Effects of Implementing State Insurance Market Reform, 2011-2012

FINAL REPORT
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Executive Summary

This study uses public data obtained from state insurance departments' websites to assess premium increases of major medical insurance policies during the period 2011 to 2012. The study further examines modification of proposed premium rate increases by state regulators, possible determinant characteristics of state markets, and possible effects of increased transparency in those markets. ASPE asked NORC to conduct this assessment in the context of recent changes in the regulation of health insurance established under the Patient Protection and Affordable Care Act (ACA).

Under the ACA, two important provisions affecting premium rate review began in 2011. First, Section 1003 authorizes state regulators, or the Department of Health and Human Services (DHHS) in cases where the state's review process is deemed ineffective, to review the reasonableness of proposed rate increases. DHHS regulations require insurers increasing premiums by 10 percent or more to justify such premium increases either to the state insurance department or to DHHS.[1] This "unreasonable rate review" program began on September 1, 2011.

The second provision aims to prevent insurers from retaining an unreasonable share of the premium dollar for administrative expenses and profits. Section 2703 of the ACA requires insurers to meet target medical loss ratios (MLRs – defined for the purposes of this regulation as the percentage of premium income spent on medical benefits and quality improvement across the whole line of business). DHHS set the MLR target at 80 percent for individual and small group coverage. Carriers not meeting this target are required to provide customers with premium rebates. In August 2012, the first rebates were issued for medical loss ratios incurred in 2011.

The objective of this study is to examine trends in premiums in the individual and small group markets in 2011 and 2012. Specific research questions include:

- How have rates of premium increases across states included in our sample changed over time?
- How do premium increases vary by type of insurance product and by states in our sample?
- What percentage of premium requests in our sample have been denied or modified?
- What are trends in premium increases at the state level for states in our sample?
- How has the transparency of rate premium increases changed over time for states in our sample?

[1] States and the Federal governments review rate increases of non-grandfathered plans in the individual and small group markets above a certain threshold (at or above 10 percent for September 2011 to August 2012) to determine if they are unreasonable. See http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

Methods

The assessment of premium rate increases follows on a prior study where NORC analyzed the same outcomes for the years 2008 to 2011. The findings from this prior study were presented in the report entitled "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011," or the Trends study. The Trends study addressed similar research questions; however it involved a different sample of states and different methods for collecting information on rate increases. While this report includes data from both studies, the Trends study included an incomplete picture of 2011, because data collection occurred during the summer and fall of 2011 before all 2011 rate filings were approved and publicly available – all Trends estimates for 2011 were given a cautionary footnote as a reminder.

This study builds upon the research and methods of the Trends study. For this study, NORC extracted data from the 24 states included in the Trends study that have public websites, through which state insurance departments make insurance rate filings available, and 5 additional states that have publicly available filings. The added states represent a mixture of population size, regulatory disposition, and geography. In total, 1,654 filings were collected for the study, 690 of which took effect in 2011 and 964 in 2012.

To increase replicability and transparency of data collection, the project team built a relational database to track queries submitted to state insurance department portals, filings downloaded from state portals, and data captured from filings in the scope of the study. NORC saved electronic copies of all these valid filings. Quality control review re-examined statistical outliers (premium increases of more than 20 percent and less than -10 percent) and observations for which the approved rate was higher than the proposed rate. NORC also conducted an audit of 100 random observations and found an error rate of approximately one percent.

To account for differences in the impact of each observation on the population insured in the individual/conversion and small group markets, weights were derived for each carrier, product and state. Carrier weights were created separately for the individual/conversion markets and small group markets using the National Association of Insurance Commissioners (NAIC) April 2011 reporting of member months in both of these markets. NORC based the weights assigned to each product on the enrollment data in the filings. In the small group market, NORC used data from the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) on the prevalence of various insurance products in that market to adjust filing weights. State weights reflect the share of national enrollment for persons enrolled in the small group and individual markets based on data from NAIC.

In calculating standard errors a finite multiplier (the percentage of enrollment in the state in the sample) was used, which greatly reduces the size of standard errors. This corrective factor helps to account for the relatively large proportion of the total affected population that is included in the sample and the collected data. Using *t*-tests at the p=.05 significance level, NORC tested for differences between years and covariates such as product type, state regulatory review, and market concentration.

Findings

Premium increases have slowed since 2011, the same year ACA rate regulations went into effect. In the individual market, the average premium increase effected declined from 11.7 percent in 2010 as estimated based on the sample of states included in the Trends study to 7.0 percent in 2011 and 7.1 percent in 2012 as estimated using the sample of states in the current study. In the small group market, premium increases declined significantly from 8.8 percent in 2010 to 6.1 percent in 2011 to 4.8 percent in 2012.

The slowing of premium increases has two dimensions. First, insurers requested smaller premium rate increases in both individual and small group markets. Second, regulators reduced insurers' requested rates of premium increase more extensively after the ACA rate review provisions went into effect. In 2011 and 2012, state regulators modified about 24 percent of rate requests in the individual market and 15 percent in the small group market, but the average reduction in requested premiums was 11 and 7 percent respectively in 2011 and 13 and 24 percent respectively in 2012.

Data from this study suggest that many carriers submitted filings in the months and weeks prior to the start of rate review required under the ACA on September 1, 2011. In August of 2011 NORC found 86 filings in the individual/conversion market, of which the majority were for increases of 10 percent or more. In contrast, insurers submitted 16 filings in September, and none of which were for 10 percent or more. In the small group market, where plan years tend to be calendar years, insurers submitted 56 filings in August and 18 in September.

After "reasonableness review" was implemented on September 1, premium increases slowed. In the individual/conversion market, average premiums rose by 7.0 percent in filings submitted both before September 1st and after, although the rates initially proposed by carriers fell from 8.1 percent to 7.5 percent. In the small group market, premium increases averaged 4.3 percent before and 3.1 percent after the provision was implemented. In the individual/conversion market fewer filings proposed increases of 10 percent or more (43 percent before to 20 percent after implementation). In the small group market, this percentage declined from 21 percent to 10 percent.

Premium increases varied considerably among individual states. Of the 16 states with reportable data in both study years in the individual market, four (Oklahoma, Oregon, Virginia, and Washington) had a statistically significant decline in the average premium rate increase from 2011 to 2012. Of the 16 states with reportable data in both study years in the small group market, eight (California, Florida, Maine, Michigan, North Carolina, New York, Oregon, and Washington) had a statistically significant decline in the average rate of premium increase from 2011 to 2012.

Limitations

While this report presents data from the current study alongside data from the Trends study, comparisons across the years should be made with caution. The Trends study included a different sample of states, employed different methods of data collection, and presented an incomplete picture of insurance filings in 2011 because data collection ended in the fall of that year.

This report can present descriptive analysis of the trends in rate increases in periods before and after ACA rate review took effect, but there is no way of knowing what would happen absent the ACA, as its provisions apply to all states. NORC did not conduct multivariate analyses to test the impact of factors unrelated to the ACA that may also have affected premium increases. It is possible that the "Great Recession" and a sudden decline in claims expenses in 2009 and 2010 contributed greatly to the slowing of premium increases. We note, however, that 2010 was a year of the highest premium increases in the individual market based on our 2008-2011 analysis in the Trends study.

Second, in both the individual and small group markets, we cannot explain why the number of fillings sometimes fluctuates dramatically from year to year for a given state.

Third, for some data fields in some filings, data were either missing or seemingly implausible. For example, some filings were missing either requested premium increases or approved rate increases; in these cases, we were unable to assess whether state regulators modified the rate originally proposed by the carrier, and so these observations were omitted from analysis of that question. In other instances, available data seemed implausible. For example, in some cases, the total reported enrollment in multiple filings from the same year by a single carrier summed to a figure much greater than that carrier's entire enrollment listed in the NAIC April Supplemental Report, suggesting that some enrollees may have been double-counted in the filings. Where enrollment data is missing or implausible, the weighting methodology employs the data from NAIC on state insurer enrollment in the individual and small group markets to cap the maximum possible weight such filings can receive. From sensitivity testing conducted

for the Trends study which had similar data, we believe that measures of central tendency in this report are robust to the particulars of the weighting method used.

Finally, it is important to note that state procedures for posting filings in their public portal and their process for reviewing filings vary, even among states that have the same regulatory authority (file and use or prior approval). In some states a new filing is filed under a separate tracking number in response to a regulator's rejection to an initial proposed rate and in other states filings capture the revised rate increase in a single filing. Additionally, although use of the SERFF portal and the SERFF file template did improve the consistency of the information presented in filings, in some cases sections of the template were left blank or could only be found in the correspondence attached to the filing. As such, while the completeness of the filing documentation submitted by carriers has improved since the beginning of the Trends study, the data presented in this report is subject to the limitations of its sources.

Conclusions

These limitations inform readers to view study findings with some caution. Nonetheless, we saw statistically significant differences in the levels of premium rate increases during different periods of time. Premium increases slowed substantially in the individual and small group markets after rate review went into effect. Results show that, on average, for the states included in our sample, insurers requested smaller premium increases after the implementation of rate review, and on average, for the states included in our sample, regulators reduced these requests significantly. The relatively large number of filings submitted before September 1, 2011, plus subsequent declines in premium increases in 2012 is consistent with the idea that insurers changed their approach after the ACA's rate review went into effect.

Introduction

The Affordable Care Act and associated regulatory changes may substantially affect the individual and small group markets for health insurance. This study uses public data obtained from websites of state insurance regulators to assess increases in the premium rates for major medical insurance policies in the individual and small group markets in 2011 and 2012. We look at outcomes such as increases in premium costs, modification of proposed premium rate increases by state regulators, possible determinant characteristics of state markets, and possible effects of increased transparency in these markets. ASPE asked NORC to conduct this assessment in the context of recent changes in the regulation of health insurance established under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA).

The assessment of premium rate increases follows on a prior study where NORC analyzed the same outcomes for the years 2008 to 2011. This prior study, known as “Trends in Health Insurance Premiums” or the “Trends study,” addressed similar research questions; however, it involved a slightly different panel of states and different methods for capturing information. While this report includes data from both studies, the Trends study included an incomplete picture of 2011 because data collection occurred during the course of the year, and some states did not make filings publicly available immediately – all Trends study estimates for 2011 were given a cautionary footnote as a reminder.

In the United States, about 22 million employees and dependents are covered under small group plans and about 14 million people are covered by individual plans.[2] Most states define the small group market as employers with 50 employees or less. Ninety-eight percent of small firms are fully-insured and purchase coverage directly from insurers, and so are subject to state regulation.[3] Individual insurance, often referred to as the “residual market,” is purchased by households where the employer(s) of working adults do not offer coverage.[4] Prior to the passage of the ACA, these markets for decades experienced higher rates of inflation than the large group market.[5,6] Aspects of the ACA are designed to enable states to better regulate insurers’ potential premium increases in the individual and small group markets.

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[2] National Health Policy Forum, *Individual and Small-Group Market Health Insurance Rate Review and Disclosure: State and Federal Roles After PPACA*, September 2011, p. 2. See http://www.nhpf.org/library/issue-briefs/IB844_RateReview_09-28-11.pdf

[3] Data are from author analyses of the 2012 Kaiser/HRET public use file. Statistic cited is Percentage of Firms with Self-Insured Plans, Overall (EMPWT) -- 1.917%. See http://kff.org/private-insurance/report/employer-health-benefits-2012-annual-survey/

[4] Alternatively, all adults in the household may be unemployed.

