**STATEMENT OF**

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**ON**

**HEALTH REFORM AND HEALTH INSURANCE PREMIUMS: EMPOWERING STATES TO SERVE CONSUMERS**

**BEFORE THE**

**UNITED STATES SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS**

**AUGUST 2, 2011**

**Senate Committee on Health, Education, Labor and Pensions**
**Hearing on "Health Reform and Health Insurance Premiums: Empowering States to Serve Consumers"**
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Chairman Harkin, Ranking Member Enzi, and Members of the Committee, thank you for the opportunity to discuss steps the Affordable Care Act takes to help make health insurance premiums more affordable for American families and businesses.

The Affordable Care Act reforms the health insurance market in a way that puts American consumers back in charge of their health coverage and care, ensuring they receive value for their premium dollars. Further, by focusing greater attention on justifications for insurance rate increases at the State and Federal level, we are already seeing positive results.

The need for these actions is clear. Over the past ten years, health insurance premiums have risen dramatically. According to a 2010 survey of employee benefits, premiums for average family coverage are up 114 percent and worker contributions are up 147 percent when compared to 2000.[1] Further, these increases in premiums outpace the rise in medical costs and wages during the same period. As a result, families and businesses saw many of their gains in earnings wiped away by the increased cost of insurance.

## Making Coverage Affordable

The Affordable Care Act helps make coverage more affordable by providing States with unprecedented resources to improve how States review proposed health insurance premium increases and hold insurance companies accountable for unjustified premiums increases. These resources for States to strengthen their insurance premium review procedures work in tandem with other policies in the Affordable Care Act to create a powerful tool to help keep health insurance premiums more affordable. These policies include:

[1] http://ehbs.kff.org/pdf/2010/8085.pdf

- **Review of Insurance Rates** brings an unprecedented level of scrutiny and transparency to health insurance rate increases. The Affordable Care Act ensures that, in any State, large proposed increases will be evaluated by experts to make sure they are based on reasonable cost assumptions and solid evidence. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for significant rate increases, as well as publicly justify and post on their website any unreasonable rate increases. These steps will allow consumers to know why they are paying the rates that they are.
- **Affordable Insurance Exchanges** can, beginning in 2014 exclude health plans that show a pattern of unjustified premium increases.

These new provisions will help moderate premium hikes and provide those who buy insurance with greater value for their premium dollar. For example, consumers in North Carolina are already feeling the benefits of the Affordable Care Act, as Blue Cross and Blue Shield of North Carolina refunded $155.8 million to 215,000 customers, in response to provisions in the law.

**Partnering with States on Rate Review Policies**

States play a critical role in the implementation of the Affordable Care Act. Since enactment, we have worked actively with Governors, insurance commissioners, Medicaid directors, and other stakeholders to implement programs to help consumers and businesses. It has been our priority to work collaboratively with our State partners as the provisions of the Affordable Care Act go into effect.

In recognition that States are the principal regulators of the private insurance market, the Affordable Care Act empowers and supports States to review unreasonable rate increases within their State, ,while CMS serves as a back-up to review rates only if a State lacks the authority or resources to do so. The Affordable Care Act provides $250 million in grants to assist States and Territories enhance their health insurance rate review process. Since enactment, $48 million has been awarded to 42 States, the District of Columbia, and the 5 Territories. In February, the availability of approximately $202 million in additional grant funding was announced to support

the continuation of such efforts. The applications for the additional grant funding are due on August 15, 2011, with awards planned for the end of fiscal year 2011.

The Government Accountability Office (GAO) report *Private Health Insurance: State Oversight of Premium Rates* shows that State insurance departments are already making good use of the rate review grants. In response to a survey conducted by GAO, 41 respondents from States that have been awarded rate review grants reported that they are making changes to enhance their health insurance premium oversight activities. States are using these grant funds to support rate review by hiring new actuarial staff, engaging in consumer transparency initiatives and developing improved information technology infrastructure to collect and analyze more robust rate filing data.

Specific examples of how States are improving their rate review processes with grant funds include:

- Tennessee is expanding the scope of rate review to small and large group policies and granting the Department of Commerce and Insurance prior approval authority and the authority to disapprove rates.
- New York is standardizing rate filing applications and expanding the information collected across all product types when reviewing rates.
- Kentucky created a new consumer-friendly website with Frequently Asked Questions (FAQs) on the rate review process and an email box to collect consumer comments. Kentucky also hired six new full time employees to assist with reviewing rates.
- Utah surpassed their goal of reviewing 50 percent of individual and small group rate filings by reviewing 100 percent of all submitted rate filings with the assistance of grant resources.

The Affordable Care Act establishes additional protections from unreasonable insurance rate increases. Starting September 1, 2011, insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets are required to publicly disclose the proposed increases and the justification for them. Such increases will be reviewed by either State or Federal experts to determine whether they are unreasonable. States with

effective rate review systems will conduct the reviews, but if a State lacks the resources or authority to conduct actuarial reviews, HHS will serve as a backup. Starting September 1, 2012, the 10 percent threshold will be replaced with a State-specific threshold, using data that reflect insurance and health care cost trends particular to that State. For those States in which a State-specific threshold is not established by that time, the 10 percent threshold will continue to apply. If an issuer wishes to implement an unreasonable rate, it will have to publish a justification for that increase on its website and on www.Healthcare.gov.

