CRS Insights

From Initial Rate Filings to Final Premiums: Peering into the Black Box

Bernadette Fernandez, Specialist in Health Care Financing (bfernandez@crs.loc.gov, 7-0322)
Annie L. Mach, Analyst in Health Care Financing (amach@crs.loc.gov, 7-7825)
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Health insurers are currently developing 2015 premiums for the individual market. There is considerable interest in 2015 premiums, as they are the first premiums developed after "near full" implementation of the Patient Protection and Affordable Care Act (ACA).

Final premiums paid by consumers are the end results of a months-long process that begins with the development of rates for proposed 2015 insurance policies. Insurers develop rates using actuarial methods with the objective that total final premiums will cover payments for medical claims, administrative costs (including taxes and fees), and profit/surplus. Before a rate becomes a premium, the rate may be reviewed by a state, as states are the principal regulators of insurance. In general, the regulatory processes by which states oversee rates include form and rate filing requirements, and rate review. Filing requirements and rate review apply to policies offered in a given state, whether or not they are offered through exchanges ("marketplaces") established under ACA. Each state specifies the timeline by which these processes occur; therefore, any rates made publicly available at this time should be viewed with caution. Often early analysis of "2015 premiums" is based on information from form and rate filings.

Form and Rate Filings

In general, states require insurers to submit health insurance information ("form filing") to the applicable state entity (usually insurance departments) when an insurer sells a new policy or changes are made to an existing policy. At a minimum, forms are filed on an annual basis, usually during the second quarter for calendar year policies. Rates are typically filed with the initial form and usually must be filed each time an insurer proposes rate changes, or if changes in the form filing affect rates.

A rate—the price for a unit of insurance—represents an actuarial estimate that accounts for a variety of allowable factors, such as projected enrollment and claims costs, policy-specific features (e.g., consumer cost-sharing, provider network), adjustments for ACA risk programs, etc. Rate filing requirements and regulatory capacity vary by state; therefore, the scope of information in such filings may differ from state to state, as does states' ability to conduct oversight. Filings also must comport with relevant federal guidance.

Rate Review

Rates submitted by insurers *may* undergo regulatory scrutiny, depending on state requirements. Three universal standards apply to state rate review activities: rates must be sufficient (to guard against insurer insolvency), but not too high (must be actuarially justified), nor unfairly discriminatory (adjustments for permissible enrollee characteristics must be based on differences in expected claims only).

State approaches to rate review vary in terms of the statutory authority to conduct reviews, the scope of review activities, and regulatory resources. States may have "prior approval" requirements, for which insurers must file proposed rate changes and the state has the authority to approve, disapprove, or modify the request. However, prior approval authority typically also includes a deeming period; if the state does not take any action and the deeming period elapses, the filing becomes effective. There are also "file and use" requirements, for which insurers file rates with the state, which become effective either immediately or on a date specified in the filing. Under either of these scenarios, the state may disapprove a rate filing if it does not meet a certain compliance standard, such as a minimum anticipated medical loss ratio. Other rate filing approaches may include filing rates as part of the general form filing requirements, or rate filing for informational purposes only.

Depending on the scope and intensity of rate review, it may take some time after the initial filing before rates are approved (if applicable in a given state). Rates are then used by insurers to develop consumer adjusted premiums: the actual amounts charged for health insurance policies, after individual characteristics are considered (e.g., age).

In addition to state requirements, ACA requires rate review of all proposed rate increases that meet or exceed a specified threshold in applicable markets. Insurers are required to submit a justification for such proposed rate increases to the relevant state and the Centers for Medicare & Medicaid Services (CMS). While CMS will publicly disclose the information, the ACA rate review process does not give CMS the authority to amend or disapprove any proposed rate increase.

Public Access to Rate Information

There is no federal requirement for states to release entire rate filings to the public. As such, there is wide variation in the information available to the general public regarding health insurance rates and when they are released. A CRS review of publicly available filings, conducted in the summer of 2013, found that 21 states did not make any information from the filings available to the public, while 16 states and the District of Columbia made entire filings available online. The remaining 13 states disclosed summary filing data and/or selected sections from the filings. It is not known whether states will follow the same disclosure patterns for 2015. The ACA grants provided to states to enhance rate review may facilitate state efforts to improve transparency throughout the review process.

Policies Offered Through Health Insurance Exchanges

Insurers that want to offer policies through exchanges must submit applications to the exchanges, with policy information including premium, benefit, and

network information. Each exchange is responsible for approving or denying insurer applications. In some instances, an exchange's review of insurers' submissions may overlap with a state's review (as described above), but the reviews are not required to be coordinated. With respect to policies offered through federally facilitated exchanges, CMS includes a proposed timeline in its March 2014 guidance to insurers. Tentatively, all final policy data must be submitted to CMS by September 4, with final approval provided no later than November 3 for participation in the 2015 benefit year. State-based exchanges may implement their own timelines for the review and approval processes.