[5] P. Ginsburg, J. Gabel and K. Hunt, “Tracking Small Firm Coverage, 1989-1996,” Health Affairs January/February, 1998, Vol 16, No. 7, pp. 167-171.

The Affordable Care Act created new reporting and regulatory requirements for health insurance issuers in the United States. In 2011, the United States Department of Health and Human Services (DHHS), acting under authority granted by the ACA, established a process for health insurance issuers to annually report premium income, administrative expenses and medical claims expenses. DHHS also created a process for state governments or DHHS officials to review increases in premiums for health insurance products sold to small groups and individuals. Under the ACA, states deemed not to have effective rate review programs would cede their review authority to DHHS.[7]

Section 1003 of the Affordable Care Act authorizes states or DHHS (in cases where the state's review process is not deemed effective) to review the reasonableness of rate increases. DHHS regulations stipulate that insurers increasing premiums by 10 percent or more must justify such premium increases either to the state insurance department or to DHHS.[8] Once a proposed rate increase is submitted, the reviewing entity may declare it a "reasonable" or "unreasonable" increase. This review does not affect the regulator's powers in state insurance markets (state legislatures retain jurisdiction over the ability to require prior approval of new rates or the ability to deny rate increases), but individual issuers' history of unreasonable rate increases may be used to exclude them from participating in the ACA-initiated health insurance exchanges in 2014.[9] The process for conducting "unreasonable rate review" was implemented on September 1, 2011. To prevent insurers from retaining an unreasonable share of the premium dollar for administrative expenses and profits, section 2703 of the ACA also requires insurers to meet target medical loss ratios (MLRs), the percentage of premium income spent on medical benefits and quality improvement within a given line of business. DHHS set the MLR target at 80 percent for individual and small group coverage. From the start of 2011 forward, carriers not meeting this target are required to provide customers with premium rebates. The first rebates were issued in August 2012 for MLRs incurred in 2011.[10]

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[6] J. Gabel and J. Pickreign, "Risky Business: When Mom and Pop Buy Insurance for Their Employees," The Commonwealth Fund, Task Force on the Future of Health Care, April 2004.

[7] National Health Policy Forum, *Individual and Small-Group Market Health Insurance Rate Review and Disclosure: State and Federal Roles After PPACA*, September 2011, p. 2. See http://www.nhpf.org/library/issue-briefs/IB844_RateReview_09-28-11.pdf

[8] States and the Federal governments review rate increases of non-grandfathered plans in the individual and small group markets above a certain threshold (at or above 10 percent for September 2011 to August 2012) to determine if they are unreasonable. See http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

[9] The ACA establishes state-based exchanges that begin operation in 2014. Exchanges are organized electronic markets that allow households to purchase insurance coverage outside of the mechanism of employer-sponsored plans. Small employers can also purchase coverage on the exchange. Exchanges are the portal where eligibility for Medicaid and subsidized private insurance are determined. Private insurers will offer plans on the exchange and the exchanges will provide extensive information about these plans. By 2017, about 18 million individuals and 4 million employer-based persons are estimated to enroll in the exchanges. See http://www.cbo.gov/sites/default/files/cbofiles/attachments/43057_HealthInsuranceExchanges.pdf.

[10] US Department of Health and Human Services press release, "Health care law saved an estimated $2.1 billion for consumers." Published September 11, 2012 at http://www.hhs.gov/news/press/2012pres/09/20120911a.html, accessed May 15, 2013.

At the time the Affordable Care Act became law, state regulatory authorities in 31 states had "prior approval" authority in the individual market and 25 states had "prior approval" authority in the small group market. This authority constrains carriers from raising premiums without approval from the state regulatory agency.[11] Since passage of the ACA, four more states have authorized rate review in the individual market and five more have authorized it in the small group market.[12] One state – Maine – has dropped "prior approval" review. Other states either do not require filings for rate increases or allow insurers to "file and use" rates without regulator approval. Some "file and use" states subject filings to retrospective review, in which the carrier may enact the rate upon filing it, but the state may still have some ability to modify or disapprove the proposed rate. In practice, differences among "file and use" states and "prior approval" states are not always clear. A state may have "prior approval" authority but approve nearly all requests. Alternatively, a "file and use" state may exercise retrospective review consistently and thus subject insurers to more rigorous review than the lax "prior approval" state. Regulators in both "prior approval" and "file and use" states are additionally asked to participate in the unreasonable rate review program for large requested rate increases, although their determinations about the reasonableness of these rates does not change whether or not they are empowered to modify or deny the rates.

In addition to authorizing states or DHHS to review the reasonableness of rate increases and establishing the MLR target, the ACA authorized a grant program that provides states with $250 million in Health Insurance Premium Review Grants over five years. The grant aims to improve how states review proposed health insurance premium increases and hold insurance companies accountable for unjustified premium increases. The grants were distributed through two cycles; Cycle I awarded $1 million to all 45 states that applied for them and the District of Columbia in 2010, for a period of performance through September 2011.[13] Cycle II grants were awarded to 28 states and the District of Columbia in 2011 for up to three years in two phases: Phase I Cycle II grants are for three years, and Phase II Cycle II grants are for one to two years, depending on the initial date of award.[14] Cycle III grants are set to be awarded in

[11] Most states have some form of "deemer" review. If the state has not issued a decision after some agreed-upon time period, the premium increases go into effect.

[12] Kaiser Family Foundation, "State Authority to Review Health Insurance Rates," http://www.statehealthfacts.org/comparetable.jsp?ind=887&cat=7, accessed August 28, 2012; also see, National Conference of State Legislatures, http://www.ncsl.org/issues-research/health/health-insurance-rate-approval-disapproval.aspx#Laws-State, accessed July 21, 2012.

[13] Office of Consumer Information and Insurance Oversight (OCIIO), "Grants to States for Health Insurance Premium Review-Cycle I." http://www.grants.gov/search/announce.do;jsessionid=y2QcRJMprnytTmFSt5JdB5QFT422FLppyNFRyL0yrFrwJtR2SNmj!1059327539. Accessed May 15, 2013

[14] Centers for Medicare and Medicaid Services, "Grants to Support States in Health Insurance Rate Review-Cycle II," http://cciio.cms.gov/resources/fundingopportunities/cycle_ii_rate_review_grants_funding_opportunity_announcement.pdf, published February 24, 2011, accessed May 15, 2013

September, 2013 for an 18-month period.[15,16] States had ranging levels of authority to prevent unreasonable premium increases before the ACA; however, states are using the funding from the Health Insurance Premium Review Grants Program to enhance their rate review process in a number of ways. These enhancements include seeking legislation to increase authority to review rates, developing infrastructure to collect, analyze, and report on rate review decisions, expanding premium review to other health insurance products, improving the operational process used to conduct reviews, increasing transparency to the public on the results of the state review, and developing and upgrading the technology used for these processes.[17]

Table 1 presents the state regulatory conditions for the 29 states included in this study (referred to as the State Market Reform study and abbreviated as "SMR study" in all tables in this report). In the individual market, we determined that four of the included states have "file and use" authority, 20 have "prior approval" authority, and five have established conditions that trigger whether a carrier or filing is subject to regulator prior approval. In the small group insurance market, we determined that 5 of the included states have "file and use" authority, 19 have "prior approval" authority, and 5 have established conditions that trigger whether a carrier or filing is subject to regulator prior approval. The states whose regulatory condition was not clearly classifiable as "file and use" or "prior approval" are grouped under the classification "other" in terms of their regulatory review authority for the purposes of analysis.[18] For example, in the individual market Virginia has "prior approval" authority for all products except HMO products. In the small group market, Pennsylvania has "prior approval" authority unless a proposed rate increase is less than 10 percent.

We determined that 9 of the 29 states included in this study had a public web portal through which some data on the individual and small group insurance markets was available prior to passage of the ACA; as of today, all do. Furthermore, 26 of the 29 included states (all except Florida, Iowa, and Oklahoma) received at least one of the Rate Review Cycle I and II grants. This suggests that regulations and funding from the ACA have contributed to efforts to strengthen the rate review process and improve public disclosure in

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[15] The Center for Consumer Information & Insurance Oversight, "New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes," http://cciio.cms.gov/Archive/Regulations/rates.html, accessed April 22, 2013

[16] Centers for Medicare and Medicaid Services, "Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing, Cycle III," http://www.grants.gov/search/synopsis.do;jsessionid=xqTpRJCNNHdyDmGrPLSJykHK19CQByXJV5GTF8TtTlNvlQsGHcY1!1059327539, published May 8, 2013, accessed May 15, 2013

[17] National Health Policy Forum, *Individual and Small-Group Market Health Insurance Rate Review and Disclosure: State and Federal Roles After PPACA*, September 2011, p. 2. See http://www.nhpf.org/library/issue-briefs/IB844_RateReview_09-28-11.pdf

[18] The Trends study used the classifications "Prior Approval", "File and Use", and "HMO Prior Approval" (prior approval for HMO products, file and use or no requirement for other products) to designate state regulatory authority – at the time, nearly all states fit one of the three categories. In subsequent tables, the Trends data for HMO Prior Approval states and the SMR data for "Other" states will both be displayed, but not directly compared to one another, as they reflect different groups of states.

many states. "Prior approval" authority seems associated with establishing a public website in several former "file and use" states. However, some "file and use" states such as California and Illinois have established a public website since the ACA was passed.

Table 1: Regulatory Authority and Public Availability of Rate Filings by State, for States Included in Study[19]

State	Filing Requirements, Individual Market	Filing Requirements, Small Group Market	Public Website Prior to ACA	Received Rate Review Cycle I Grant	Received Rate Review Cycle II grant
AL	File and Use except for HMOs, which need prior approval	File and Use except for HMOs, which need prior approval		x	
AR	Prior Approval	Prior Approval	x	x	x
CA	File and Use	File and Use		x	x
CO	Prior Approval	Prior Approval	x	x	x
CT	Prior Approval	Prior Approval for HMO Small Group Plans; Actuarial certification without enforcement authority for non-HMO plan types		x	
DC	Prior Approval	Prior Approval		x	x
DE	File and Use	File and Use		x	
FL	Prior Approval	Prior Approval	x		
IA	Prior Approval	Prior Approval			
IL	File and Use	File and Use		x	x
IN	Prior Approval	Prior Approval		x	x
KS	Prior Approval*	Prior Approval*		x	
KY	Prior Approval	Prior Approval		x	x

[19] In Table 1, we gathered the information in the "Filing Requirements" columns from "Private Health Insurance Premiums and Rate Reviews," a report published by the Congressional Research Service, and from two tables in Kaiser Family Foundation (KFF) State Health Facts reports (Individual Market: http://kff.org/other/state-indicator/rate-review-individual/#notes-1; Small Group: http://kff.org/other/state-indicator/rate-review-small-group/#notes-1). The KKF reports indicate the rate filing requirements and rate review authority for each state as of January 2012, based on data collection and analysis by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute. We compared the regulatory statuses displayed in the KFF tables to those presented in the Congressional Research Service report. For any discrepancies, we sought additional information to determine the current (2013) state review authority and filing requirements. We determined final regulatory requirements for such states using Department of Insurance (DOI) website information or by contacting state Department of Insurance employees via phone or email.

We gathered the information in the column "Public website prior to ACA" from the HHS report "Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities" (http://www.healthcare.gov/news/factsheets/2010/08/rateschart.html).

We gathered the information in the "Received Rate Review Cycle I/II Grant" columns from the CCIIO report "Rate Review Grants" (http://cciio.cms.gov/archive/grants/rate-review-grants-map.html).

