate filings. Further, in some states, authority to approve or disapprove rate filings varies by market.[14]

According to a report published by CRS, in 2010, insurance departments in 19 states were authorized by their state to approve or disapprove proposed premium rates in all markets before they went into effect—known as prior approval authority.[15] Officials in states with prior approval authority may review a carrier's rate filing using the state's standards governing health insurance premium rates. In some cases, the state officials may also consider input from the public on the proposed rate, which can be obtained, among other ways, through public hearings or public comment periods. If a proposed rate does not meet a state's standards, officials in states with prior approval authority can, among other things, deny the proposed rate or request that the carrier submit a new rate filing that addresses the issues that the state identified during its review. If a proposed rate meets a state's standards, the officials may approve the rate filing. However, in some states, if the officials do not review a proposed rate filing and take action within a specified time period, the carrier's submitted rate filing is deemed approved under state law.

[14]According to NAIC, in some states, authority to approve or disapprove rate filings may also vary by type of insurance product.

[15]Mark Newsom and Bernadette Fernandez, "Private Health Insurance Premiums and Rate Reviews," *Congressional Research Service* (Washington, D.C., Jan. 11, 2011).

According to CRS, insurance departments in another 10 states were authorized to disapprove rate filings in all markets in 2010, but not to approve rate filings before a carrier could begin using the premium rate or rates proposed in the filing. In 9 of these states, carriers were required to submit rate filings prior to the effective date of the proposed rate—known as file and use authority. In one state, carriers could begin using a new premium rate and then file it with the state—known as use and file authority. In departments with file and use authority or use and file authority, the state officials may review a carrier's rate filing using the state's standards governing health insurance rates. If a proposed rate does not meet these standards, the officials can, among other things, deny the proposed premium rate or request that the carrier submit a new rate filing that addresses the issues that the state identified during its review. However, the state officials do not have the authority to approve a rate filing before the proposed premium rate goes into effect, and unless the rate filing has been disapproved, a carrier may begin using the new premium rate as of its effective date.

In six states, insurance departments were not authorized to approve or disapprove rate filings in any market in 2010, according to CRS. In three of these states, a carrier was required to submit rate filings for informational purposes only, known as information only authority. In the other three states, carriers were not required to submit rate filings with the states.

In addition, in one state, carriers were not required to file rates for approval or disapproval each time the carrier proposed to change premium rates. Instead, carriers were required to file premium rates with the form that was filed when the plan was initially offered on the market—this form includes the language in the insurance contract. This is known as file with form authority.

According to CRS, in the remaining 15 states, authority to approve or disapprove rate filings varied by market in 2010. For example, a state insurance department may have prior approval authority in the individual market, but have information only authority in the small-group and large-group markets subject to their regulation.

HHS's Role in Oversight of Health Insurance Premium Rates

PPACA, signed into law in March 2010, established a role for HHS by requiring the Secretary of HHS to work with states to establish a process for the annual review of unreasonable premium increases. PPACA also established a state grant program to be administered by HHS beginning in fiscal year 2010.

HHS has taken steps to work with states to establish a process for reviewing premium rate increases each year. In December 2010, HHS published a proposed rule,[16] and in May 2011, HHS issued a final rule that established a threshold for review of rate increases for the individual and small-group markets and outlined a process by which certain rate increases would be reviewed either by HHS or a state.[17] The final rule also included a process by which HHS would determine if a state's existing rate review program was effective.[18] HHS would review rates in states determined not to have an effective rate review program; in these instances, HHS would determine if a rate increase over an applicable threshold in the individual and small-group market was unreasonable based on whether it was excessive, unjustified, or unfairly

[16]75 Fed. Reg. 81004 (Dec. 23, 2010).

[17]Rate Increase Disclosure and Review; Final Rule, 76 Fed. Reg. 29964 (May 23, 2011) (codified at 45 C.F.R. subtitle A, subchapter B, part 154). The rule is effective July 18, 2011. The rule would require the review of all proposed rate increases over an applicable threshold to determine whether the rate increases and their underlying assumptions were reasonable. 45 C.F.R. §154.200. All proposed rate increases over the threshold would be reviewed either by a state—if it is determined by HHS to have an effective rate review program and provides its final determination of whether a rate increase is unreasonable within 5 business days following the state's final determination—or by HHS. 45 C.F.R. § 154.210.

[18]According to the final rule, HHS would determine if a state has an effective rate review process based on the following criteria: (1) whether the state receives from carriers data and documentation sufficient to determine whether a rate increase is unreasonable; (2) whether the state conducts an effective and timely review of the data and documentation submitted by carriers in support of a proposed rate increase; (3) whether the state review examines the reasonableness of the assumptions used by the carrier in developing its rate proposal and the historic data underlying those assumptions and data related to past projections and actual experience; (4) whether the state review takes into consideration certain specified factors; (5) whether the state applies a standard set forth in state statute or regulation when making the determination of whether a rate increase is unreasonable; and (6) whether the state provides access from its web site to information regarding proposed premium rate increases, and has a mechanism for receiving public comments on those proposed rate increases. 45 C.F.R. § 154.301.

discriminatory.[19] In developing this final rule, HHS worked with states to understand various states' rate review authorities.

HHS has also begun administering a state grant program to enhance states' existing rate review processes and provide HHS with information on state trends in premium increases in health insurance coverage. PPACA established this 5-year, $250 million state grant program to be administered by HHS, beginning in fiscal year 2010. HHS announced the first cycle of rate review grants in June 2010, awarding $46 million ($1 million per state) to the 46 states that applied for the grants.[20] According to HHS, grant recipients proposed to use this Cycle I grant funding in a number of ways, including seeking additional legislative authority to review premium rate filings, expanding the scope of their reviews, improving the rate review process, and developing and upgrading technology. HHS announced the second cycle of rate review grants in February 2011 with $199 million available in grant funding to states.[21]

Reported Practices for Overseeing Premium Rates, as Well as Outcomes of Rate Reviews, Varied across States in 2010

Through our survey and interviews with state officials, 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. In addition, the reported outcomes of rate filing reviews varied widely across states in 2010, in particular, the extent to which rate filings were disapproved, withdrawn, or resulted in lower rates than originally proposed.

[19]45 C.F.R. § 154.205.

[20]Survey respondents from Florida reported that the state rescinded its acceptance of the HHS rate review grant.

[21]"Grants to Support States in Health Insurance Rate Review-Cycle II," accessed July 22, 2011, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=12332.

While Nearly All State Officials Reported Reviewing Premium Rates in 2010, the Timing of Reviews, Information Reviewed, and Extent of Consumer Involvement in Reviews Varied

Nearly all—48 out of 50—of the state officials who responded to our survey reported that they reviewed rate filings in 2010.[22] Further, respondents from 30 states—over two-thirds of the states that provided data on the number of rate filings reviewed in 2010—reported that they reviewed at least 95 percent of rate filings received in 2010.[23] Among the survey respondents that reported reviewing less than 95 percent of rate filings in 2010, some reported that a portion of the rate filings were deemed approved without a review because they did not approve or disapprove them within a specified time period. Others reported that they did not review rate filings in certain markets. For example, respondents from 4 of these states reported that they did not review any rate filings received in the large-group market subject to their regulation in 2010. In addition, some respondents that reported reviewing rate filings in 2010 reported that they did not receive rate filings in certain markets. For example, respondents from 9 states—nearly one quarter of the states that provided information by market—reported that they did not receive rate filings in the large-group market in 2010.[24] (See appendix II for more information on the results of our survey.)

While our survey responses indicated that most states reviewed most of the rate filings they received in 2010, the responses to our survey also showed that how states reviewed the rate filings varied in 2010. Specifically, the practices reported by state insurance officials varied in terms of (1) the timing of rate filing reviews—whether rate filings were reviewed before or after the rates took effect, (2) the information considered during reviews, and (3) opportunities for consumer involvement in rate reviews.

[22]Survey respondents from two states—Illinois and Louisiana—reported that they did not review rate filings in 2010 because their state insurance departments did not have sufficient authority to approve or disapprove rate filings.

[23]Survey respondents from 44 states provided data on the number of rate filings reviewed in 2010. Respondents from four states—Missouri, Montana, Oklahoma, and Virginia—reported reviewing rate filings in 2010 but did not provide the number of rate filings reviewed in 2010.

[24]Survey respondents from 39 states provided information by market.