After reviewing and considering more than 60 stakeholder comments, CMS issued a final rate review regulation (CMS-9999-FC) on May 19, 2011. The final rule makes certain that potentially unreasonable health insurance premium increases will be thoroughly reviewed, and ensures that consumers will have access to clear information about those increases. This analysis is expected to help moderate premium hikes and provide those who buy insurance with greater value for their premium dollar. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for significant rate increases, as well as publicly justify and post on their website any unreasonable rate increases. These steps will allow consumers to better understand why their premiums are increasing.

The regulation (CMS-9999-FC) finalizes the proposed rule (OCIIO-9999-P) that was issued on December 23, 2010. The final rule includes several additions to the proposed rule that reflect feedback received through the comment process. For example, the final rule includes a requirement that States and CMS provide an opportunity for public input in the evaluation of rate increases subject to review. This will strengthen the consumer transparency aspects of the new rule. The change from a 10 percent threshold in 2011 to a State-specific threshold in 2012 was also based on public input. CMS will work with States to develop State-specific thresholds that reflect the insurance and health care cost trends in each State. In the final rule, due to comments received from State regulators and other stakeholders on the proposed rule, we requested further comment from the public on applying the rate review rule to individual and small group coverage sold through associations.

**Impact of Rate Review**

CMS is committed to supporting the States as the primary regulator of the private health insurance market. This new system has already begun to help States strengthen or create rate review processes. As of May 2011, 18 States had proposed legislation to increase their ability to review premium rates, 25 States had hired additional staff to review rates, and 34 were engaged in rate review contract activity. In addition, 33 States were enhancing their IT capacity for rate review and 34 States were working to enhance consumer transparency and provide consumer education on the rate review process.

The rate review regulation establishes the criteria for determining whether or not a State has an effective rate review program. HHS worked closely with State regulators to determine if a State has an effective program based on the criteria set forth in the regulation and has notified the States of the Department's initial determinations. I am pleased that 40 States and the District of Columbia will be reviewing rates in all markets. This result serves to preserve the historic role of the States in regulating health insurance markets.

Experience shows that rate review helps to lower the cost of coverage for people and employers. Recent examples include:

- Rhode Island's Insurance Commissioner was able to use its rate review authority to reduce a proposed increase by a major insurer in that State by 6 percentage points – lowering a proposed increase of 7.9 percent to 1.9 percent.[2]
- Californians were saved from a third rate increase in less than a year when a California carrier withdrew its proposed increase after it drew scrutiny from the State Insurance Commissioner. The three rate increases would have totaled as much as 87 percent for some policyholders.[3]
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7 percent cut to 14 percent after public outcry drew attention to it.[4]

[2] http://wrnihealthcareblog.wordpress.com/2011/03/09/koller-slashes-bcbs-proposed-rate-increase/
[3] http://www.insurance.ca.gov/0400-news/0100-press-releases/2011/release040-11.cfm
[4] http://www.inforum.com/event/article/id/314397/

- In Connecticut, one insurer requested an increase of 20 percent. The Insurance Department rejected this increase as excessive, and because of the law in Connecticut, it cannot go into effect.[5]
- About 59,000 individual insurance customers were protected from significantly higher premiums when the Oregon Insurance Division rejected a 22.1 percent premium increase in favor of a lower, 12.8 percent increase.[6]

These examples demonstrate the impact that transparency and scrutiny can have to make health insurance premiums affordable for all Americans.

**Transparency and Accountability**

As we have implemented these new programs and processes, we have pursued them in an open and transparent manner. CMS has published extensive information on our rulemaking and other decisions on the website www.CCIIO.CMS.gov and on the consumer-oriented www.HealthCare.gov to ensure that information is widely available for public input and understanding.

For example, the Affordable Care Act requires the Secretary, in conjunction with the States, to develop a process for the review and disclosure of unreasonable rates. The implementation process began with a Request for Comment published on April 14, 2010, and continued with a proposed rule, published on December 23, 2010. HHS reviewed all public comments and issued a final rule on May 19, 2011, with a 60 day comment period related to association coverage.

The process for seeking public input continues after the issuance of regulations. Based on comments and questions HHS, Labor, and the Treasury have received on regulations issued to date, we have provided additional interpretive guidance to affected parties on regulations relating to grandfathering, medical loss ratio, PCIP, ERRP, internal and external appeals, and provisions relating to annual limits on health plan coverage. We continue to work with stakeholders to implement the Affordable Care Act and to provide additional clarity.

[5] http://www.hartfordbusiness.com/news15875.html
[6] http://www.oregonhealthrates.org/?pg=public_hearing.html

## Conclusion

The Affordable Care Act includes a wide variety of provisions designed to promote accountability, affordability, quality and accessibility in the health care system for all Americans, and to make the health insurance market more consumer-friendly and transparent. The law is working to make coverage more affordable by holding insurers accountable for the premiums they charge consumers.