*We determined that Kansas has a de facto prior approval filing requirement based on a conversation with a Kansas Department of Insurance representative on April 8, 2013.

State	Filing Requirements, Individual Market	Filing Requirements, Small Group Market	Public Website Prior to ACA	Received Rate Review Cycle I Grant	Received Rate Review Cycle II grant
ME	File and Use, unless a 80% minimum loss ratio is not met, the carrier does not have a credible block of business and the increase is greater than or equal to 10%. Otherwise, the state has prior approval authority.	File and Use, unless a 80% minimum loss ratio is not met, the carrier does not have a credible block of business and the increase is greater than or equal to 10%. Otherwise, the state has prior approval authority.	x	x	
MI	Prior Approval	Prior Approval	x	x	x
MN	Prior Approval	Prior Approval			x
NC	Prior Approval	Prior Approval	x	x	x
NE	Prior Approval	Prior Approval		x	x
NJ	File and Use (with a 80% MLR requirement)	File and Use (with a 80% MLR requirement)		x	x
NV	Prior Approval	Prior Approval		x	x
NY	Prior Approval	Prior Approval		x	x
OK	Individual Major Medical is File and Use; Individual HMO is Prior Approval	Prior Approval			
OR	Prior Approval	Prior Approval	x	x	x
PA	Prior Approval	Prior Approval, but File and Use if the rate increase is below 10%	x	x	x
RI	Prior Approval	Prior Approval		x	x
TN	Prior Approval	Prior Approval		x	x
VA	Prior Approval, except for HMOs which are File and Use	File and Use		x	
WA	Prior Approval	Prior Approval		x	
WI	File and Use	File and Use	x	x	x

Study Objectives and Research Questions

This study is, in many ways, a follow-up to a previous study, *Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011,* (referred to as Trends study), in which NORC used multiple modes of data collection to assess the state of the individual and small group insurance markets prior to implementation of the ACA. Data quality, particularly for the beginning of the study period, was problematic, and this follow-up study has leveraged lessons learned to improve transparency and replicability. In the current study, ASPE has asked NORC to track the trends in premium increases between 2011 and 2012. This period covers the eight months before the implementation of the Rate Review Program as well as the 16 months after its implementation in order to capture information on potential impacts of the reform program. NORC has analyzed these data to describe how premium increases vary by state and type of insurance products as well as how premium increases have changed

over time. NORC also looked at the trends in premium requests being modified or denied and the overall transparency of rate information for the years 2011 and 2012. Specific research questions included:

- How have rates of premium increases changed over time?
- How do premium increases vary by type of insurance product and by state?
- What percentage of premium requests have been denied or modified?
- What are state trends in premium increases?
- How has the transparency of rate premium increases changed over time?

Related Studies

In September of 2012, the U.S. Department of Health & Human Services released their 2012 Annual Rate Review Report[20] and cited major savings for consumers in both the individual and small group markets. Their report examined important aspects of the Rate Review Program, including 1) lowering rate increases and saving consumers' money; 2) increasing transparency in the insurance market; and, 3) enhancing state rate review programs. By examining the data collected from states (and the District of Columbia) that participate in the Rate Review Grants program, DHHS was able to analyze requests for all rate increases, including those below the 10 percent threshold for public reporting. Their report concluded that in 2011 the estimated national average rate increase implemented in the individual market was 1.4 percent lower than the initial request from insurance companies, resulting in nearly $425 million in consumer savings. For the small group market, the estimated rate increases implemented were around 0.8 percent lower and resulted in consumer savings of over $600 million. It is important to note that DHHS' analysis was not weighted by enrollment. To estimate premium savings for consumers, DHHS multiplied the average difference between requested and approved rates by the estimated average premium collected through MLR annual reports.

A subsequent research brief released by ASPE in February 2013, "Health Insurance Premium Increases in the Individual Market since the Passage of the Affordable Care Act," provides a closer, enrollment-weighted look at activities in the individual insurance market during 2009-2013.[21] The study evaluated rates of premium increases, as well as the prevalence of filings with increases of 10 percent or more – which would be subject to the September 2011 rate review requirement and public disclosure. Average rates of premium increase fell from 11.6 percent in 2010 to 8.1 percent in 2012, with a preliminary

[20] Department of Health and Human Services, "2012 Annual Rate Review Report: Rate Review Saves Estimated $1 Billion for Consumers," http://www.healthcare.gov/news/reports/rate-review09112012a.html. Published September 11, 2012, accessed April 8, 2013.

[21] Department of Health and Human Services, "Health Insurance Premium Increases in the Individual Market since the Passage of the Affordable Care Act," http://aspe.hhs.gov/health/reports/2013/rateincreaseindvmkt/rb.pdf. Published February 22, 2013, accessed May 29, 2013.

estimate for 2013 of 7.9 percent. Whereas the majority of filings submitted in 2009, 2010, and 2011 proposed increases 10 percent or more, only 34 percent did in 2012, and a preliminary estimate for 2013 of 14 percent of filings did so.

In October of 2012, The Kaiser Family Foundation (KFF) published a study entitled "Quantifying the Effects of Health Insurance Rate Review," which also looked at individual and small group markets.[22] This study consisted of reviewing rate filings submitted in 2011 and reviewed by either the state or federal government before May 1, 2012. The study looked at filings for major medical insurance projects affecting 100 or more policyholders. The filings were found online through public websites run either by the federal government (DHHS) or the individual state. Subsequently, the KFF study contains filings from 22 states and the District of Columbia for all rate changes, as well as filings that had requested increases above 10 percent from 11 states that have effective state reviews and 13 states subject to DHHS review.[23]

The KFF report's analysis of publicly available data from states with effective rate review programs concludes that, "[Evidence] suggests that these programs have a material influence on the premiums that ultimately get charged to individuals and small businesses."[24] According to their study, rates that went into effect were about 20 percent lower than the rates originally requested. By analyzing 2011 data, the KFF report was also able to observe the period before and after the implementation of the ACA's rate review requirements. While on average the requested rate change remained fairly constant through 2011, there was an observed spike in requests in August 2011 before the September implementation date. There was also an observed drop in the number of requests above the 10 percent threshold once the new ACA requirements went into effect. In addition, the study concluded that, of the filings analyzed, about one in five requests to change premiums were denied, lowered, or withdrawn during state review. In an analysis of filings from the 13 states using federal review, KFF reported that plans having a rate increase greater than 10 percent requested average rate increases of 16 percent. Of 48 filings analyzed, 37 were determined unreasonable, 9 were "not unreasonable," and 2 were withdrawn by the insurer prior to review.

The House Committee on Energy and Commerce recently released an analysis of five states disclosing information about plans likely to be offered on Affordable Care Act health insurance marketplaces when

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[22] Kaiser Family Foundation, "Quantifying the Effects of Health Insurance Rate Review," October 2012. http://www.kff.org/healthreform/upload/8376.pdf. Accessed April 8, 2013.

[23] Ibid. pp 5, 9, 11.

[24] Ibid. pg 13.

they open in 2014.[25] In order to evaluate the costs paid by a given enrollee from year to year, the study looks at the "rates for those who stay in comparable plans offered by their current insurer," in addition to the carrier's proposed or approved average premium rate change. Some detail about states' respective regulation of the individual insurance market and participating carriers is also included. The report concludes that early results from the five states that have released public data on the 2014 individual market suggest an improvement compared to the decade prior to passage of the Affordable Care Act, and that consumers in many states will have improved access to insurance plans comparable to their current benefits but less expensive.

In addition to these studies, NORC's study from November of last year, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011," is also relevant – estimates from that study are based on a slightly different sample and drew on slightly different data collection methods from the current study, but are roughly comparable. The Trends study estimated the lowest premium increases in both the individual and small group markets during these four years in 2011, the first year in which carriers were subject to the MLR requirements of the ACA.

[25] House of Representatives Committee on Energy and Commerce Democratic Staff, "Analysis of Recent Filings of Proposed Affordable Care Act Insurance Rates in Five States," http://democrats.energycommerce.house.gov/sites/default/files/documents/Memo-ACA-Insurance-Premiums-2013-5-20.pdf. Published May 20, 2013, accessed May 29, 2013.

Methodology

This study builds upon the research and methods of the 2012 Trends study report prepared for DHHS. Based on our experience with the data quality of maintained paper filings among many states in the Trends study, we relied exclusively on data from filings and summary information available electronically from public state websites for this study. In contrast, the Trends study report utilized filings that were obtained through multiple methods including in-person visits to state departments of insurance (undertaken by a NORC subcontractor) and direct appeals to state insurance commissioners for data not published online. These methods were used because fewer states had public web portals with posted filings at the time of data collection, and because in-person data collection was the originally intended data collection method for all states, based on the prior experience of insurance-industry consultants.

For this report, we compiled and analyzed data on publicly available rate increase filings for the years 2011 and 2012 for comprehensive major medical insurance products from the individual and small group markets that were available from the sample of 29 states.

Selection of State Sample

There were 29 states included in the study. All states had publicly available data posted on their state website. Of the 29 study states, 24 were also included in the Trends study. For this report, we excluded six states that were in the Trends study that did not have public websites (Hawaii, Idaho, Massachusetts, Maryland, Ohio, and South Dakota). We added five states not in the Trends study sample. These states, the District of Columbia, Delaware, Nevada, New York, and Tennessee, all have publically available data on rate increase filings through their state website and vary with respect to population size, regulatory framework and geography.[26]

Table 2: States in Study Sample

New for SMR	In Both SMR and Trends	In Trends only
DC, DE, NV, NY TN	AL, AR, CA, CO, CT, FL, IA, IL, IN, KS, KY, ME, MI, MN, NC, NE, NJ, OK, OR, PA, RI, VA, WA, WI	HI, ID, MA, MD, OH, SD

Data Collection

This section describes the steps take to extract and enter the rate increase filings analyzed for the study.

[26] Among states with public websites that were not selected, South Carolina and Vermont both lacked data for 2011. North Dakota and New Mexico were not selected.

Querying of State Portals and Extraction of Filings

Having selected the states, NORC needed to identify carriers from those states operating in the small group and individual/conversion market. This began with obtaining the most current NAIC Supplement Health Exhibit from 2011, which lists the carriers operating in each state and market, as well as total premium dollars and enrollment. [27] We used this data to identify all health insurance carriers in the individual and small group markets that had a market share of greater than one percent. A floor of five carriers from each state and market was also set, regardless of market share, allowing additional sampling from states with highly-concentrated markets. When applying these two standards (at least one percent market share or top five carriers), NORC used the one that allowed the inclusion of more carriers. The NAIC exhibit also provided data on member enrollment which was essential for constructing weights (as was done for the Trends study).

Research staff began by searching through each state's website. Because of the design of these sites and the organization of the rate filing data at the state level, we found there were multiple ways to search for and access filings for specific carriers and applicable markets. Furthermore, we found that in some cases different approaches to searching lead to unexplained differences in the filings retrieved. Therefore, we built a list of all possible query options (search terms and paths) for locating filings submitted by the carriers identified in each state. NovaRest, an actuarial consulting firm and NORC's subcontractor on the Trends study, reviewed this list of potential query options, to determine which queries from each state's total list would be used in the data extraction phase. This was necessary because states do not use a universal system for classifying insurance products, and so NovaRest's familiarity with various state markets was needed to identify labels associated with major medical products. Once the list of queries had been winnowed to fit the study's parameters, we employed this constricted list to create a query guidance document. We used this document to develop a list of queries for each state to obtain all health insurance filings for major medical policies in the individual and small group markets.