Timing of Rate Reviews

Respondents from 38 states reported that all rate filings they reviewed were reviewed before the rates took effect, while respondents from 8 states reported reviewing at least some rate filings after the rates went into effect.[25] Some of the variation in the timing of rate filing reviews was consistent with differences across states in their reported authorities for state insurance departments to approve or disapprove rate filings. For example, survey respondents from some states reporting prior approval authority—such as Maryland and West Virginia—were among respondents from the 38 states that reported that all rate filings the state reviewed were reviewed before the rates took effect in 2010. Similarly, survey respondents from another state—Utah—reported that at least some rate filings were reviewed after the rates went into effect, because the department had file and use authority and it was not always possible to review rate filings before they went into effect. However, not all variation in states' practices was consistent with differences in state insurance departments' authorities to review and approve or disapprove rate filings. For example, survey respondents from California—who indicated that they did not have the authority to approve rate filings before carriers could begin using the rates—reported that all rate filings reviewed in 2010 were reviewed prior to the rates going into effect.

Information Considered during Rate Reviews

According to our survey results and interviews with state insurance department officials, the information considered as a part of the states' reviews of rate filings varied. For example, as shown in table 1, our survey results indicated that nearly all survey respondents reported reviewing information such as medical trend, a carrier's rate history, and reasons for rate revisions. In contrast, fewer than half of state survey respondents reported reviewing carrier capital levels compared with states' minimum requirements or compared with an upper threshold.[26] (See appendix III for more detailed information about carrier capital levels.) Overall, when asked to select from a list of 13 possible types of information considered during rate filing reviews in 2010, 7 respondents

[25]Respondents from 2 of the 48 states that reported reviewing rates in 2010 did not respond to this question.

[26]States review carrier capital levels compared with minimum required levels in order to ensure that the carriers can meet their financial obligations. In addition, some states may review carrier capital levels compared with an upper threshold because concerns have been raised about carriers maintaining potentially excessive amounts of surplus.

reported that they reviewed fewer than 5 of the items that we listed, while 13 respondents reported reviewing more than 10 items.[27]

Table 1: Selected Types of Information State Survey Respondents Reported Considering When Reviewing Rate Filings during 2010

Type of information considered[a]	Number of state survey respondents that reported considering the type of information when reviewing rate filings (as a percentage of responding states that reviewed rate filings during 2010)
Medical trend	44 (92%)
Rate history (for rate changes only)	44 (92%)
Reasons for rate revision (for rate changes only)	43 (90%)
Benefits provided	40 (83%)
Medical loss ratio	40 (83%)
Utilization of services	32 (67%)
Carrier administrative costs	32 (67%)
Enrollee risk profiles/ rating characteristics	28 (58%)
Cost sharing	28 (58%)
Carrier profit	27 (56%)
Carrier reserves (i.e., liabilities)	24 (50%)
Carrier capital levels compared with state minimum requirements	18 (38%)
Carrier capital levels compared with an upper threshold	8 (17%)

Source: GAO analysis.

Note: Forty-eight states reported that they reviewed at least one rate filing in 2010.

[a]List created by GAO based on information from NAIC and HHS.

[27]The list of information that survey respondents were provided included: medical trend, rate history (for rate changes only), reasons for rate revision (for rate changes only), benefits provided, medical loss ratio, utilization of services, carrier administrative costs, enrollee risk profiles/rating characteristics, cost sharing, carrier profit, carrier reserves (i.e., liabilities), carrier capital levels compared with states' minimum requirements, and carrier capital levels compared with an upper threshold. We created these categories based on a review of the possible types of information that state officials might consider when reviewing rate filings, including information from NAIC and HHS. However, some states may have also reviewed information that was not included in our list.

Some survey respondents also reported conducting relatively more comprehensive reviews and analyses of rate filings, while other respondents reported reviewing relatively little information or conducting cursory reviews of the information they received. For example, survey respondents from Texas reported that for all filings reviewed, all assumptions, including the experience underlying the assumptions, were reviewed by department actuaries for reasonableness, while respondents from Pennsylvania and Missouri reported that they did not always perform a detailed review of information provided in rate filings. Respondents from Pennsylvania reported that while they compared data submitted by carriers in rate filings to the carriers' previous rate filings, the state's department of insurance did not have adequate capacity to perform a detailed review of all rate filings received from carriers. Respondents from Missouri reported that they looked through the information provided by carriers in rate filings in 2010, but that they did not have the authority to do a more comprehensive review.

We also found that the type of information states reported reviewing in 2010 varied by market or product type. For example, officials from Maine told us that they reviewed information such as medical trend and benefits provided when reviewing rate filings in the individual market and under certain circumstances in the small-group market. However, they told us that they conducted a more limited review in the small-group market if the carrier's rate filing guaranteed a medical loss ratio of at least 78 percent and the plan covered more than 1,000 lives.[28] In another example, Michigan officials reported that, in 2010, they reviewed a number of types of information for health maintenance organization (HMO) rate filings, including rating methods and charts that showed the levels of premium rate increases from the previous year. These officials told us that the state required HMO rates to be "fair, sound, and reasonable" in relation to the services provided, and that HMOs had to provide sufficient data to support this. In contrast, the officials told us that the state's requirement for commercial carriers in the individual market was to meet a medical loss ratio of 50 to 65 percent, depending on certain characteristics of the insurance products.

[28]A medical loss ratio has traditionally been reported as the percentage of premium dollars that a carrier spends on medical care, versus how much is spent on other functions, such as administrative costs and profits.

While state survey respondents reported a range of information that they considered during rate filing reviews, over half of the respondents reported independently verifying at least some of this information. The remaining respondents reported that they did not independently verify any information submitted by carriers in rate filings in 2010.[29,30] Survey respondents that reported independently verifying information for at least some rates filings in 2010 also reported different ways in which information they received from carriers was independently verified. For example, survey respondents from Rhode Island reported that the standard of independent verification varied depending on the rate filing, and that the steps taken included making independent calculations with submitted rate filing data and comparing these calculations with external sources of data.[31] In another example, respondents from Michigan reported that in 2010 the department of insurance had staff conduct on-site reviews of carrier billing statements in the small and large-group markets in order to verify the information submitted in rate filings.

Opportunities for Consumer Involvement in Rate Reviews

Survey respondents from 14 states reported providing opportunities for consumers to be involved in the oversight of health insurance premium rates in 2010.[32] Our survey results indicated that these consumer opportunities varied and included opportunities to participate in rate review hearings—which allow consumers and others to present evidence for or against rate increases—public comment periods, or on consumer advisory boards.

Survey respondents from six states reported conducting rate review hearings in at least one market in 2010 to provide consumers with opportunities to be involved in the oversight of premium rates.[33] (See

[29]Out of the 48 survey respondents that reported reviewing rates in 2010, 28 reported independently verifying at least some of this information, while 20 reported that they did not independently verify any information submitted by carriers.

[30]We did not define "independent verification" for state survey respondents, so there may be some variation in what was considered as independent verification.

[31]Survey respondents from Rhode Island reported that substantial verification was required for rate filings that the department viewed as important, while relatively minor verification took place for filings that were considered "peripheral."

[32]Survey respondents from 47 states answered our question about providing opportunities for consumers to be involved in the oversight of health insurance premium rates in 2010.

[33]Respondents from Connecticut, Iowa, Michigan, and New Mexico reported that they only held rate hearings for rates filed in the individual market in 2010.

table 2 for information on reported opportunities for consumer involvement in states' rate review practices in 2010.) For example, officials from Maine that we interviewed told us that the insurance department held rate hearings for two large carriers in 2010 and that the size of the rate increase and the number of people affected were among the factors considered in determining whether to hold a rate hearing. The officials explained that if there is a hearing, the Maine Bureau of Insurance issues a notice and interested parties, such as the attorney general or consumer organizations, can participate by presenting evidence for or against rate increases. Maine officials said that, before rate review hearings are held, carriers share information about the rate filing, but that additional details identified at a hearing may trigger a request for further information. Maine officials said that after the state reviews all of the information, the state either approves the rate or disapproves the rate with an explanation of what the state would approve.

Table 2: Reported Opportunities for Consumer Involvement in States' Rate Review Practices in 2010

State	Rate hearings	Public comment periods	Other[a]
California			✓
Connecticut	✓	✓	
Iowa	✓	✓	
Maine	✓	✓	
Michigan	✓	✓	
New Mexico	✓		
New York		✓	
Oregon		✓	
Pennsylvania		✓	
Rhode Island	✓	✓	✓
Texas			✓
Washington			✓
West Virginia			✓
Wisconsin			✓

Source: GAO analysis.

