NASHP

Toolkit: Health Insurance Rate Review Authority to Control Health Care Costs, Including Model Legislation and Regulatory Language

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For over a decade, Rhode Island [https://www.nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/] has used its health insurance rate review authority to constrain the growth of hospital prices to the rate of inflation plus one percent. Other states, including Colorado and Delaware, are moving to implement similar strategies giving the insurance commissioner the authority to enforce affordability standards as part of the health insurance rate review process.

This toolkit allows states to assess their existing health insurance rate review laws for the authority to regulate hospital cost growth; and proposes model statutory and regulatory text to provide a state insurance commissioner with the ability to condition health insurance rate approval on meeting affordability standards in hospital cost growth.

Assess Your State's Existing Rate Review Authority

There are three main questions to assess a state's existing authority to implement an affordability standard via health insurance rate review:

Type of rate review: Does your state require prior approval or file-and-use for health insurance rates? Does the type of rate review authority vary by market segment?

Scope of rate review: Does your state insurance rate review authority extend to the fully insured large group market or does it only cover the small group and individual markets?

Consumer protection authority: Do your state insurance rate review laws include as one of the purposes or duties protecting consumers, promoting the public interest or welfare, or improving affordability?

Type of Rate Review. *Although a state may be in a better position to enact an affordability standard via health insurance rate review if it has prior approval authority rather than file and use authority, a state can start with the authority it has and use retrospective enforcement under file and use review.*

The first question addresses the type of the state's rate review authority [https://www.kff.org/wp-content/uploads/2013/01/8392.pdf] , the process under which the state's insurance commissioner reviews and approves health insurance premium rates and increases to ensure they are accurate and justifiable. There are two general types of rate review authority: "prior approval" and "file and use." Under prior approval authority, the health insurance carriers must file their rates and supporting data a certain time period in advance of the rates' effective date, and insurance regulators have the authority to review and disapprove any rates that they do not meet the state's regulatory standards. Under file and use authority, insurance carriers' rates go into effect before the insurance regulators may review it, but the regulators may be able to review and take action afterwards, usually based on consumer complaints. Many states follow a prior approval system of rate review.[1] [#toggle-id-4] Other states follow a file-and-use system of rate review.[2] [#toggle-id-4] Finally, some states use different systems for different market segments, such as requiring prior approval for individual and small groups and file-and-use for large group policies.

Scope of Authority. *States should understand the scope of their health insurance rate review authority, including which market segments to which the authority extends: individual, small group, or large group markets.*

States that only extend health insurance rate review requirements to the individual and small group markets could enact an affordability standard applicable to those market segments as a starting point. But to have a larger impact on health care costs overall, the rate review authority would need to extend to the large group market as well. This is particularly true if the insurance carriers in that state develop different contracts and rates for small and individual markets than for the large group market. In other states, however, there may be sufficient overlap in the carriers' contracts and fee schedules between the market segments that even if the affordability standard is applied to a more limited segment (e.g., the individual and small group markets) there may be a spillover effect in the large group market.

Consumer protection authority. *If a state's existing health insurance rate review laws include authority to take steps to protect consumers, protect the public's interest or welfare, or promote affordability, then the model statutory text below may be unnecessary. The state could rely on that existing authority and implement rulemaking to establish an affordability standard.*

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Model Statutory Authority for Health Insurance Affordability Standard

To implement an affordability standard, a state's rate review statute must give the insurance commissioner the authority to assess a broader array of statutory factors in rate review beyond insurer solvency to include consumer protection and affordability. For example, a typical state statute may require that health insurance rates are not "excessive, inadequate, or unfairly discriminatory." This

type of rate review authority was traditionally aimed at marketplace behaviors [https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2667214] of insurers in a property-casualty model addressing insurer insolvency and discriminatory pricing, but does not target the key problem driving health insurance premiums up: rising hospital prices. Thus, to implement a hospital affordability standard in most states, the insurance commissioner's statutory rate review authority would likely need to be augmented.