After validating the query guidance document and creating the query list, research analysts employed these documents to conduct data extraction by downloading filings from each state's website. Data extraction began when an analyst entered the first unique query (for most states, a permutation of attribute-based filters) from the state's query list in each state's web portal. The output of this search was captured as part of a relational database created in Microsoft Access, to associate all filings produced with a unique source query, and the process continued until all unique query permutations were searched. For

[27] Comparable data from the California Department of Managed Health Care (DMHC), which is not a member of NAIC, was used to supplement information from the California Department of Insurance, which is. This and all subsequent references to NAIC data also include this additional DMHC data.

each filing we used in the study, we have captured the exact parameters entered into a State's search portal and saved a screenshot associated with that query to record all filings that resulted from the query at that point in time. We also documented the number of results returned by each unique query permutation.

The individual filings were then entered into a Data Extraction form. We captured all relevant tracking variables including:

- State
- Market type
- Carrier type
- NAIC Carrier Code
- Three digit record code
- SERFF number
- State ID number
- Extraction date
- Tracking information (Name of extracted file, URL, and extraction date)

This process continued until every filing document connected to the unique query from the permutation list had been extracted. Each Data Extraction form corresponded with a downloaded PDF of the filing found on the state's web portal. For quality assurance purposes NORC used pre-populated drop-down menus in the Access user interface wherever possible to reduce transcription error.

Some states included in this study use the SERFF system, which is a standardized, automated electronic system that allows insurance companies to submit insurance rate filings and allows states to review, comment, and respond (with an approval or rejection). Querying of state portals that were hosted by the SERFF system could be conducted using standardized query terms. Some states, in addition to using a SERFF system, also used a standardized SERFF template for rate filings, and these templates presented information in a consistent format allowing for easier review of important data elements. However, all filings, regardless of whether they used the SERFF template or not, often had missing information or had information captured only in the correspondence attached to the filing form.

Data Entry

Within the Microsoft Access relational database, each filing corresponds to a single data entry form. Analysts used this database of filings to capture the analytic variables from each PDF filing. Similar to the data extraction phase, NORC used pre-populated drop-down menus to reduce transcription error for quality control/quality assurance purposes. Variables captured in this phase of the project included:

- Unique identifier
- Market classification
- Insurer name
- Insurer NAIC code
- Date filing filed
- Date filing approved/filed
- Date effective
- Filing status
- Business status
- Increase period
- Proposed rate
- Approved rate
- Approved minimum and maximum rate increase
- Product type
- Reported member months
- Numbers of group contracts
- Numbers of covered members

For analytic purposes, NORC assigned product types listed in the filings to one of three categories with the intention of simplifying and standardizing classifications across states. Each product type identified in a filing was recorded as "HMO, EPO, POS"; "PPO, High Deductible"; or "Indemnity, Fee-for-Service, Conventional." Product types with other labels were researched to make an assignment based on benefit structure, particularly whether the plan has a provider network and if so, how out-of-network care is covered. NORC coded filings that include two or more types of insurance product as having both or all three as appropriate. NORC recorded values for plan enrollment – member months, group contracts, or covered members – by product type.

Research analysts flagged any questions with a filing during data entry for review. Additionally, they manually checked each filing during the data entry process to ensure that it fell within the parameters of the study. Despite the fact that queries were designed to return only "in-scope" data, NORC research staff found many of the extracted filings were actually not part of the study's area of focus. This implies continuing inconsistency in the quality of the state portals used. The analysts excluded filings if they did not meet the study's targeted market class, type of insurance, membership, and effective date (see Table 3 for additional details).

Table 3: Reasons to Exclude Filings during the Data Entry Phase

Variable	Filings Outside Scope of Study
Market classification	Large group market "Any Size" group market
Date Effective	Prior to 1/1/2011 or after 12/31/2012[28]
Numbers of covered members	Zero enrollment (i.e. new plans, empty contracts)
Filing type	Non-rate increase filings (i.e. form filings)
Type of Insurance	Hospital indemnity Hospital-Surgical Medicare Supplement, Medigap, or Medicare Advantage Prescription Drug-only or Rx-only Long-term care Medicaid managed care Limited benefit Dental Vision State high-risk plans

After data entry for a state was finished, NORC conducted a multi-step review process, using a combination of randomized and purposive techniques to ensure data consistency, completeness, and quality. Initially, a first reviewer examined all filings flagged for review by the original research analyst entering filing data. The reviewer commented on all filings and instructed the original research analyst to either exclude the filing or address the specific issue as instructed.

The second review process examined 100 randomly selected filings to determine an overall error rate for the filings. Our lead analyst selected these 100 filings randomly from a pool of all possible valid state filings. A research analyst different than the one responsible for the original data entry examined each of the 100 filings for errors within each of the date entry variables captured for the filing; any errors encountered were manually corrected and tallied. The error rate for the data entry phase of this project was approximately one percent among analytic variables, and many of the issues found were errors of omission resulting from interpretation of idiosyncratically reported data. Subsequent investigations and corrections likely reduced this rate further.

NORC analysts cleaned the data in two stages. First we reviewed filings marked as valid for errors such as erroneously checked boxes (i.e. not checked as an invalid filing, but no information entered), clear typographic mistakes (i.e. incorrect date typed), and outlier values for analytic variables. Second, we examined filings with data which tripped automated "flags" programmed using SAS. These flags identified a number of types of anomalies such as records with no year assigned to filing, no rate change proposed or approved, or a minimum rate change larger than the maximum rate change. Analysts

[28] If effective date missing, filings excluded on the basis of date used the following rule – the approval date must fall between 10/1/2010 and 12/31/2012 to be included.

reviewed the flagged variables, made corrections as needed, and summarized the changes in an open "Notes" field for another reviewer to examine.

Quality Assurance

As discussed in previous sections, NORC took multiple steps to ensure quality in the data collection phase of this project. Research analysts extracting and entering data on filings used an Access database for all steps of the data collection process, linking each step and creating meta-data on the process. Screen shot images were saved for every query to ensure that every available filing (at the time of query) was downloaded for review. During data entry, wherever possible, drop-down menus were used to ensure standardized capture of information. NORC reviewed a random sample of 100 filings, discussed in the prior section, for errors in data entry, and an error rate of approximately one percent was calculated. Subsequent meta-analysis of these errors found many were variables omitted when they were available in the filing or entered despite conflicting evidence (i.e. of another value) in the filing – both of these types are fundamentally due to judgment calls in reconciling information from different parts of the same filing document. A single filing pdf document may contain correspondence between the filing carrier and state regulators that spans several months, but individual pages are often undated, and it is not always clear which part of the filing indicates its final disposition.

Every effort was made to capture data for variables that were key to the analysis. If a key variable was noted as missing from the filing, additional investigation was done to confirm whether the data was truly missing from the filing. After building the final database, we performed additional checks on outliers. NORC re-examined observations with a premium rate increase of less than -10 percent or greater than 20 percent to look for and correct any data entry errors. Similarly, NORC also checked the observations showing an approved premium rate increase in excess of the requested rate increase to ensure the accuracy of the captured rate increase data.

Data Analysis

The following section describes the data analysis processes of this report, including weighting and statistical testing.

Weighting

Given the method used to obtain the sample, probabilities of selection are not available. However, it is possible to derive survey weights by appropriately representing each filing's relative size from the 2011 NAIC (number of member-months by carrier), 2010 MEPS-IC (estimated enrollment distribution by state by product for the small group market), and, in some cases, carrier filings (number of reported members).

We combined the individual and conversion markets for weight calculation and refer to them in this discussion as the “individual market”. The final weights represent the contribution to the estimates for each filing.

A multi-step process was used to calculate weights. The first six steps implemented at the “state-market-year” level – (that is, each observation with a specific combination of those three variables gets its own weight). The last three steps are calculations at the level of “market-year”. The list below, as well as Tables 4 and 5, summarize each step used for weighting.

1. Initial carrier weights were generated (to reflect the carrier’s relative contribution to the estimates);
2. Applied within-carrier filing adjustments to the initial carrier weight (to adjust for multiple filings by a carrier);
3. Applied state-level product adjustments to the initial carrier weights (small group market only) (to adjust for product enrollment distributions);
4. Applied within-carrier enrollment adjustments to the initial carrier weights (to adjust for the relative size of each filing);
5. Applied weight control adjustments to the initial carrier weights (to control the weights to sum to one within a state-year);
6. Calculated final state-level weights (for use in deriving state-level estimates);
7. Applied national-level adjustments (to adjust for the relative size of each state);
8. Applied national-level single-filer adjustments (to control the influence of single-filers within a state);
9. Calculated final national-level weights (for use in deriving state-level estimates).

Initial Carrier Weights: The source for the initial carrier weights is the 2011 NAIC supplemental data file. We used information on member-months from NAIC to assign initial carrier weights to reflect the relative contribution to the estimates by carrier within strata defined by market (individual, small group), year, and state. Initial carrier weights are defined as:

$$IW_{TYSi} = \frac{M_{TYSi}}{\sum_{i \in TYS} M_{TYSi}}$$

where

M_{TYSi} = number of member-months reported from the 2011 NAIC for sample carrier *i* reporting in year Y from market type T in state S

Within-Carrier Filing Adjustments: As each carrier may have multiple filings within a market type/year/state, the initial carrier weight must be adjusted to reflect the number of filings within each carrier so as not to over-represent carriers with multiple filings.[29] The within-carrier filing adjustment is defined as:

$$CFA_{TYSi} = \left\{ \frac{1}{n_{TYSi}} \right.$$

where

n_{TYSi} = number of filings for carrier i from market type T for year Y in state S

State-Level Product Adjustments (small group market only): For the small group market, an adjustment to the survey weights is made so that distributions of the resulting survey weights reflect estimated enrollment distributions from MEPS-IC by state and product. (This information is not available for the individual market.) The sum of the within-carrier filing adjusted weights by product type is adjusted to reflect the MEPS-IC distributions. The product adjustment is defined as:

$$SPA_{GYSP} = \left\{ \frac{D_{GYSP}}{\sum_{f \in P} \left(IW_{GYSif} * FA_{GYSif} \right) \Big/ \sum_{f \in GYS} \left(IW_{GYSif} * FA_{GYSif} \right)} \right.$$

[29] While we aggregate conversion filings with those from the individual market for the purposes of analysis, we do not expect these conversion filings to measurably impact the findings as they are few in number (approximately 11% of the individual market sample by count) and they tend to have low enrollments.

where the sum in the first term of the denominator is across all filings for product type P for which small group filings G[30] were obtained for year Y from state S, and the sum in the second term is across all filings for which small group filings were obtained for year Y from state S. This latter term is used to scale the first term to sum to 1.0.

$D_{GYSP} = \frac{N_{GYSP}}{\sum_{P \in S_f} N_{GYSP}} =$ estimated enrollment distribution of the small group market for product type P (relative to product types for which filings were obtained in year Y) within state S from the 2010 MEPS-IC data; f refers to a filing obtained from sample carrier i reporting in year Y from market type G (see footnote 28, *infra*) in state S

For example, from Table 4 ID=234, the numerator=0.258, the first part of the denominator is the sum of filing adjusted weights for P=HMO (0.803314), and the second part of the denominator is the sum of all filing adjusted weights (1.0). The formula then is 0.258 / (0.803314 / 1) = 0.320880, which is Column I in Table 4.

Not all small group filings had their product type identified. As a result, no adjustment is applied to those specific filings.