Note: Respondents from 47 states reported that they reviewed at least one rate filing in 2010 and responded to our question about consumer involvement. Of these 47 states, survey respondents in 33 states reported that they did not provide consumers with any opportunities to be involved in the rate review process in 2010.

[a]Other types of opportunities that survey respondents reported providing to consumers included: consumer advisory boards/ panels, providing information about rate filings on the insurance department's web site, and making rate filings available through the state's open records process.

Survey respondents from eight states reported that they provided consumers with opportunities to participate in public comment periods for premium rates in 2010. For example, respondents from Pennsylvania reported that rate filings were posted in the *Pennsylvania Bulletin*—a publication that provides information on rulemaking in the state—for 30 days for public review and comment. In addition, officials from Maine told us that they did not make decisions on rate filings until consumers had an opportunity to comment on proposed rate changes. These officials added that they are required to wait at least 40 days after carriers notify policyholders of a proposed rate change before making a decision, providing consumers with an opportunity to comment.

Survey respondents from six states reported providing consumers with other opportunities to be involved in the oversight process. For example, respondents from two states—Rhode Island and Washington—reported that they provided consumers with opportunities to participate in consumer advisory boards in 2010. In addition, respondents from Texas reported that rate filings were available to consumers upon request and that the Texas Department of Insurance held stakeholder meetings during which consumer representatives participated in discussions about rate review regulations.

Outcomes of Premium Rate Reviews Varied in 2010

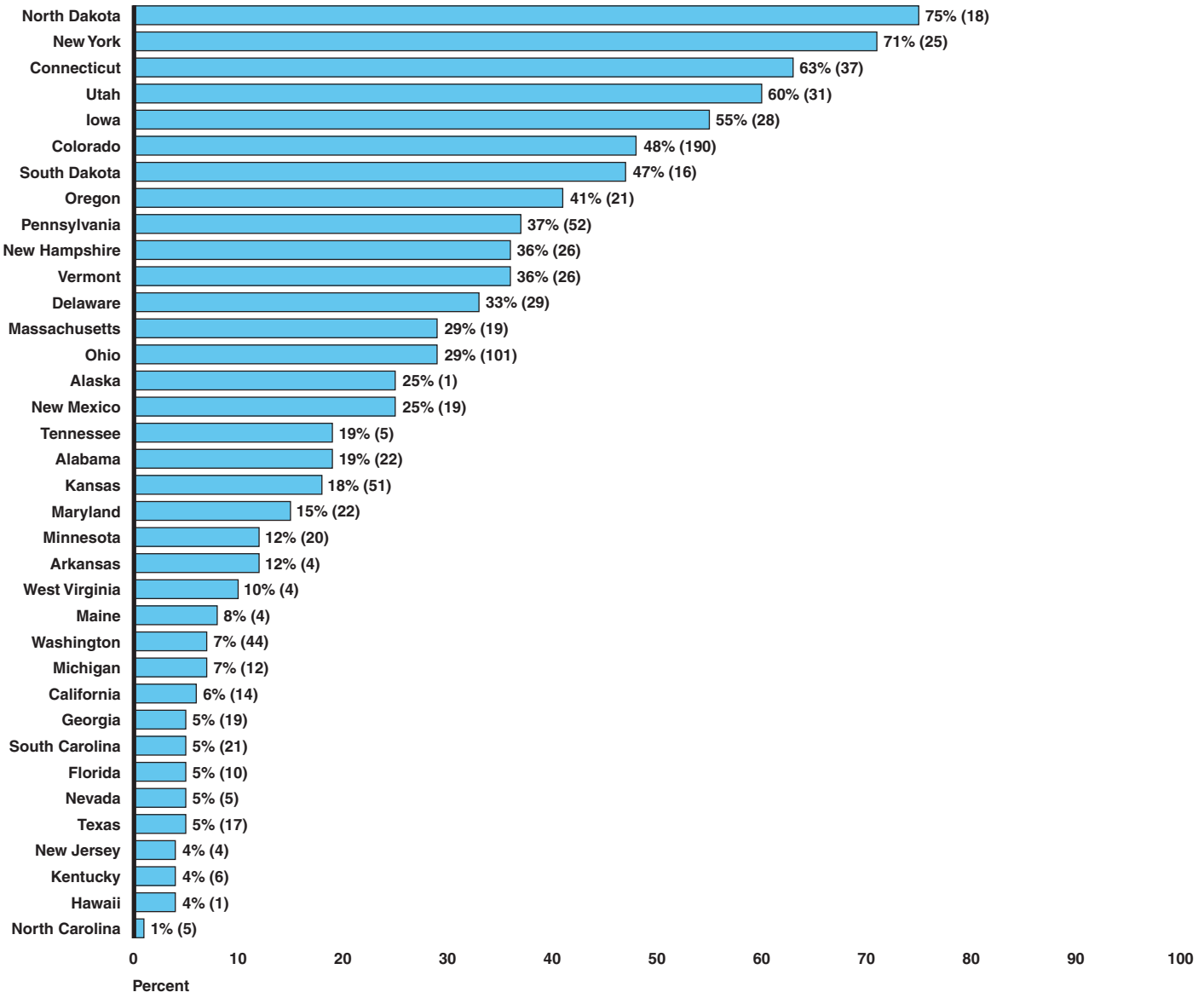
The outcomes of states' reviews of premium rates in 2010 also varied. While survey respondents from 36 states reported that at least one rate filing was disapproved, withdrawn, or resulted in a rate lower than originally proposed in 2010,[34] the percentage of rate reviews that resulted

[34]Respondents from six states—Arizona, Idaho, Missouri, Nebraska, Wisconsin, and Wyoming—reported that they did not have any rate filings that were disapproved, withdrawn, or resulted in lower rates than originally proposed in 2010. Respondents from six states—the District of Columbia, Mississippi, Montana, Oklahoma, Rhode Island, and Virginia—did not respond to the question, or did not have the information available to answer the question.

in these types of outcomes varied widely among these states.[35] Specifically, survey respondents from 5 of these states—Connecticut, Iowa, New York, North Dakota, and Utah—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 13 of these states reported that these outcomes occurred in less than 10 percent of rate reviews. An additional 6 survey respondents reported that they did not have any rate filings that were disapproved, withdrawn, or resulted in lower rates than originally proposed in 2010. (Fig. 1 provides information on the percentage and reported number of rate filings that were disapproved, withdrawn, or resulted in lower rates than originally proposed by state in 2010.)

[35]States' determinations to disapprove rates may vary. Regulators in one state might disapprove a rate filing for not containing complete information, while regulators in another state might remind the carrier to submit the required information without automatically disapproving the rate. An official from Michigan told us that the office usually notified carriers ahead of time if it intended to disapprove a rate filing or approve a rate filing with modifications because carriers usually preferred to withdraw filings and resubmit them, rather than have the office disapprove rate filings or approve them with modifications.

Figure 1: Percentage and Reported Number of Rate Filings That Were Disapproved, Withdrawn, or Resulted in Lower Rates Than Originally Proposed by State in 2010



Source: GAO analysis.

Notes: Respondents from six states—Arizona, Idaho, Missouri, Nebraska, Wisconsin, and Wyoming—reported that they did not have any rate filings that were disapproved, withdrawn, or resulted in lower rates than originally proposed in 2010. Respondents from six states—the District of Columbia, Mississippi, Montana, Oklahoma, Rhode Island, and Virginia—did not respond to the question or did not have the information available to answer the question. Respondents from two states reported that their states did not review rate filings in 2010. One state, Indiana, did not complete a survey.

States' determinations to disapprove rates may vary. For example, regulators in one state might disapprove a rate filing for not containing complete information, while regulators in another state might remind the carrier to submit the required information without automatically disapproving the rate.

Officials from some states reported that since rate review takes place over time, the rate filings on which action is taken in 2010 may not be exactly the same set of rate filings received in 2010.