To provide authority to implement affordability standards via health insurance rate review, the statutory text ought to be drafted broadly enough to authorize the insurance commissioner to pursue policies to protect the public interest and promote health care affordability. However, the statutory text should leave specification of the affordability standard and implementation to regulation to preserve flexibility to pursue other policy objectives, such as the promotion of primary care, alternative payment models, or the reduction of health disparities.

To extend the Insurance Commissioner's authority to implement an affordability standard, a state could add the following text to the statutory provisions governing Commissioner's existing rate review authority.

Powers and Duties of the Commissioner

- With respect to health insurance as defined in [code section], the Commissioner shall discharge the powers and duties of office to:
- Protect the public interest and the interests of consumers;
- Encourage the fair treatment of providers;
- View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access.

Rate Filing Requirements

- In discharging the duties of the Office, including but not limited to the Commissioner's decisions to approve, disapprove, modify or take any other action authorized by law with respect to a health insurer's filing of health insurance rates or rate formulas under [cite to code provisions], the Commissioner may consider whether the health insurer's products are affordable and whether the carrier has implemented effective strategies to enhance the affordability of its products.
- The Insurance Commissioner may promulgate regulations to carry out the powers and duties of this Section, including without limitation, to implement rate filing requirements, establish affordability standards, impose penalties, and ensure compliance with this section.

Note: States may want to add provisions to the rulemaking authorization to include other policy objectives related to affordability, including investments in primary care and alternative payment models.

+ **Model Regulations for an Affordability Standard**

Under the statutory authority set forth above, the Insurance Commissioner could implement a regulatory affordability standard as a requirement for approval of health insurance rate filings. These model regulations provide for specific standards of affordability of health insurance premiums, including a provision that limits the rate of growth of hospital inpatient and outpatient rates in provider contracts. The model is based on rules in Rhode Island [https://rules.sos.ri.gov/regulations/part/230-20-30-4] that limit the aggregate increase in health insurers' contracts with hospitals to the annual rate of inflation, calculated as the Consumer Price Index – Urban plus 1 percent.[3] [#toggle-id-4] In addition to establishing the

affordability standard, the model regulations provide for monitoring and enforcement.

Affordability Standard for Hospital Contracts

- Applicability. The Affordability Standard set forth in this Section shall apply to contracts between a health insurer and a hospital licensed in the state which are entered into, renewed, or amended on or after [January 1, 2022]. To ensure compliance with this Section, in the event of any hospital conversions, mergers, acquisitions, or changes of ownership or control, the health insurer shall, in terms of calculating the rate increase, treat the contract of the successor hospital or entity as a continuation of the contract of the predecessor hospital or entity with whom the health insurer had contracted.
- Affordability Standard. Each health insurer shall include in its hospital contracts a provision that agrees on rates for each contract year. Review and prior approval by the Commissioner shall be required if either:
- The aggregate rate increase, calculated as the weighted average increase for inpatient and outpatient services, is greater than the Consumer Price Index for All Urban Consumers: All Items Less Food and Energy("CPI-Urban") percentage increase, as determined by the Commissioner by [October 1] each year based on the most recently published United States Bureau of Labor Statistics data, plus one percent (CPI-Urban + 1%), or
- Separation of Inpatient and Outpatient Services. The Commissioner may, in his or her discretion, calculate average rate increases separately for inpatient and outpatient services and require that neither the inpatient nor the outpatient average rate increases in any hospital contract exceed CPI-Urban plus 1 percent.
- The Commissioner, upon petition by a health insurer for good cause shown, or in his or her discretion as necessary to carry out the purposes of the laws and regulations administered by the

[Department], may modify or waive one or more of the requirements of this Section. Any such modifications shall be considered and made during the formal process of the Commissioner's review and approval of health insurance rates filed by the health insurer, or in accordance with a process that the Commissioner may specify.