Within-Carrier Enrollment Adjustments: The survey weights are further adjusted to reflect the relative size (if known) of each filing for a carrier. Each filing contained information on either the number of covered members, the number of contracts, both, or neither. Using filings with both the number of covered members and the number of contracts, an estimate of the number of covered members was imputed for those filings with only the number of contracts. The within-carrier product adjustment is defined as:

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[30] In this case, G is a constant – the market type T is either small group (G) or individual (I), but the product adjustment is only possible for the small group (G) market type.

$$CEA_{TYSPif} = \begin{cases} \dfrac{E_{TYSPif}}{\sum_{P}\left(\sum_{f \in TYSPi} E_{TYSPif}\right) \Big/ \sum_{P} n_{TYSPi}} & \text{if } E_{TYPSif} \text{ known for all filings for year Y in state S for carrier i} \\ \dfrac{E_{TYSPif}}{\sum_{f \in TYSPi} E_{TYSPif} \Big/ n_{TYSPi}} & \text{if } E_{TYPSif} \text{ known for all filings within product type P for year Y in state S for carrier i, but not known for all filings for all product types for year Y in state S for carrier i} \\ 1 & \text{if } E_{TYSif} \text{ not known for all filings within product type P for year Y in state S for carrier i} \end{cases}$$

where

E_{TYSPif} = number of members reported on filing f from individual carrier i for product P from market type T for year Y in state S

n_{TYSPi} = number of filings for carrier i for product P from market type T for year Y in state S

State-Level Weight Adjustments

As the sum of the preliminary survey weights are not constrained to equal 1.0, the weights must by adjusted so as to control the sum of the survey weights to be equal to 1.0.

For the individual market, the state-level weight adjustment is defined as:

$$SWA_{IYSPif} = \left\{ \dfrac{IW_{IYSi} * CFA_{IYSi} * CEA_{IYSPif}}{\sum_{i,f,P}\left(IW_{IYSi} * CFA_{IYSi} * CEA_{IYSPif}\right)} \right.$$

For the small group market, the state-level weight adjustment is defined as:

$$SWA_{GYSPif} = \left\{ \frac{IW_{GYSi} * CFA_{GYSi} * SPA_{GYSP} * CEA_{GYSPif}}{\sum_{i,f,P} \left(IW_{GYSi} * CFA_{GYSi} * SPA_{GYSP} * CEA_{GYSPif} \right)} \right.$$

Final State-Level Weights

The final state-level survey weight for the individual market can thus be defined as the product of the initial carrier weight and the adjustments made for the individual market:

$$SW_{IYSPif} = IW_{IYSi} * CFA_{IYSi} * CEA_{IYSPif} * SWA_{IYSPif}$$

The final state-level survey weight for the small group market can thus be defined as the product of the initial carrier weight and the adjustments made for the individual market:

$$SW_{GYSPif} = IW_{GYSi} * CFA_{GYSi} * SPA_{GYSP} * CEA_{GYSPif} * SWA_{GYSPif}$$

These final state-level survey weights sum to one with a state/market/year.

National-Level Adjustments

We applied a national adjustment to the final state-level survey weights to reflect the relative sizes across states within a market type (Table 5). The national adjustment is defined as:

$$NA_{TS'Y} = \begin{cases} 1 \text{ for single-filer states} \\ \dfrac{M_{TYS'}}{\sum_{S' \in Y} M_{TYS'}} \text{ for all other states} \end{cases}$$

where

S' = set of sample states for which more than one filing was obtained for year Y

$M_{TS'}$ = number of member-months reported from the 2011 NAIC for all carriers from market type T in state S'

National-Level Single-Filer Adjustments

Given the uncertainty associated with estimates from states with only one filer a final adjustment is applied so as to have those single filers included in the estimates but representing only themselves. This is accomplished through separate adjustments being applied to the single filers and all other filers. Note that this adjustment factor applies to only four filings in the individual market in 2011 and two in the individual market in 2012.

The national-level single filer adjustment is defined as:

$$NSA_{TSYi} = \begin{cases} \dfrac{M_{TYS''i}}{\sum_{S \in Y} M_{TYS}} \text{ for single-filer states} \\ \dfrac{\sum_{S \in Y} M_{TYS} - \sum_{i \in S''} M_{TYS''i}}{\sum_{S \in Y} M_{TYS}} \text{ for all other states} \end{cases}$$

S” = set of sample states for which only one filing was obtained for year Y

M_{TSY} = number of member-months reported from the 2011 NAIC for all carriers from market type T in state S (the set of sample states for which filings were obtained for year Y)

$M_{TS'Yi}$ = number of member-months reported from the 2011 NAIC for sample carrier i reporting in year Y from market type T in state *S”*

Final National-Level Weights

The final national-level survey weight is then defined as:

$$NW_{TYSPif} = SW_{TYSPif} * NA_{TSY} * NSA_{TSYi}$$

Table 4: State-Level Weight Calculation for 2012 Connecticut Small Group Market

ID (A)	Carrier (B)	Product (C)	Carrier Member-Months from NAIC (D)	Initial Carrier Weight (E)	Number of Filings within Carrier (F)	Within-Carrier Filing Adjustment Factor (G)	Filing Adjusted Weight	MEPS-IC Distribution (H)	Adjusted MEPS-IC Distribution	State Product Adjustment (I)	Product Adjusted Weight	Enrollment from Filing (J)	Within-Carrier Enrollment Adjustment (K)	Preliminary Weight	State-Level Weight Adjustment (L)	Final State-Level Weight (M)
213	11209	HMO	95,747	0.032254	2	0.500	0.016127	0.2226	0.2578	0.3173	0.005117	13237	1.9735	0.010098	1.268	0.012618
214	11209	PPO	95,747	0.032254	2	0.500	0.016127	0.6409	0.7422	3.9567	0.063811	178	0.0265	0.001693	1.268	0.002116
222	60217	HMO	989,174	0.333223	1	1.000	0.333223	0.2226	0.2578	0.3173	0.105727	55582	1.0000	0.105727	1.268	0.132115
231	78026	HMO	554,159	0.186680	1	1.000	0.186680	0.2226	0.2578	0.3173	0.059231	45093	1.0000	0.059231	1.268	0.074014
236	95675	HMO	700,295	0.235908	2	0.500	0.117954	0.2226	0.2578	0.3173	0.037425	42498	1.6292	0.060975	1.268	0.076194
237	95675	PPO	700,295	0.235908	2	0.500	0.117954	0.6409	0.7422	3.9567	0.466714	9671	0.3708	0.173037	1.268	0.216226
240	95935	HMO	317,663	0.107011	4	0.250	0.026753	0.2226	0.2578	0.3173	0.008488	5961	0.5258	0.004463	1.268	0.005577
241	95935	PPO	317,663	0.107011	4	0.250	0.026753	0.6409	0.7422	3.9567	0.105854	26262	2.3165	0.245214	1.268	0.306417
242	95935	HMO	317,663	0.107011	4	0.250	0.026753	0.2226	0.2578	0.3173	0.008488	1864	0.1644	0.001396	1.268	0.001744
243	95935	PPO	317,663	0.107011	4	0.250	0.026753	0.6409	0.7422	3.9567	0.105854	11260	0.9932	0.105137	1.268	0.131378
247	96798	HMO	311,465	0.104923	1	1.000	0.104923	0.2226	0.2578	0.3173	0.033291	27084	1.0000	0.033291	1.268	0.041600
N/A	N/A	IND	N/A	N/A	N/A	N/A	N/A	0.1365	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total			**2,968,503**	**1.525**			**0.968**				**0.931**			**0.788**		**1.000**

Table 5: National-Level Weight Calculation for 2012 Connecticut Small Group Market

ID (A)	Carrier (B)	Product (C)	State (D)	Final State-Level Weight (E)	Carrier Member-Months from NAIC (F)	State Member-Months from NAIC (G)	National-Level Adjustment (H)	National-Level Single File Adjustment (I)	Final National-Level Weight (J)
213	11209	HMO	CT	0.012618	95,747	3,640,884	0.026235099	1	0.000331
214	11209	PPO	CT	0.002116	95,747	3,640,884	0.026235099	1	0.000056
222	60217	HMO	CT	0.132115	989,174	3,640,884	0.026235099	1	0.003466
231	78026	HMO	CT	0.074014	554,159	3,640,884	0.026235099	1	0.001942
236	95675	HMO	CT	0.076194	700,295	3,640,884	0.026235099	1	0.001999
237	95675	PPO	CT	0.216226	700,295	3,640,884	0.026235099	1	0.005673
240	95935	HMO	CT	0.005577	317,663	3,640,884	0.026235099	1	0.000146
241	95935	PPO	CT	0.306417	317,663	3,640,884	0.026235099	1	0.008039
242	95935	HMO	CT	0.001744	317,663	3,640,884	0.026235099	1	0.000046
243	95935	PPO	CT	0.131378	317,663	3,640,884	0.026235099	1	0.003447
247	96798	HMO	CT	0.041600	311,465	3,640,884	0.026235099	1	0.001091
						138,779,122			

Imputations

Values for item non-response were not imputed. The weighting mechanism described above does make adjustments for non-responding carriers in any given year. Most important, we have not imputed any values for dependent variables – premium increases or approval by the state regulatory authority.

"Any Size Group" Filings

Some filings were filed in the SERFF system under the designation "any size group." Further examination showed that some but not all of the business covered in these filings was in the small group market. Following discussion with ASPE and analysis by the NORC team, "any size group" filings were only included in the study if they were submitted by a sampled carrier but no other data (i.e. small group-only filings) from that carrier's business in the given state and year were available. Because most "any size group" filings did not separate reported enrollment figures into small group and large group components, enrollment data for these observations were considered missing. As a result of this procedure, 53 "any size group" filings were incorporated in our analysis.

Adjustments to Filings with Greater Than Annual Increase Periods

For filings where the period between the effective date of the approved premium increase and the effective date of the last approved premium increase was greater than one year, adjustments were made to the increase such that they represented an annual period of increase, using exponentiation to account for compounding effects. For example if an insurer requested a 30% increase after three years of stable rates, this rate would be adjusted down to 9.1% for the year, which is 1.30 raised to the 1/3 power minus one.

Statistical Testing

We conducted descriptive analyses to address the study research questions. *T*-tests were used to determine whether means were significantly different, and estimates of variance were corrected for using finite population correction. The paper presents national and state-wide results. We examine multi-year trends for dependent variables, and analyze variations in dependent variables by selected independent variables. Dependent variables are:

1. Premium increases
2. Percent of rate increases approved by state regulators
3. Percent of premium rate increases modified by state regulators

We present findings separately for the individual insurance and small group markets. Key covariates are:

1. State regulatory authority
    a. Prior approval
    b. File and use
    c. HMO review authority only
    d. Rate review authority
    e. No requirement for filing
2. Product type (HMO, PPO/HDHP, indemnity)
3. Carrier size (top three carrier in the state and market, other)
4. Market concentration in the individual and small group markets
    a. High – Largest three carriers in state have 80 or more percent of the market
    b. Medium – Largest three carriers in state have 50-79 percent of the market
    c. Low – Largest three carriers in state have less than 50 percent of the market

For state-level estimates, we required filings to encompass a minimum proportion of 50 percent of NAIC-reported state-wide enrollment to report results for a given state and year to ensure reliability. Multivariate modeling is beyond the scope of this study.