Some of the state survey respondents reported that at least one rate filing was disapproved, withdrawn, or resulted in rates lower than originally proposed in 2010 even though they did not have explicit authority to approve rate filings in 2010. For example, officials from the California Department of Insurance reported that even though the department did not have the authority to approve rate filings and could only disapprove rate filings if they were not compliant with certain state standards, such as compliance with a 70 percent lifetime anticipated loss ratio,[36] the department negotiated with carriers to voluntarily reduce proposed rates in 2010. Survey respondents from California reported that 14 out of 225 rate filings in 2010 were disapproved, withdrawn, or resulted in rates lower than originally proposed. Specifically, officials from the California Department of Insurance told us that they negotiated with carriers to reduce proposed rates by 2 percentage points to 25 percentage points in 2010. These officials also told us that they negotiated with one carrier not to raise rates in 2010 although the carrier had originally proposed a 10-percent average increase in rates. In another example, although survey respondents from Alabama reported that they did not have prior approval authority, they reported that 22 rate filings were disapproved, withdrawn, or resulted in rates lower than originally proposed in 2010.

States also varied in the markets in which rates were disapproved, withdrawn, or resulted in rates lower than originally proposed in 2010. For example, survey respondents from nine states—Alaska, Arkansas, Hawaii, Kansas, Kentucky, Maine, Nevada, New Jersey, and North Carolina—reported that while they reviewed rate filings in multiple markets, only reviews for the individual market resulted in rates that were disapproved, withdrawn, or resulted in rates lower than originally proposed. In other states, respondents reported that rate filings in multiple

[36]The California Code of Regulations defines the lifetime anticipated loss ratio as the ratio of (1) the sum of the accumulated value of past incurred claims since the inception of the policy and the present value of future anticipated claims, to (2) the sum of the accumulated value of past earned premiums and the present value of future anticipated premiums earnings.

markets resulted in these types of outcomes in 2010. For example, survey respondents from 12 states reported that rate filings in all three markets resulted in these types of outcomes in 2010.

State Officials Reported Taking Steps to Improve Processes, Increase Capacity, and Obtain Additional Legislative Authority to Oversee Premium Rates

Our survey of state insurance department officials found that 41 respondents from states that were awarded Cycle I HHS rate review grants have begun making three types of changes in order to enhance their states' abilities to oversee health insurance premium rates. Specifically, respondents reported that they have taken steps in order to (1) improve their processes for reviewing premium rates, (2) increase their capacity to oversee premium rates, and (3) obtain additional legislative authority for overseeing premium rates.[37,38]

Improve rate review processes. More than four-fifths of the state survey respondents that reported making changes to their oversight of premium rates reported that they had taken various steps to improve the processes used for reviewing health insurance premium rates.[39] These steps consisted primarily of the following:

- *Examining existing rate review processes to identify areas for improvement*. Twenty-two survey respondents reported taking steps to either review their existing rate review processes or develop new

[37]While 41 of the 45 state survey respondents that were awarded HHS rate review grants reported taking steps to make changes to their oversight of health insurance premium rates, 4 respondents—from Florida, Kansas, New Hampshire, and North Dakota—reported that they had not, for various reasons. For example, respondents from North Dakota reported that they had not taken steps to make changes due in part to limited staff resources. In another example, respondents from Florida reported that the state rescinded its acceptance of the HHS rate review grant. HHS awarded a total of 46 Cycle I rate review grants, but 1 state grantee—Indiana—did not respond to our survey.

[38]While five state survey respondents—from Alaska, Georgia, Iowa, Minnesota, and Wyoming—reported that their states did not apply for an HHS rate review grant, some of these states may also be making changes to their oversight of health insurance premium rates. For example, survey respondents from Alaska reported that legislation has been proposed to expand rate review authority to all carriers in the state. Additionally, respondents from Georgia reported that the insurance department created a health insurance advisory committee in 2011 and that the committee's meetings are open to the public.

[39]Of the 41 survey respondents who reported making changes to their oversight of premium rates, 34 reported that they had taken steps to improve the processes used for reviewing premium rates.

processes. More than two-thirds of these 22 respondents reported that their state contracted with outside actuarial or other consultants to review the states' rate review processes and make recommendations for improvement. For example, respondents from Louisiana—who, according to officials, previously did not review most premium rate filings because they did not have the authority to approve or disapprove rates—reported that they had contracted with an actuary to help them develop a rate review process.[40] In another example, respondents from North Carolina reported that an outside actuarial firm independently reviewed the department's health insurance rate review process and recommended ways that the department could improve and enhance its review process. Similarly, respondents from Tennessee reported that they had obtained information from contract actuaries on how to enhance the state's review of rate filings. In addition, four of these respondents reported taking steps to develop standardized procedures for reviewing rate filings. For example, respondents from Illinois reported that their insurance department is developing protocols for the collection, analysis, and publication of rate filings.

- *Changing information that carriers are required to submit in rate filings*. Thirteen survey respondents reported taking steps to change the rate filing information that carriers are required to submit to the state insurance department in order to improve reviews of rate filings. For example, respondents from Oregon reported that they will require carriers to provide in their rate filings a detailed breakdown of medical costs and how premiums are spent on medical procedures and services. In another example, respondents from Virginia reported that their state is expanding the information required from carriers in rate filing submissions by developing a uniform submission checklist.

- *Incorporating additional data or analyses in rate filing reviews*. Eleven survey respondents reported purchasing data or conducting additional data analyses in order to improve the quality of their states' rate filing reviews. For example, respondents from Ohio reported taking steps to obtain national claims data on health costs which, according to the respondents, would enable the department of insurance to use a

[40]In their HHS Cycle I rate review grant application, officials from the Louisiana Department of Insurance reported that the state reviewed premium rate filings for long-term care and Medicare supplemental health insurance products, but did not review any other health insurance premium rate filings.

separate data source to verify the costs submitted by carriers in their rate filings.[41] In another example, respondents from Virginia reported that their state had begun undertaking detailed analyses of premium trends in the state's individual and small-group markets. According to the state respondents, these analyses will provide rate reviewers with benchmark industry values for various factors, such as underlying costs and benefit changes, which will help focus rate reviewers' efforts on the drivers of a given rate increase. The respondents reported that these analyses will also allow reviewers to more easily identify potentially excessive or unreasonable rate increases.

- *Involving consumers in the rate review process*. Three survey respondents reported taking steps to increase consumer involvement in the rate review process.[42] For example, respondents from Connecticut reported that the state's insurance department has posted all rate filings received from carriers on its web site and created an online application that allows consumers to comment on the proposed rates. In another example, respondents from Oregon reported that the state's insurance department has contracted with a consumer advocacy organization to provide comments on rate filings on a regular basis. Finally, respondents from Nevada reported that the state is taking steps to create a rate hearing process that will allow consumer advocates to represent the interests of consumers at the hearings.

Increase capacity to oversee rates. Over two-thirds of the state survey respondents that reported making changes to rate oversight reported that they have begun to make changes to increase their capacity to oversee premium rates.[43] These reported changes consisted primarily of hiring

[41]Similarly, although the respondents from Texas did not provide this information in their survey response, officials from Texas told us separately that they have taken steps to purchase a database in order to compare information submitted in rate filings to health care claims costs, which state officials would estimate using the new database. These officials told us that they had not had the funds previously to purchase this database.

[42]Additionally, 16 respondents reported taking steps to provide consumers with information about premium rates. Nine of these 16 reported doing so by posting rate filing information online, such as by posting rate filings to the state insurance department's web site or, in one example, by creating a web-based tool to notify consumers when their insurance company files for a rate increase.

[43]Of the 41 survey respondents who reported making changes to their oversight of premium rates, 29 respondents reported that they have begun to make changes to increase their capacity to oversee premium rates.

staff or outside actuaries, and improving the information technology systems used to collect and analyze rate filing data.

Twenty survey respondents reported hiring additional staff or contracting with external actuaries and consultants to improve capacity in various ways, such as to review rates, coordinate the rate review process or provide administrative support to review staff, and train staff. For example, respondents from Oregon reported hiring staff to perform a comprehensive and timely review of the filings, and to review rate filings for completeness upon receipt. In another example, respondents from West Virginia reported that they used a portion of their HHS grant funding to obtain external actuarial support for reviewing rate filings. In addition, Illinois officials told us that they have taken steps to hire two internal actuaries, as well as other analytical staff to help with the processing of rate filings to help relieve the workload of current office staff.