- Monitoring and Enforcement.
- Monitoring. Health insurers shall provide to the Commissioner in a timely manner and in the format requested by the Commissioner, such data as the Commissioner determines is necessary to evaluate the Affordability Standard and to monitor compliance with the Affordability Standard established in this Section. Such data may include any hospital or provider reimbursement contract, unit cost trends.
- Consent to Public Release. Hospital contracts shall include terms that relinquish the right of either party to contest the public release, by state officials or the parties to the contract of the provisions of the contract demonstrating compliance with the requirements of this Section; provided that the health insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.
- If any health insurer fails to comply with the requirements of the Affordability Standard set forth in this Section, the Commissioner may take any or all of the following enforcement actions: deny approval of any rate filing application, condition approval on corrective action, require additional monitoring or reporting of data, and/or impose any penalties under the Commissioner's authority under [citation to code sections].

Further Considerations.

To implement the affordability standard as part of health insurance rate review, the Office of the Insurance Commissioner must have the staffing capacity, budget, and content and actuarial experts (whether in-house or under contract). To assist with enforcement, the department can use its existing authority to conduct market conduct examinations to evaluate the payment rates in health insurance-provider contracts, and to charge the costs of the examination to the insurers.[4] [#toggle-id-4]

As drafted here, the affordability standard would only target hospital prices, but future iterations of the model could expand the scope of review beyond hospital services to include professional services, particularly those of physician groups owned by hospitals. Further, the affordability standard could also aim to target increased costs from utilization, not just prices, in the form of an overall revenue cap. Second, once a state has a working affordability standard in place, it can consider ways to address distributional and rate inequities particularly among independent community hospitals, rural hospitals, safety net hospitals that may be paid less than hospitals in larger health systems. Finally, states looking to implement a health care cost growth benchmark could find ways to harmonize the affordability standards with the cost growth benchmark, including coordination of information reporting and review.

It is worth noting that state regulators who have implemented an affordability standard via the health insurance rate review authority recommend keeping the program simple initially, because it is easier to implement and to communicate to policymakers, stakeholders, and the public. Thus, any future adjustments and refinements must be balanced against the costs of increased regulatory complexity.

+ **Notes**

[1] For example, North Carolina provides, "No policy of group or blanket accident, health or accident and health insurance shall be delivered or issued for delivery in this State unless the form of the policy contracts including the master policy contract, the individual certificates thereunder, the applications for the contract, and a schedule of the premium rates pertaining to such form or forms, have been filed with and the forms approved by the Commissioner." N.C. Gen. Stat. § 58-51-85 [https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chap 51-85.pdf]

[2] For example, Georgia provides, "Any . . . insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule at least 45 days prior to any indicated effective date for all insurance other than personal private passenger motor vehicle insurance. No rate, rating plan, rating system, or underwriting rule required to be filed under this subsection will become effective, nor may any premium be collected by any insurer thereunder, unless the filing has been received by the Commissioner in his office not less than 45 days prior to its effective date." GA. Code Ann. § 33-9-21 [https://codes.findlaw.com/ga/title-33-insurance/ga-code-sect-33-9-21.html] (d).

[3] 230 R.I. Code R. 20-30-4.10. Earlier, Rhode Island's regulatory affordability standard was limited to the annual increase in the Medicare Hospital Price index, plus one percent, requiring insurers' hospital contracts to "Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract." (effective 2012).

[4] For example, Rhode Island's market conduct examination authority is codified at 27 R.I. Gen. Laws § 27-13.1-1 to -8 [http://webserver.rilegislature.gov/Statutes/TITLE27/27-13.1/INDEX.HTM] . The costs of examinations are paid by the insurers. *See* 27 R.I. Gen. Laws § 27-13.1-7 [http://webserver.rilegislature.gov/Statutes/TITLE27/27-13.1/27-13.1-7.HTM] .