Presentation of Findings

Findings from the analysis of the data collected for this study are presented alongside findings that were previously presented in the Trends study. As noted earlier, the Trends study sample included six states (Hawaii, Idaho, Massachusetts, Maryland, Ohio, and South Dakota) that are not included in the current study because they did not have publicly available filings posted on their website. The Trends study included data collected for filings that were effective 2008 through the middle of 2011, thus 2011 data for the Trends study do not represent a full year's worth of data. This study (referred to as SMR study in all tables) includes data collected for all filings from sampled carriers that had an effective date of 2011 and 2012 in the 29 states described earlier.

While there were some differences in methodology between the Trends study and the current study, there are also important similarities to note. Data for both studies were extracted from filings submitted by health insurance carriers to state regulatory authorities. One methodological improvement to the current study is that there is a clear audit trail documenting the process of extracting data from filings obtained from public websites.

In reporting figures for individual states and markets, we do not display figures if filings constitute less than 50 percent of state enrollment for the year. Non-reportable states are listed as N/R. However, all filings are included in the calculation of national figures, including states where enrollment was insufficient for state reporting. Unless otherwise noted, all premium increases presented are calculated based on the implied final increase rate. The final implied rate would include the increases that are reviewed and approved by state regulators, and in cases of filings where an approved rate is not available, (and there is no clear indication that the filing was disapproved by the state or withdrawn by the carrier) the proposed rate.

Final Sample

The process of data extraction resulted in 3,373 filings. Of these, 1,439 filings met our study's inclusion criteria and 1,934 were excluded for the reasons noted in Table 6. The majority of excluded filings (74 percent) were excluded because they were filings from the large group market, had an effective date that was not in the study time period (not 2011 or 2012), were form filings (non-rate increase filings), or were "any size" filings that were excluded using the decision rule described above in this report's Methods section. For analytic purposes, filings containing more than one product type were split into multiple observations, each containing a single product type with its respective enrollment. As many of the 1,439 filings had information on more than one product type, our final database (as of May 29th, 2013) includes a total of 1,654 observations, with 758 in the individual market and 896 from the small group market (Table 6).

Table 6: Number of Excluded Filings and Reason for Exclusion

Reasons for Exclusion	Number Excluded
Large group	462
Date out of study period	342
Document type	322
Any size group	309
New product	126
Type of insurance	102
Carrier not in sample	69
Proprietary or un-viewable filings	61
Indiana "group" filings – state could not differentiate between small and large	57
Duplicate	29
Zero enrollment	27
New business only	23
Null record	5
Total	**1934**

Findings

The number of filings collected for each state in the study sample varied over the two year study period and across the individual and small group markets. We begin our discussion of the findings with a description of the data available in the final sample of filings included in the study as well as the percentage of member-months for the carriers represented by the filings in the study.

Trends in Data Collection

Table 7 presents the number of filings included in the study for the individual and small group markets. The number of filings nationally for the individual market increased slightly from 2011 to 2012, from 363 in 2011, to 395 in 2012 (see Table 7). In the small group market, the number of filings increased more dramatically from 2011 to 2012, with 327 in 2011, and 569 in 2012. There were nine states where the number of individual market filings available in 2012 was lower than the number of filings available in 2011. In the small group market, 22 states had an increase in the number of filings from 2011 to 2012, with the greatest increase in Wisconsin with 4 filings in 2011 and 102 filings in 2012.

Filings for the Trends study were collected through multiple data collection methods including making copies of filings obtained on-site at state insurance department offices, downloading filings from state websites, and contacting state insurance departments to obtain electronic copies of filings. A comparison of the number of filings in the small group market collected during the Trends study nationally for 2008 to the filings collected in this study for 2012 shows an increase, with 139 filings in 2008 compared to 569 in 2012. In the individual market, there were more filings collected for 2010 in the Trends study (573) compared to the number of filings collected for 2012 in this study (395). As noted in the Methods section, this study only collected data on a subset of carriers with substantial presence in state markets – this is a change from the data collection procedure for the Trends study, and much of the difference in total filings collected by the two studies is explained by either changes in the panel of states or in the sample of carriers. The number of filings in each year and market associated with each independent variable is included in Appendix B.

Table 7: Number of Filings by State for Individual and Small Group Markets, Trends Study (2008-2011) and SMR Study (2011-2012)

State*	Individual / Conversion Trends 2008	Individual / Conversion Trends 2009	Individual / Conversion Trends 2010	Individual / Conversion Trends† 2011	Individual / Conversion SMR 2011	Individual / Conversion SMR 2012	State	Small group Trends 2008	Small group Trends 2009	Small group Trends 2010	Small group Trends† 2011	Small group SMR 2011	Small group SMR 2012
AL	-	2	4	4	3	4	AL	2	1	3	7	5	2
AR	13	16	21	9	5	2	AR	-	-	-	-	-	-
CA	-	1	30	19	13	18	CA	-	4	3	28	30	33
CO	15	27	45	54	32	29	CO	15	25	30	26	10	22
CT	-	5	6	9	10	12	CT	2	-	6	2	7	11
DC					1	9	DC					7	16
DE					6	-	DE					-	2
FL	42	74	62	72	31	17	FL	44	31	52	45	48	26
HI	-	1	-	-			HI	3	2	-	1		
IA	56	58	32	21	11	8	IA	1	-	-	1	3	12
ID	8	4	3	1			ID	1	6	2	1		
IL	48	81	32	-	1	14	IL	-	-	-	-	9	26
IN	52	47	29	6	24	10	IN‡	6	10	23	12	-	-
KS	-	2	1	-	3	10	KS	-	6	8	7	23	15
KY	8	2	18	6	1	12	KY	9	8	10	14	7	16
MA	-	-	-	-			MA	-	-	-	3		
MD	2	1	2	13			MD	5	9	6	8		
ME	3	5	10	8	6	5	ME	.	2	4	40	30	47
MI	3	3	1	2	21	13	MI	.	.	.	.	9	29
MN	2	8	11	5	-	6	MN	3	1	4	2	-	4
NC	9	18	27	16	8	10	NC	8	5	2	16	10	14
NE	-	1	3	18	1	7	NE	-	-	1	14	3	6
NJ	-	23	38	54	-	4	NJ	27	32	39	28	-	15
NV					22	22	NV					12	21
NY					4	5	NY					31	24
OH	1	3	21	8			OH	-	2	15	11		
OK	1	2	4	7	11	15	OK	-	-	-	-	11	19
OR	20	33	21	26	38	41	OR	10	28	20	15	21	17
PA	16	30	24	35	10	32	PA	3	1	1	2	-	24
RI	1	2	1	1	-	1	RI	-	-	5	3	-	7
SD	1	5	7	-			SD	-	-	-	-		
TN					4	8	TN					6	11
VA	-	6	19	2	7	23	VA	-	1	20	8	33	34
WA	2	7	20	11	22	28	WA	-	1	9	6	8	14
WI	62	73	81	39	68	30	WI	-	-	-	9	4	102
TOTAL US	365	540	573	446	363	395	TOTAL US	139	175	263	309	327	569

* The Trends study did not include DC, DE, NV, NY and TN in the state sample, so these cells are left blank for the Trends columns. This report does not include HI, ID, MA, MD, OH and SD in the state sample, so these cells are left blank for the SMR columns. Missing values for states included in the study are denoted with a dash.

† Trends data for 2011 are incomplete (see Methods section).

‡ Filings downloaded from Indiana's state portal did not differentiate between small and large group market. A representative from the Indiana Department of Insurance confirmed on March 28, 2013 that the Indiana Rate Watch portal has no way of separating small and large group data. Therefore all "group" filings were excluded from analysis (as seen in Table 6).

Percentage of Member-months Represented in Data

The carriers represented by the filings captured in the database for this study in 2011 and 2012 represent more than half of national member-months in both markets (Table 8). In the individual market the filings from carriers constitute 65.1 percent of national member-months, including states not sampled, in 2011 and 68.9 percent of member-months in 2012. In the small group market the filings from carriers is 50.5 percent of national member-months, including states not sampled, in 2011 and 63.9 percent in 2012.

For the purpose of this study, state-level estimates are only considered reportable if the percentage of member-months represented for that state in the sample year is at least 50 percent using the weighted value of each filing. In 2011, there are eight states in the individual market that have less than 50 percent of member-months represented in the sample and three with no data available (see footnote to Table 8), but in 2012 there are only three states that do not meet the reportability threshold and one with no data available. In the small group market there are five states that have less than 50 percent of member-months represented in the 2011 sample year and seven with no data available, and four states that have less than 50 percent of member-months represented in the 2012 sample year and two with no data available. Additionally, state estimates based on a single filing are not reportable, regardless of the percentage of member months represented; the individual market in Arkansas in 2012 is the only case, in which over 50 percent of member-months are represented but the state-level estimate is not reportable.

For the individual market, California had 100 percent of its member-months represented for both 2011 and 2012. Four other states, Connecticut, Nevada, Oregon and Washington, had more than 90 percent of its member months represented in both years in the individual market. In the small group market, California and Washington had 100 percent of their member-months represented for both 2011 and 2012, and three other states including Florida, Kentucky, and Michigan all had greater than 90 percent of member months represented in both years.

Table 8: Percentage of Member-Months Included in the Sample by State for Individual and Small Group Markets, Trends Study (2008-2011) and SMR Study (2011-2012)