Seventeen respondents reported taking steps to increase their capacity to oversee premium rates by improving information technology and data systems used in the review process. Nine of these respondents reported taking steps to enhance their use of the System for Electronic Rate and Form Filing (SERFF)—a web-based electronic system developed by NAIC for states to collect electronic rate filings from carriers—such as by working with NAIC or by improving their insurance department's information technology infrastructure to support the use of SERFF.[44] Additionally, some respondents also reported taking steps to make other improvements, such as creating or improving additional databases in order to collect rate filing data and analyze trends in rate filings.[45] For example, respondents from Wisconsin reported that their office contracted with an actuarial firm using HHS grant funds in part to develop a database to standardize, analyze, and monitor rates in the individual and small-group markets, which will enable the office to track historical rate change data and monitor rate changes. In another example, respondents from Illinois reported that they launched a web-based system in February 2011 for carriers to use when reporting rate changes,

[44]NAIC officials told us that SERFF is designed to improve the efficiency of the rate and form filing and approval process, reducing the time and cost involved in making regulatory filings by enabling companies to send and states to receive, comment on, and approve or disapprove rate filings.

[45]In addition, an NAIC official told us that all states that were awarded HHS rate review grants agreed to use $18,808 from their grants to support SERFF.

while continuing to work with NAIC on SERFF improvements with the intention of eventually merging the state's data system with SERFF.

Obtain additional legislative authority. More than a third of state survey respondents that reported making changes to rate oversight 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.[46] For example, respondents from Montana reported that legislation has been introduced that would give the state the authority to require carriers to submit rate filings for review. In another example, Illinois officials told us that the state has authority to require some carriers to submit rate filings, but the state does not have the authority to approve these filings before the rates take effect. The officials told us that legislation has been introduced to obtain prior approval authority. Additionally, respondents from North Carolina reported that the department has sought additional prior approval authority over small-group health insurance rates in addition to its existing prior approval authority over rates in the individual, small-group, and large-group health insurance markets. Finally, some states reported taking steps to review their current authority to determine if changes were necessary.

Agency Comments

HHS provided us with written comments on a draft version of this report. These comments are reprinted in appendix IV. HHS and NAIC also provided technical comments, which we incorporated as appropriate.

In its written comments, HHS noted that health insurance premiums have doubled on average over the last 10 years, putting coverage out of reach for many Americans. Further, HHS noted that as recently as the end of 2010, fewer than half of the states and territories had the legal authority to reject a proposed increase if the increase was excessive, lacked justification, or failed to meet other state standards.

[46]Of the 41 survey respondents who reported making changes to their oversight of premium rates, 17 reported that their states have taken steps in order to obtain additional legislative authority for overseeing health insurance premium rates. While most of these 17 survey respondents reported seeking additional authority to review or approve rate filings, some respondents reported that their state sought authority for other reasons related to rate review, such as increasing transparency of the rate review process for consumers and strengthening data requirements of carriers when submitting rate filings.

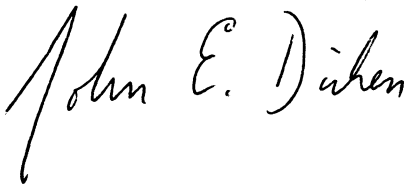
In its written comments, HHS also noted the steps it is taking to improve transparency, help states improve their health insurance rate review, and assure consumers that any premium increases are being spent on medical care. Specifically, HHS noted its requirement that, starting in September 2011, certain insurers seeking rate increases of 10 percent or more in the individual and small-group markets publicly disclose the proposed increases and their justification for them.[47] According to HHS, this requirement will help promote competition, encourage insurers to work towards controlling health care costs, and discourage insurers from charging unjustified premiums. In its comments, HHS also discussed the state grant program provided for by PPACA to help states improve their health insurance rate review. As our report notes, in addition to grants awarded in 2010, HHS announced in February 2011 that nearly $200 million in additional grant funds were available to help states establish an effective rate review program. Finally, the comments from HHS point out that their rate review regulation will work in conjunction with their medical loss ratio regulation released on November 22, 2010, which is intended to ensure that premiums are being spent on health care and quality-related costs, not administrative costs and executive salaries.[48]

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO web site at http://www.gao.gov.

[47] *See* 76 Fed. Reg. 29985-86 (codified at 45 C.F.R. §§ 154.200, 154.215).

[48] *See* 75 Fed. Reg. 74864, 74921 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158); 75 Fed. Reg. 82277, 82278 (Dec. 30, 2010) (to be codified at 45 C.F.R. pt. 158) (providing corrections for technical and typographical errors in the Dec. 1, 2010 interim final rule).

If you or your staff have any questions about this report, please contact me 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 report. GAO staff who made key contributions to this report are listed in appendix V.



John E. Dicken
Director, Health Care

Appendix I: Scope and Methodology

Our objectives were to describe (1) states' practices for overseeing health insurance premium rates in 2010, including the outcomes of premium rate reviews, and (2) changes that states that received Department of Health and Human Services (HHS) rate review grants have begun making to enhance their oversight of health insurance premium rates.

To describe states' practices for overseeing health insurance premium rates in 2010, including the outcomes of rate reviews, we analyzed data from our web-based survey sent to officials of the insurance departments[1] of all 50 states and the District of Columbia (collectively referred to as "states"). We obtained the names, titles, phone numbers, and e-mail addresses of our state insurance department survey contacts by calling each insurance department and asking for the most appropriate contact. The survey primarily contained questions on state practices for overseeing rates during calendar year 2010, such as the number of filings received, reviewed, and outcomes of review, the timing of state review, factors considered during review, independent verification of carrier data, consumer involvement, and capacity and resources to review rates. During the development of our survey, we pretested it with insurance department officials from three states—Michigan, Tennessee, and West Virginia—to ensure that our questions and response choices were clear, appropriate, and answerable. We made changes to the content of the questionnaire based on their feedback. We conducted the survey from February 25, 2011, through April 4, 2011. Of the 51 state insurance departments, 50 completed the survey.[2] However, not all states responded to each question in the survey. Additionally, some survey respondents reported that they did not have data that could be sorted by health insurance market. See appendix II for the complete results of the survey.

Because we sent the survey of state insurance departments to the complete universe of potential respondents, it was not subject to sampling error. However, the practical difficulties of conducting any survey may introduce errors, commonly referred to as nonsampling errors. For

[1]For 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.

[2]The Indiana Department of Insurance declined to complete our survey.

example, difficulties in how a particular question was interpreted, in the sources of information that were available to respondents, or in how the data were entered into a database or were analyzed could introduce unwanted variability into the survey results. We encountered instances of nonsampling survey error in analyzing the survey responses. Specifically, in some instances, respondents provided conflicting, vague, or incomplete information. We generally addressed these errors by contacting the state insurance department officials involved and clarifying their responses. However, we did not independently verify the information and data provided by the state survey respondents.

To obtain more in-depth information on states' practices for overseeing rates in calendar year 2010, we interviewed state insurance department officials from a judgmental sample of five states: California, Illinois, Maine, Michigan, and Texas. To ensure that we identified a range of states for our in-depth interviews, we considered

- state insurance departments' authorities in 2010 for reviewing health insurance premium rates, as reported by the National Association of Insurance Commissioners (NAIC);
- states' plans to change their premium rate oversight practices, as described in their Cycle I rate review grant applications to HHS submitted in June and July of 2010;
- states' population sizes; and
- states' geographic locations.

These criteria allowed us, in our view, to obtain information from insurance departments in a diverse mix of states, but the findings from our in-depth interviews cannot be generalized to all states because the states selected were part of a judgmental sample. We used information obtained during these interviews throughout this report.

To describe changes that states have begun making to enhance their oversight of premium rates, we relied primarily on data collected in our state insurance department survey, in which we asked respondents to describe through open-ended responses steps taken to implement the changes to premium rate oversight that were proposed in states' Cycle I

rate review grant applications to HHS.[3] We then performed a content analysis of these open-ended responses through the following process: From a preliminary analysis of the survey responses, we identified a total of 13 types of state changes such as hiring staff or consultants to review rates, involving consumers in the rate oversight process, and improving information technology. We then grouped those types of changes reported by survey respondents into three categories of reported changes. Two GAO analysts independently assigned codes to each response, and if respondents provided conflicting or vague information, we addressed these errors by contacting the state insurance department officials involved and clarifying their responses; however, we did not independently verify the information provided in the survey responses. To gain further information on state changes to rate oversight practices, we also asked about changes during our in-depth interviews with insurance department officials in five states described above. In addition, we interviewed officials from the Center for Consumer Information and Insurance Oversight within the Centers for Medicare & Medicaid Services, and reviewed portions of the states' Cycle I rate review grant applications submitted to HHS and other relevant HHS documents.

To gather additional information related to both of our research objectives, we interviewed a range of experts and organizations including NAIC, the American Academy of Actuaries, America's Health Insurance Plans, two large carriers based on their number of covered lives, NAIC consumer representatives (individuals who represent consumer interests at meetings with NAIC), and various advocacy groups such as Families USA and Consumers Union.

We conducted this performance audit from September 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[3]Forty-five of our 50 state survey respondents reported that they applied for an HHS Cycle I rate review grant. Survey respondents from five states—Alaska, Georgia, Iowa, Minnesota, and Wyoming—did not apply for an HHS rate review grant and therefore did not indicate in our survey if they had taken steps to make changes to rate oversight as described in rate review grant applications to HHS.

Appendix II: Additional Results from Our Survey on State Oversight of Health Insurance Premium Rates

This appendix presents additional results from our survey of insurance department officials in all 50 states and the District of Columbia on their oversight of health insurance premium rates in 2010, and changes they have begun to make to enhance their oversight of health insurance premium rates.

Table 3 presents survey responses by state on the number of rate filings that were received, reviewed, and disapproved, withdrawn, or resulted in rates lower than originally proposed in the individual, small-group, and large-group markets in 2010.

Table 3: Number of Rate Filings Received, Reviewed, and Disapproved, Withdrawn, or Resulting in Rates Lower Than Originally Proposed in 2010 in the Individual, Small-Group, and Large-Group Markets, by State

	Rate filings received				Rate filings reviewed				Rate filings disapproved, withdrawn, or resulting in lower rates			
State	Indiv.	Small	Large	Total[a]	Indiv.	Small	Large	Total[a]	Indiv.	Small	Large	Total[a]
AL	30	9	35	117	30	9	35	117	10	2	8	22
AK	2	2	0	4	2	2	0	4	1	0	0	1
AZ[b,c]	54	0	0	54	52	0	0	52	0	0	0	0
AR	23	2	9	34	23	2	9	34	4	0	0	4
CA	248	0	0	248	225	0	0	225	14	0	0	14
CO[d]	232	54	113	399	232	54	113	399	125	17	48	190
CT	33	15	12	60	33	15	11	59	24	8	5	37
DE	25	27	25	89	25	27	25	89	16	5	0	29
DC	68	NA	NA	310	68	NA	NA	310	NA	NA	NA	NA
FL	72	147	0	219	66	141	0	207	3	7	0	10
GA	152	75	129	356	152	75	129	356	8	4	7	19
HI	6	6	13	25	6	6	13	25	1	0	0	1
ID	22	40	2	64	7	2	0	9	0	0	0	0
IL[e]	84	0	0	84	0	0	0	0	0	0	0	0
IN[f]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
IA	51	0	0	51	51	0	0	51	28	0	0	28
KS	93	62	121	276	93	62	121	276	51	0	0	51
KY	69	94	12	175	57	72	9	138	6	0	0	6
LA[e]	112	5	13	195	0	0	0	0	0	0	0	0
ME[b]	19	32	40	91	19	32	0	51	4	0	0	4
MD	24	68	53	145	24	68	53	145	8	10	4	22
MA[g]	18	48	28	94	18	48	0	66	0	19	0	19

State	Rate filings received				Rate filings reviewed				Rate filings disapproved, withdrawn, or resulting in lower rates			
	Indiv.	Small	Large	Total[a]	Indiv.	Small	Large	Total[a]	Indiv.	Small	Large	Total[a]
MI	NA	NA	NA	182	NA	NA	NA	182	NA	NA	NA	12
MN	73	61	35	169	73	61	35	169	17	3	0	20
MS	7	3	5	15	7	3	5	15	NA	NA	NA	NA
MO	44	10	2	56	NA	NA	NA	NA	0	0	0	0
MT[h]	36	17	4	57	NA	NA	NA	NA	NA	NA	NA	NA
NE	NA	NA	NA	302	NA	NA	NA	302	NA	NA	NA	0
NV	51	22	33	106	51	22	33	106	5	0	0	5
NH	22	33	17	72	22	33	17	72	12	11	3	26
NJ	27	49	14	90	27	49	14	90	4	0	0	4
NM	31	28	18	77	31	28	18	77	10	4	5	19
NY[i]	27	73	26	126	7	18	10	35	3	15	7	25
NC	169	103	292	564	169	103	178	450	5	0	0	5
ND	NA	NA	NA	43	NA	NA	NA	24	NA	NA	NA	18
OH	191	109	47	347	194	109	51	354	72	16	13	101
OK[j]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
OR	57	36	0	93	35	16	0	51	13	8	0	21
PA	84	26	58	168	84	26	29	139	46	4	2	52
RI	6	6	10	37	6	6	12	39	NA	NA	NA	NA
SC	NA	NA	NA	417	NA	NA	NA	417	NA	NA	NA	21
SD	34	0	0	34	34	0	0	34	16	0	0	16
TN	26	16	27	69	26	0	0	26	5	0	0	5
TX	423	32	52	507	298	27	52	377	15	2	0	17
UT[c]	35	109	0	144	13	39	0	52	10	21	0	31
VT	21	30	22	73	21	30	22	73	5	13	8	26
VA[b,j]	NA	NA	NA	110	NA	NA	NA	NA	NA	NA	NA	NA
WA	23	21	579	623	23	21	579	623	13	3	28	44
WV[k]	20	12	2	42	20	12	2	42	2	0	0	4
WI	99	0	0	99	99	0	0	99	0	0	0	0
WY	3	4	4	11	1	2	2	5	0	0	0	0
TOTAL	**2,946**	**1,486**	**1,852**	**7,723**	**2,424**	**1,220**	**1,577**	**6,466**	**556**	**172**	**138**	**929**

Source: GAO analysis.

Notes: NA refers to respondents that either did not provide a response, or reported that they did not have data available to answer the question.

In the small-group market, enrollees generally obtain health insurance coverage through a group health plan offered by a small employer, and in the large-group market, enrollees generally obtain coverage through a group health plan offered by a large employer. In the period reflected in our survey, states generally defined a small employer as an employer with at least 2 but not more than 50 employees, and a large employer as an employer with at least 51 employees.

Officials from some states reported that since rate review takes place over time, the rate filings on which action is taken in 2010 may not be exactly the same set of rate filings received in 2010.

[a]Totals do not always equal the sum of the individual, small-group, and large-group markets. Some states reported rate filings that could not be separated by market.

[b]Survey respondents reported that some of the rate filing data were estimated or may not be accurate because of system limitations.

[c]Reported numbers do not include limited benefit plans, known also as mini-med plans.

[d]Survey respondent reported that the state's definitions of individual and small-group markets differ from federal definitions.

[e]Survey respondents reported that they did not review any rate filings during calendar year 2010.

[f]Officials from Indiana did not complete the survey.

[g]Survey respondents reported that their numbers for the small-group market represent a merged market consisting of small groups and individuals.

[h]Survey respondents reported that they did not complete any reviews of rate filings during 2010 because they first received rate filing data from carriers in December 2010 and the data were incomplete.

[i]Reported numbers represent filings for rate changes only.

[j]Survey respondents reported data system limitations which prevented them from reporting certain rate filing data.

[k]Data provided represent the time period of August 15, 2010, through December 31, 2010, because survey respondents reported that they began to collect rate filings on August 15, 2010.

Table 4 presents the number of survey respondents that reported that the state insurance department required actuarial justification for rate filings, and whether the justifications were reviewed by an actuary in 2010 in the individual, small-group, and large-group markets.