State*	Individual & Conversion Trends 2008	Individual & Conversion Trends 2009	Individual & Conversion Trends 2010	Individual & Conversion Trends† 2011	Individual & Conversion SMR 2011	Individual & Conversion SMR 2012	State*	Small Group Trends 2008	Small Group Trends 2009	Small Group Trends 2010	Small Group Trends 2011†	Small Group SMR 2011	Small Group SMR 2012
AL	-	**85.7%	**85.7%	**85.9%	**87.9%	**87.9%	AL	**95.7%	**95.7%	**96.3%	**99.3%	**91.6%	2.2%
AR	1.3%	11.8%	10.9%	**81.0%	**83.7%	77.2%	AR	-	-	-	-	-	-
CA	-	7.6%	**91.3%	**100.0%	**100.0%	**100.0%	CA	-	10.1%	10.1%	**100.0%	**100.0%	**100.0%
CO	16.9%	46.1%	**57.8%	**54.8%	**77.5%	**86.6%	CO	41.8%	**94.5%	**88.8%	**94.0%	**81.2%	**89.4%
CT	-	**71.7%	35.6%	**74.8%	**96.1%	**94.4%	CT	8.5%	-	**64.3%	39.0%	**63.7%	**81.5%
DC					7.5%	**69.0%	DC					4.1%	**65.4%
DE					44.8%	-	DE					-	7.5%
FL	**67.2%	**67.7%	**78.0%	**64.6%	**75.4%	**66.8%	FL	**65.3%	**70.3%	**72.0%	**55.3%	**99.5%	**97.9%
HI	-	46.8%	-	-			HI	82.3%	14.8%	-	67.5%		
IA	**91.9%	**89.9%	**84.8%	**87.1%	**83.7%	**87.6%	IA	0.1%	-	-	0.3%	12.2%	23.3%
ID	37.1%	**71.5%	**72.3%	33.9%			ID	42.6%	87.7%	43.0%	42.6%		
IL	**72.4%	**72.5%	**72.1%	-	1.5%	**85.7%	IL					**60.8%	**73.1%
IN	**92.9%	**86.4%	**73.8%	8.1%	**67.4%	**71.4%	IN	0.8%	**58.5%	**62.4%	**74.7%	-	-
KS	-	19.1%	0.0%		7.1%	**85.2%	KS	-	1.5%	1.4%	8.8%	**77.9%	**67.4%
KY	**94.5%	**94.5%	**94.5%	**95.1%	14.3%	**91.4%	KY	**90.3%	**95.5%	**90.7%	**95.4%	**99.7%	**100.0%
MA							MA				26.5%		
MD	1.9%	3.7%	27.6%	**72.2%			MD	6.0%	**61.5%	**77.7%	**68.5%		
ME	49.9%	**50.2%	**98.4%	**98.6%	**92.7%	**58.4%	ME	-	0.0%	7.5%	**71.4%	**91.1%	**89.6%
MI	1.8%	1.8%	0.0%	1.0%	**65.7%	12.8%	MI					**93.4%	**100.0%
MN	9.6%	**83.3%	**83.4%	**83.3%	-	**87.7%	MN	7.1%	0.4%	**84.4%	**54.8%	-	**61.2%
NC	9.7%	12.1%	**84.6%	**89.7%	**87.4%	**87.4%	NC	**63.4%	**63.9%	**63.3%	**69.5%	**74.5%	**74.5%
NE	-	62.7%	**62.8%	**69.5%	1.1%	**87.0%	NE	-	-	42.0%	37.3%	22.1%	28.1%
NJ	-	**80.9%	**81.8%	**81.8%	-	**71.4%	NJ	**86.2%	**84.0%	**86.2%	**79.5%	-	**64.0%
NV					**96.6%	**96.6%	NV					**61.5%	**73.7%
NY					25.2%	**72.0%	NY					**84.7%	**83.0%
OH	1.8%	1.8%	41.8%	39.2%			OH	-	6.5%	**66.4%	**68.6%		
OK	4.2%	**62.8%	**62.8%	**62.8%	**71.3%	**84.5%	OK					37.2%	**86.4%
OR	**83.0%	**99.2%	**96.0%	**89.7%	**92.5%	**90.1%	OR	**65.0%	**100.0%	**99.9%	**99.5%	**98.9%	**77.7%
PA	39.5%	47.7%	**62.3%	**54.7%	**59.2%	**68.8%	PA	12.9%	1.1%	1.1%	6.8%	-	**74.2%
RI	0.5%	47.8%	47.3%	47.3%	-	48.4%	RI	-	-	**70.7%	**71.2%	-	**87.6%
SD	5.1%	**86.3%	**87.6%				SD						
TN					12.7%	**55.9%	TN					**71.9%	**72.5%
VA	-	**73.2%	**77.0%	0.5%	**81.8%	**84.6%	VA	-	0.0%	**54.9%	**57.6%	**73.6%	**71.4%
WA	43.2%	9.7%	**100.0%	**87.2%	**91.7%	**91.7%	WA	-	13.0%	**71.0%	24.1%	**100.0%	**100.0%
WI	**80.8%	**79.3%	**77.4%	**50.3%	**66.5%	**55.5%	WI	-	-	-	0.0%	4.6%	**96.1%
Mean US	51.1%	70.6%	70.3%	63.9%	65.1%	68.9%	Mean US	31.2%	46.1%	47.8%	55.8%	50.5%	63.9%

† Trends data for 2011 are incomplete (see Methods section).
Note: State estimates highlighted in blue** are reportable. State estimates containing only one filing, no matter its enrollment, are not considered reportable.
* The Trends study did not include DC, DE, NV, NY and TN in the state sample, so these cells are left blank for the Trends columns. This report does not include HI, ID, MA, MD, OH and SD in the state sample, so these cells are left blank for the SMR columns. Missing values for states included in the study are denoted with a dash.

Tables 9 and 10 present the percent of national member-months represented in the study by state regulatory review authority for the individual and small group markets. As noted earlier, states' regulatory approval authority is classified in three ways: "prior approval," "file and use," or "other." In the Trends study, states were classified as "prior approval," "file and use," or "HMO prior approval."[31] Many states have recently become more transparent and have provided more detail about their regulatory review authority. This new information was taken into account when classifying states' regulatory authority for the current study (as seen in Table 1). The "other" category in this study includes states that have prior approval authority only for HMO plans (such as Alabama), but also includes states with other types of authority, including Virginia, which is has prior approval authority except for HMOs, which may file and use rate changes.

As with the Trends study, "prior approval" states accounted for the greatest share of national enrollment from our filings in both 2011 and 2012. In 2011, filings in our database from "prior approval" states constituted 42.5 percent of the national member-months in the individual market and 33.2 percent in the small group market, whereas filings from "file and use" states accounted for 16.2 percent of national enrollment in the individual market and 13.2 percent of national enrollment in the small group market. In 2012, filings in our database in "prior approval" states constituted 45.2 percent of national member-months in the individual market and 35.4 percent in the small group market, whereas filings from "file and use" states accounted for 16.0 percent of national enrollment in the individual market and 13.5 percent in the small group market.

Table 9: Percent of National Member-Months Represented in the Sample, by Rate Regulatory Review for the Individual/Conversion Market

State Regulatory Status	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Total	51.1%	70.6%	70.3%	63.9%	65.1%	68.9%
File and Use	7.6%	20.1%	20.1%	15.6%	16.2%	16.0%
Prior Approval	42.4%	49.0%	49.0%	47.1%	42.5%	45.2%
HMO Prior Approval	1.2%	1.5%	1.2%	1.2%	NA	NA
Other	N/A	N/A	N/A	N/A	6.4%	7.6%

† Trends data for 2011 are incomplete (see Methods section).

N/A = Not available

[31] See discussion around Table 1, and footnote *infra*, for more detail.

Table 10: Percent of National Member-Months Represented in the Sample, by Rate Regulatory Review for the Small Group Market

State Regulatory Status	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Total	31.2%	46.1%	47.8%	55.8%	50.5%	63.9%
File and Use	2.4%	9.4%	10.0%	12.1%	13.2%	13.5%
Prior Approval	27.4%	29.4%	29.9%	34.8%	33.2%	35.4%
HMO Prior Approval	4.4%	7.3%	7.9%	8.9%	N/A	N/A
Other	N/A	N/A	N/A	N/A	4.0%	15.0%

† Trends data for 2011 are incomplete (see Methods section).

N/A = Not available

Availability of Enrollment Data in Filings

Enrollment information was captured in filings in three ways: the reported number of covered lives, the number of member-months covered by the plan, and the number of group contracts. If a filing contained any of these three pieces of information, we considered it to have enrollment data present; adjustments made during the weighting process detailed in this report's Methods section facilitated comparison of different measures of enrollment. Table 11 presents the number and percentage of filings with enrollment data.

Among all filings in the database, the percentage of filings that included enrollment data increased over the two years included in this study (Table 11). In the individual market, this percentage increased from 76.6 percent in 2011 to 84.6 percent in 2012. In the small group market, corresponding figures increased from 78.3 percent to 88.0 percent.

Table 11: Number and Percentage of Filings with Enrollment Data, by Market and Year

	Market	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	Trends Total 2008-2011†	SMR 2011	SMR 2012	SMR Total 2011-2012
Number of Filings with Enrollment Data	Individual	183	348	408	357	1296	278	334	612
	Small Group	116	150	227	287	780	256	501	757
Percentage of Filings with Enrollment Data	Individual	50.1%	64.4%	71.2%	80.0%	67.4%	76.6%	84.6%	80.7%
	Small Group	83.5%	85.7%	86.3%	92.9%	88.0%	78.3%	88.0%	84.5%

† Trends data for 2011 are incomplete (see Methods section).

Filings submitted through SERFF have several standardized options to indicate their status – in prior approval states, the most common of these are "approved" and "disapproved," while in file and use states, most are labeled "filed." In some cases, however, data were ambiguous: some filings from prior approval states are labeled "filed," and a few filings have unusual labels including "acknowledged," "closed," or "received." We believe that, for this former group labeled "filed", the state regulator may not have issued a final determination, allowing the carrier to implement the rate increase under "deemer" rules.[32] For the purposes of our analysis, acknowledged and closed filings are considered "filed"; in addition to approved, disapproved, and filed, we also categorized filings as "withdrawn" (by the carrier without being enacted) or "pending" (still under state review at the time of data collection). Some filings had no information about filing status. In both the individual and small group markets, file and use and "other" states were dominated by filings with the status of "filed", which tells us little about state review. As a result, in assessing the quality of data on filing disposition status, we feel the most meaningful analysis is limited to prior approval states. In this section, we consider the prevalence of filings with a "finalized" disposition – those labeled approved, disapproved, or withdrawn – as compared to those with "incomplete" dispositions – labeled filed, pending, or missing a value for approval status. Later in the Findings section of this report, our analysis of Approval Rates of State Regulators compares the prevalence of filings labeled approved or filed to those with another status (see Tables 24-30).

Table 12 presents the number and percentage of filings that had finalized approval status (approved, disapproved or withdrawn) among all filings from states with prior approval authority. In the individual group market the percentage of filings with a finalized approval status decreased slightly from 2011 to 2012 (86.7 percent to 82.3 percent, respectively). In the small group market, the percentage of filings with finalized approval status increased slightly across the two-year study period, at 81.8 percent in 2011 and 85.7 percent in 2012. All file and use states are excluded from this table.

[32] Some prior approval states have a "deemer" clause. If the state has not acted on the carrier's rate request, that request goes into effect 30, 60, or 90 days after the insurer files its request, depending upon the state law. In the rate filings, the designated status is occasionally "closed" or "filed", but never "deemed". Some of the rate filings with no disposition may have been settled under "deemer" rules.

Table 12: Number and Percentage of Filings with Finalized Approval Status‡ in States with Regulator Prior Approval, by Market and Year

	Market	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	Trends Total 2008-2011†	SMR 2011	SMR 2012	Total 2011-2012
Number of Filings with Data on Approval Status	Individual	213	349	365	311	1238	215	232	447
	Small Group	102	130	181	161	574	171	234	405
Percentage of Filings with Data on Approval Status	Individual	86.6%	93.1%	87.7%	86.9%	88.7%	86.7%	82.3%	84.3%
	Small Group	78.5%	82.3%	84.6%	71.2%	78.8%	81.8%	85.7%	84.0%

† Trends data for 2011 are incomplete (see Methods section).
‡ As described above, "finalized approval status" refers to filings which are considered approved, disapproved, or withdrawn by the carrier.

Table 13 presents the number and percentage of filings that had grandfathered status. Provisions in the ACA allowed for insurance plans that already existed on March 23, 2010 to retain a "grandfathered" status. This status means that these health plans do not have to meet all the requirements such as providing certain recommended preventive services at no additional charge to the consumer, or offering protections when a consumer appeals claims and coverage denials. Other requirements of the ACA still apply to all plans regardless of grandfathered status. Examples of these requirements include the provision that prohibits plans from applying a lifetime dollar limit to key health benefits and the requirement that health care coverage must be extended to dependent adult children until the age of 26. [33]

In the individual group market the percentage of filings with information on whether the plan had grandfathered status decreased slightly from 2011 to 2012 (60.1 percent to 58.2 percent, respectively). In the small group market, the percentage of filings with information on grandfathered status increased from 27.2 percent in 2011 to 50.6 percent in 2012. As nearly half of the filings in the individual market and more than half of the filings in the small group market are missing any information on grandfathered status, additional analyses to compare grandfathered versus non-grandfathered plan were not conducted.

[33] Department of Health and Human Services. "Grandfathered Health Plans" 2012 August. Available at http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html. Accessed 10 May 2013.