Table 4: Actuarial Justifications Required and Reviewed in 2010, by State

State	Actuarial justifications required				Actuarial justifications reviewed
	Individual market	Small-group market	Large-group market	Justifications required but data not collected by market	
AL[a]					All
AK	✓	✓			None
AZ[b]	✓				None
AR	✓	✓			Less than half
CA					NA
CO[c]	✓	✓	✓		More than half
CT	✓	✓	✓		All
DE	✓	✓	✓		All
DC				✓	All
FL	✓	✓			All
GA	✓	✓	✓		Less than half
HI					Less than half
ID	✓	✓			Less than half
IL[d]	NA	NA	NA	NA	NA
IN[e]	NA	NA	NA	NA	NA
IA	✓				All
KS	✓	✓	✓		Less than half
KY	✓	✓	✓		All
LA[d]	NA	NA	NA	NA	NA
ME[f]	✓	✓			All
MD	✓	✓	✓		All
MA[g]	✓	✓			More than half
MI				✓	Less than half
MN	✓	✓			All
MS	✓	✓	✓		All
MO					NA
MT					None
NE	✓	✓	✓		All

State	Actuarial justifications required				Actuarial justifications reviewed
	Individual market	Small-group market	Large-group market	Justifications required but data not collected by market	
NV	✓	✓	✓		All
NH	✓	✓	✓		All
NJ	✓	✓	✓		All
NM	✓	✓	✓		All
NY[h]	✓	✓	✓		All
NC[i]	✓	✓	✓		Less than half
ND	✓	✓	✓		All
OH[j]	✓	✓	✓		All
OK		✓			All
OR	✓	✓			All
PA	✓	✓	✓		All
RI	✓	✓	✓		All
SC	✓	✓	✓		All
SD	✓				Less than half
TN	✓				All
TX	✓	✓	✓		More than half
UT	✓	✓			Less than half
VT	✓	✓	✓		All
VA	✓				Less than half
WA	✓	✓			None
WV	✓	✓			None
WI	✓				Less than half
WY[k]	✓	✓	✓		All

Source: GAO analysis.

Note: NA refers to respondents that did not provide a response to the question.

[a]Survey respondents reported that they do not require actuarial justifications from carriers, but that they request that carriers submit them. The respondents reported that they review all actuarial justifications that they receive.

[b]Survey respondents reported that the state does not have employed or contracted actuaries, but requires actuarial justification and certification on every filing and tries to ensure that the certification is appropriate.

[c]Survey respondents reported that their definitions of individual and small-group markets differ from federal definitions.

[d]Survey respondents were directed to skip this question because they reported that they did not review rate filings in 2010.

[e]Officials from Indiana did not complete the survey.

[f]Survey respondents reported that in the small-group market, actuarial justification is required in the small-group market for carriers that do not meet state-defined covered lives and medical loss ratio thresholds.

[g]Survey respondents reported that their numbers reported for the small-group market represent a merged market consisting of small groups and individuals.

[h]Reported numbers represent filings for rate changes only.

[i]Survey respondents reported that for the individual market, actuarial justifications are required for rate revisions for all carrier types, while in the small-group and large-group markets, actuarial justifications are only required for certain carrier types (e.g., HMOs).

[j]Survey respondents reported that actuarial analysts (i.e., analysts who are not credentialed actuaries but are supervised by credentialed actuaries) reviewed the actuarial justifications.

[k]Survey respondents reported that only HMO filings received an actuarial review.

Table 5 presents survey responses on states' capacity and resources to review rate filings in 2010.

Table 5: Reported Capacity and Resources to Review Rate Filings in 2010, by State

	State reported sufficient capacity and resources to review rates in 2010		
State	**Yes**	**No**	**No response**
AL	✓		
AK	✓		
AZ		✓	
AR		✓	
CA		✓	
CO	✓		
CT	✓		
DE	✓		
DC		✓	
FL	✓		
GA	✓		
HI	✓		
ID		✓	
IL			✓
IN[a]			✓
IA	✓		
KS	✓		
KY	✓		
LA			✓
ME	✓		
MD	✓		
MA	✓		
MI	✓		
MN	✓		
MS	✓		
MO		✓	
MT	✓		
NE	✓		
NV		✓	
NH	✓		
NJ	✓		

	State reported sufficient capacity and resources to review rates in 2010		
State	**Yes**	**No**	**No response**
NM	✓		
NY	✓		
NC	✓		
ND	✓		
OH	✓		
OK	✓		
OR		✓	
PA		✓	
RI		✓	
SC		✓	
SD	✓		
TN		✓	
TX	✓		
UT		✓	
VT	✓		
VA		✓	
WA	✓		
WV	✓		
WI		✓	
WY	✓		
Total	**33**	**15**	**3**

Source: GAO analysis.

[a]Officials from Indiana did not complete the survey.

Table 6 presents information on the types of changes that survey respondents that had been awarded HHS Cycle I rate review grants reported making to enhance their oversight of health insurance premium rates.

Table 6: Summary of Content Analysis of Reported Changes to State Oversight of Health Insurance Premium Rates

State survey respondent reported taking steps to make any of the following changes:	41 respondents
Improve the rate review process	34 respondents
-Develop a process or review the existing process (includes seeking recommendations or stakeholder input)	22 respondents
-Provide rate information to consumers	16 respondents
-Change the information required from carriers in rate filings	13 respondents
-Obtain additional data sources, or conduct studies or additional data analyses to improve rate review	11 respondents
-Involve consumers in the rate review process	3 respondents
-Other	5 respondents
Increase capacity to oversee rates	29 respondents
-Improve information technology or data systems used in the review process	17 respondents
-Hire staff, actuaries, or actuarial consultants to review rates	16 respondents
-Hire staff to coordinate the state's review process	4 respondents
-Hire staff, actuaries, or consultants to train staff	3 respondents
-Hire administrative support staff for rate review staff	3 respondents
-Other	4 respondents
Obtain additional legislative authority	17 respondents
-Obtain additional legislative authority to require rate filings or to review or approve rates	11 respondents
-Obtain additional legislative authority for changes other than to require rate filings or to review or approve rates	5 respondents
-Review existing authority to determine if the state will pursue additional legislative authority	3 respondents
-Other	2 respondents

Source: GAO analysis.

Note: The total number of respondents that reported taking steps to improve the rate review process, increase capacity to oversee rates, and obtain additional legislative authority exceeds the total number of respondents that reported taking steps to make changes (n=41) because most survey respondents reported taking steps to make more than one type of change.

Appendix III: Carrier Capital Levels

State officials monitor carriers' capital levels to help ensure that carriers can meet their financial obligations. State officials' primary objective when monitoring capital levels has been to ensure the adequacy of carriers' capital to make sure that consumers and health care providers are not left with unpaid claims. The focus, therefore, has been on monitoring capital levels to ensure that they exceed minimum requirements.[1] Officials from some states have noted that they review this information when reviewing rate filings.

NAIC developed a formula and model law for states to use in determining and regulating the adequacy of carriers' capital.[2] The risk-based capital (RBC) formula generates the minimum amount of capital that a carrier is required to maintain to avoid regulatory action by the state. The formula takes into account, among other things, the risk of medical expenses exceeding the premiums collected. According to NAIC, 37 states had adopted legislation or regulations based on *NAIC's Risk-Based Capital (RBC) for Health Organizations Model Act* as of July 2010 in order to monitor carriers' capital.[3] However, an NAIC official told us that all states must follow the RBC model act in order to meet NAIC accreditation standards.

Under NAIC's model law, the baseline level at which a state may take regulatory action against a carrier is the authorized control level. If a carrier's total adjusted capital—which includes shareholders' funds and adjustments on equity, asset values, and reserves—dips below its authorized control level, the state insurance regulator can place the

[1]NAIC officials told us that state officials monitor carrier capital levels for solvency concerns through off-site analysis and on-site examination, including tracking capital levels to help ensure that carriers can meet their financial obligations.

[2]NAIC is an organization comprised of insurance regulators from all 50 states and the District of Columbia, as well as five U.S. territories. As part of its work, NAIC develops model laws to promote uniformity among state regulators. For NAIC's model law pertaining to carriers' capital, see NAIC Model Laws, Regulations and Guidelines, Volume III, 315-1: *Risk-Based Capital (RBC) for Health Organizations Model Act*. Current through Release No. 92, July 2010.

[3]NAIC defined a health organization as "a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under state statute." NAIC's definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer under state statute and that is otherwise subject to either the life or property and casualty RBC requirements.

carrier under regulatory control.[4] The RBC ratio is the ratio of the carrier's total adjusted capital to its authorized control level; state officials become involved when the ratio drops below 200 percent.[5] If the RBC ratio is 200 percent or more, no action is required. As shown in table 7 below, NAIC data show that, from 2005 through 2010, except for carriers with less than $10 million in assets, carriers' median RBC ratios were generally higher for carriers reporting greater assets.

[4]According to NAIC, a state insurance regulator will have the authority to place a carrier under regulatory control in this situation if the state has passed legislation based on NAIC's model law.

[5]Under NAIC's model law, different levels of action are triggered based on a carrier's RBC ratio. An RBC ratio of 150 to 200 percent triggers a company action level and the carrier must outline a financial plan that identifies the conditions that contributed to the company's financial condition. An RBC ratio of 100 to 150 percent triggers a regulatory action level. At this level, a carrier is required to file an action plan, and the state insurance commissioner is required to perform examinations or analyses of the carrier's business and operations. An RBC ratio of 70 to 100 percent triggers an authorized control level, which means that the state regulator is authorized to take control of the carrier. An RBC ratio of less than 70 percent triggers a mandatory control level, which requires the state regulator to take control of the carrier. NAIC officials told us that state officials track many different aspects of carriers' financial performance to identify any concerning trends or results. They told us that this allows the officials to work with carriers to hopefully remedy any concerns before the carrier reaches a capital level that would trigger an RBC action level.

Table 7: Median Risk-Based Capital Ratios by Asset Size, 2005–2010

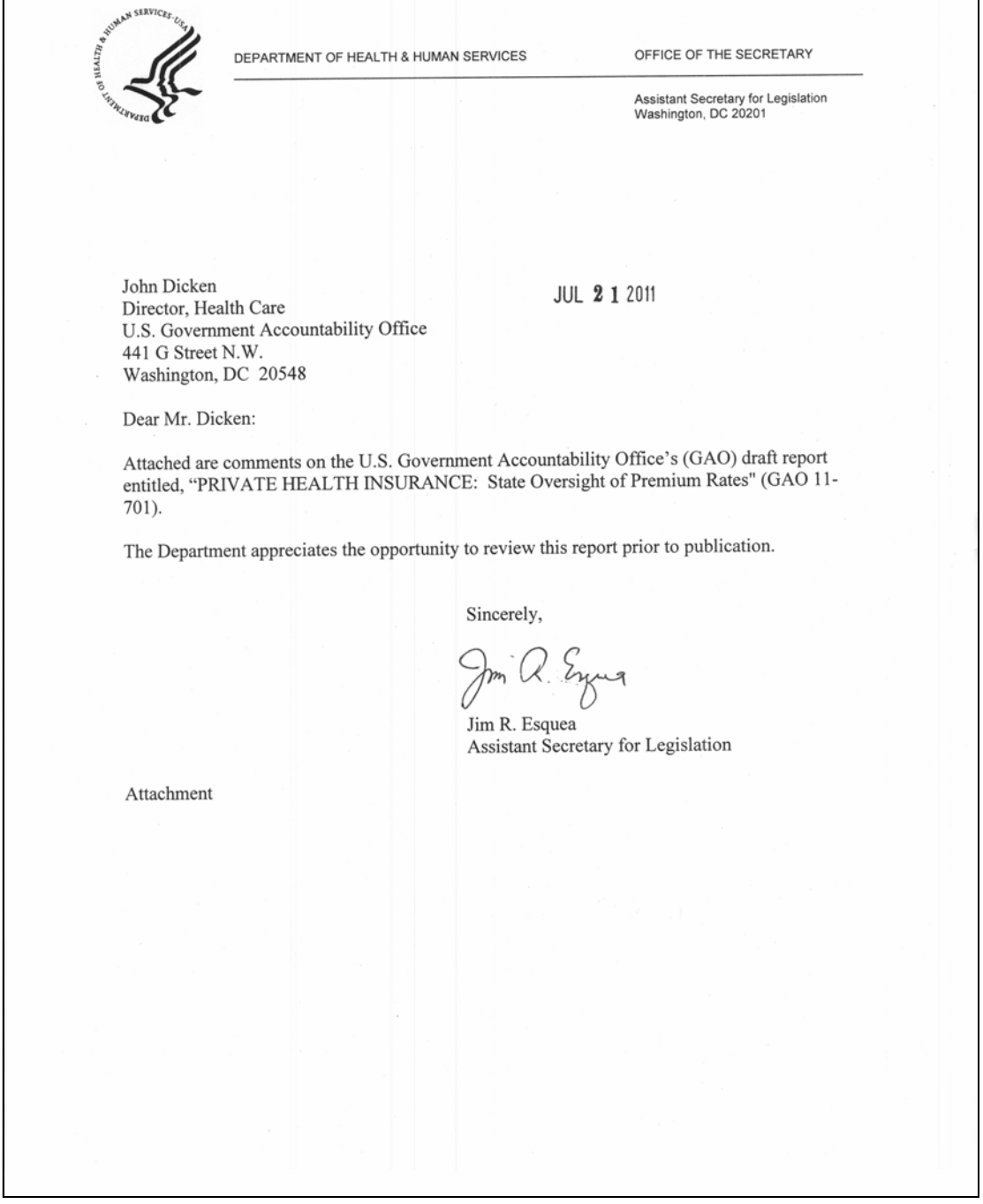
	Median risk-based capital ratio[b]						
Carrier asset size	2005	2006	2007	2008	2009	2010	Number of carriers represented in 2010[a]
Less than $10 million	938%	958%	855%	852%	958%	1165%	269
$10 million to $25 million	422%	438%	497%	465%	448%	491%	99
$25 million to $100 million	444%	431%	451%	425%	429%	497%	217
$100 million to $250 million	512%	542%	500%	472%	446%	496%	132
More than $250 million	659%	687%	675%	543%	568%	639%	139
All carriers	574%	582%	589%	545%	533%	606%	856

Source: NAIC.

[a]This column indicates the number of carriers included in each asset size category in 2010. This includes all carriers that submitted an annual health statement to NAIC.

[b]A carrier's risk-based capital ratio is the ratio of the carrier's total adjusted capital (TAC) to its authorized control level risk-based capital (ACL RBC). ACL RBC is the level at which a state insurance regulator has the authority to place a carrier under regulatory control.

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 21 2011

John Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "PRIVATE HEALTH INSURANCE: State Oversight of Premium Rates" (GAO 11-701).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: STATE OVERSIGHT OF HEALTH INSURANCE PREMIUM RATES" (GAO-11-701)

For too long, insurance companies in many States have increased health insurance premiums with little oversight, transparency, or public accountability. Health insurance premiums have doubled on average over the last ten years, much faster than wages and inflation, putting coverage out of reach for millions of Americans. As recently as December 2010, fewer than half of States and Territories had the legal authority to reject a proposed increase if the increase was excessive, lacked justification, or failed to meet other State standards. Additionally, many States that had authority lacked the resources needed to exercise it meaningfully. This lack of authority and resources for States has contributed to unjustified premium increases.

Starting in September 2011, HHS is requiring that all non-grandfathered insurers seeking rate increases of 10 percent or more in the individual and small group markets publicly disclose the proposed increases and their justification for them. Disclosing proposed increases, along with the insurer's justification, sheds light on industry pricing practices that some experts believe have led to unnecessarily high prices. This transparency in the health insurance market will help to promote competition, encourage insurers to work towards controlling health care costs, and discourage insurers from charging unjustified premiums.

The Affordable Care Act (ACA) also provides $250 million for a grant program to States to help them improve their health insurance rate review and reporting processes. Forty-three States and the District of Columbia are using $44 million in initial grants awarded by HHS in August 2010 to help them improve their oversight of proposed health insurance rate increases. In February 2011, HHS announced that nearly $200 million in additional grant funds are available to help States establish an effective rate review program by:

- Ensuring proposed rate hikes are comprehensively reviewed in an open and transparent process and, to the extent allowed by State law, that unreasonable rate hikes are not approved; and,

- Developing an infrastructure to collect, analyze, and report critical information about rate review outcomes and trends including, to the extent allowed by State law, whether or not proposed rate increases have been approved.

The grant program will continue to make funding available for States to continue program improvements and ensure that unreasonable rate increases in all States will be thoroughly reviewed.

Rate review regulation will also work in conjunction with the medical loss ratio regulation released on November 22, 2010 to make the health insurance marketplace more transparent and increase the value consumers receive for their health care premium

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: STATE OVERSIGHT OF HEALTH INSURANCE PREMIUM RATES" (GAO-11-701)

dollars. This proposed rate review regulation allows consumers to see what increases are being proposed and why. The medical loss ratio regulation ensures that premiums are being spent on health care and quality-related costs, not administrative costs and executive salaries. These two provisions of the ACA work together to assure consumers that any increase in their premium is reasonable and that their premium dollars are being spent on their medical care.

2

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; George Bogart; Kelly DeMots; Krister Friday; Linda Galib; and Peter Mangano made key contributions to this report.

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