Table 13: Number and Percentage of Filings with Grandfathered Status, by Market and Year

	Market	SMR 2011	SMR 2012	Total 2011-2012
Number of Filings with Data on Grandfathered Status	Individual	218	230	448
	Small Group	89	288	377
Percentage of Filings with Data on Grandfathered Status	Individual	60.1%	58.2%	59.1%
	Small Group	27.2%	50.6%	42.1%

Trends in Premium Rate Increases

In this section, we review findings related to trends in premium rate increases. As noted in the Methods section of this report, the average rate of premium increase refers to rates that have been approved by state regulators, or in cases of filings where an approved rate is not available (and there is no clear indication that the filing was disapproved by the state or withdrawn by the carrier), the rates initially proposed by carriers in their filings.

National Trends: Individual and Small Group Markets

Over the study period, the rate of growth in premiums on a national scale was about constant in the individual market, but declined significantly in the small group market. The average premium increase in the individual market was 7.0 percent in 2011 and 7.1 percent in 2012, down from 11.7 percent in 2010. In contrast, the small group premium growth rate declined significantly from 2011 to 2012. In 2010, the year before the ACA rate review, the figure was 8.8 percent. The average premium increase in this market was 6.1 percent in 2011 and 4.8 percent in 2012 (Table 14).

Table 14: Average Rate of Premium Increase, by Year and Market

Market	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Individual/Conversion	9.9%*	10.8%*	11.7%*	8.6%	7.0%	7.1%
Small Group	11.2%*	11.2%*	8.8%*	6.7%	6.1%	4.8%*

† Trends data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from 2011 at $p < .05$. (Trends values are compared to Trends 2011 and SMR values are compared to SMR 2011)

State-level premium increase estimates are reported in Table 15 for all states with reportable data included in this study and for six additional states included in the Trends report. With smaller sample sizes in individual states, one would expect that it would be more difficult to detect significant changes from year to year at the state level than at the national level. This expectation is reflected in our individual

market state level results.[34] Only four of 16 states with reportable data and no missing information in both 2011 and 2012 had statistically significant declines in rates of premium increase: Oklahoma, Oregon, Virginia, and Washington (Table 15). Four states with reportable data and no missing information – Colorado, Connecticut, Nevada, and Pennsylvania – had a statistically significant increase in premium rate growth. For the remaining eight states with reportable data, the change in premium rates between 2011 and 2012 was not statistically significant.

However, our individual market results also show that few states experienced consistently high premium rate increases. Among the 16 states with reportable data in 2011 and 2012, only Virginia had premium increases at double-digit rates in both years. Premiums increased at single-digit rates or below in 11 of 16 states in both years. Several states had particularly low premium increase rates. Among states with reportable data, North Carolina had premium rate increases of less than 5 percent in both 2011 and 2012.

[34] Two states – Arkansas and Indiana – were included in the individual market part of the study but not in the small group market part due to missing or incomplete data. Therefore, the total state sample size is 29 in the individual market but only 27 in the small group market. For state level analysis, the sample size is further reduced for two reasons. First, some states had missing data for a particular year. Second, we classified state-level data as not reportable (N/R) when the proportion of state member months in our data for that year is less than 50%. The mean US figure is a weighted average which includes data from all states in the sample, even those with non-reportable state-level estimates.

Table 15: Premium Increases in Individual and Small Group Markets, by Year, and by State, Trends Study (2008-2011) and SMR Study (2011-2012)

	Individual/ Conversion Trends 2008	Individual/ Conversion Trends 2009	Individual/ Conversion Trends 2010	Individual/ Conversion Trends 2011†	Individual/ Conversion SMR 2011	Individual/ Conversion SMR 2012		Small Group Trends 2008	Small Group Trends 2009	Small Group Trends 2010	Small Group Trends 2011†	Small Group SMR 2011	Small Group SMR 2012
AL	-	17.5%*	10.8%*	9.0%	7.7%	7.1%	**AL**	9.0%*	8.9%	8.7%*	2.6%	3.9%	N/R
AR	N/R	N/R	N/R	7.2%	8.6%	N/R	**AR**	-	-	-	-		
CA	-	N/R	15.7%*	7.3%	8.6%	8.6%	**CA**	-	N/R	N/R	8.0%	7.0%	5.3%*
CO	N/R	N/R	16.4%*	10.9%	0.7%	10.1%*	**CO**	N/R	4.9%*	8.0%*	3.8%	(1.3)%	6.4%*
CT	-	20.1%*	N/R	8.2%	1.6%	6.1%*	**CT**	N/R	-	16.1%*	N/R	3.2%	7.6%*
DC					N/R	3.0%	**DC**					N/R	1.3%
DE					N/R	N/R	**DE**					N/R	N/R
FL	8.2%*	8.9%	13.6%*	9.6%	7.2%	7.9%	**FL**	17.7%*	13.3%*	11.6%*	5.0%	8.6%	7.9%*
HI	-	N/R	-	-			**HI**	8.7%	N/R	-	N/R		
IA	2.8%*	7.3%*	18.4%*	10.1%	6.5%	7.1%	**IA**	N/R	-	-	N/R	N/R	N/R
ID	N/R	6.9%	3.0%	N/R			**ID**	N/R	2.8%	N/R	N/R		
IL	14.4%	10.4%	9.6%	-	N/R	7.3%	**IL**	-	-	-	-	(0.4)%	3.3%*
IN	13.5%	15.1%	8.2%	N/R	5.3%	3.3%	**IN**	N/R	20.1%*	(1.2)%	1.7%		
KS	-	N/R	N/R	-	N/R	8.4%	**KS**	-	N/R	N/R	N/R	2.6%	1.2%
KY	8.1%*	7.1%*	5.5%*	2.8%	N/R	0.5%	**KY**	(0.4)%*	3.7%*	5.4%	6.1%	(1.0)%	3.4%*
MA	-	-	-	-			**MA**	-	-	-	N/R		
MD	N/R	N/R	N/R	N/R			**MD**	1.6%	12.4%	0.7%	-		
ME	N/R	11.0%*	11.1%*	5.2%	5.2%	3.5%	**ME**	-	N/R	N/R	16.5%	9.9%	7.1%*
MI	N/R	N/R	N/R	N/R	11.0%	N/R	**MI**	-	-	-	-	8.9%	5.9%*
MN	N/R	10.7%*	7.4%	7.3%	-	2.6%	**MN**	N/R	N/R	2.6%	(0.3)%	N/R	(0.6)%
NC	N/R	N/R	11.6%*	5.2%	3.7%	3.7%	**NC**	33.7%	9.8%	15.7%	-	10.1%	6.4%*
NE	-	N/R	21.8%*	10.1%	N/R	11.5%	**NE**	-	-	N/R	N/R	N/R	N/R
NJ	-	4.1%*	10.8%*	12.7%	-	3.3%	**NJ**	14.3%	18.8%*	20.6%*	14.5%	N/R	4.7%
NV					(12.6)%	6.8%*	**NV**					0.2%	2.5%*
NY					N/R	8.6%	**NY**					15.5%	8.8%*
OH	N/R	N/R	N/R	N/R			**OH**	-	N/R	5.6%*	(0.4)%		
OK	N/R	8.2%	13.0%*	9.9%	10.0%	5.8%*	**OK**	-	-	-	-	N/R	1.0%
OR	12.2%*	15.2%*	14.9%*	9.0%	9.0%	6.2%*	**OR**	4.7%	6.1%	12.7%*	6.0%	6.1%	4.2%*
PA	N/R	N/R	9.0%*	6.9%	4.5%	7.3%*	**PA**	N/R	N/R	N/R	N/R	-	1.4%
RI	N/R	N/R	N/R	-	-	N/R	**RI**	-	-	1.3%*	11.6%	-	4.0%
SD	N/R	14.1%	16.2%	-			**SD**	-	-	-	-		
TN					N/R	8.0%	**TN**					(2.4)%	(2.8)%
VA	-	13.8%	8.9%	-	14.1%	10.8%*	**VA**	-	N/R	0.0%	0.3%	0.3%	2.7%*
WA	N/R	N/R	12.8%*	11.2%	12.3%	7.2%*	**WA**	-	N/R	4.2%	N/R	11.3%	3.0%*
WI	14.7%*	11.1%	14.0%*	11.8%	9.2%	10.5%	**WI**	-	-	-	N/R	N/R	3.7%*
Mean US	9.9%*	10.8%*	11.7%*	8.6%	7.0%	7.1%	**Mean US**	11.2%*	11.2%*	8.8%*	6.7%	6.1%	4.8%*

† - Trends data from 2011 is incomplete (see Methods section).
Note: Some estimates are not reportable (N/R) because the proportion of state member months is less than 50%. The mean US figure is a weighted average.
The Trends study did not include DC, DE, NV, NY and TN in the state sample, so these cells are left blank for the Trends columns. This report does not include HI, ID, MA, MD, OH and SD in the state sample, so these cells are left blank for the SMR columns. Missing values for states included in the study are denoted with a dash.
* Estimate is significantly different from 2011 at $p < .05$. (Trends values are compared to Trends 2011 and SMR values are compared to SMR 2011)

We found that state level results in the small group market were similarly variable. In the small group market, eight of 16 states with reportable data and no missing values in both 2011 and 2012 had statistically significant declines in premium growth. These states were California, Florida, Maine, Michigan, North Carolina, New York, Oregon, and Washington. Six states had statistically significant increases in in premium rate growth. These states were Colorado, Connecticut, Illinois, Kentucky, Nevada, and Virginia. For the remaining two states –Kansas and Tennessee – the difference between the 2011 and 2012 premium growth rates was not significant (Table 15).

However, our results also show that no states experienced consistently high premium rate increases in the small group market. None of the included states had premiums increase at double-digit rates in both 2011 and 2012. Only three states – North Carolina, New York, and Washington – had double digit premium increase rates in one year, all in 2011. Six of the 16 states with reportable data in both study years had premium increases of less than 5 percent in both 2011 and 2012.

Trends for "Prior Approval" States and Other States

Our analysis shows a clear relationship between premium increase in the individual market and a state's regulatory authority. Premium increases were significantly higher in "file and use" states than in "prior approval" states for both 2011 and 2012 (Table 16). States classified as having an "other" regulatory review status also experienced significantly higher premium increases than "prior approval" states in both years. However, this result should be interpreted with caution, as only five states were classified as "other" in the individual market. As described earlier in this report, we classified this set of states as "other" because their regulatory authority did not clearly fit into one category. For example, in the individual market Alabama has "file and use" authority for all products except HMOs, which need prior approval from the state Department of Insurance.

"Prior approval" states had the lowest premium rate increases in the individual market in both 2011 and 2012, a continuation of trends from 2008 to 2010. Although the magnitude of premium increase was lowest in "prior approval" states, we also found that this set of states had a 1.2 percentage point increase in premium growth rate from 2011 to 2012. In the same period, the premium growth rate declined by 0.3 percentage points in "file and use" states and by 3.5 percentage points in "other" states (Table 16). While they do not establish cause and effect, these findings show that rate increases dropped in the period of time immediately following implementation of more stringent rate review.

Table 16: Average Premium Increase by Regulatory Review, Individual/Conversion

State Regulatory Status	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
File and Use	12.9%*	12.2%*	13.6%*	8.1%	8.8%*	8.5%*
Prior Approval	9.3%	10.5%	10.8%	8.9%	5.8%	6.6%
HMO Prior Approval	N/R	N/R	N/R	9.9%	N/A	N/A
Other	N/A	N/A	N/A	N/A	11.1%*	7.6%*

Note: Entries with fewer than five filings are not reported (N/R).
† Trends data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from prior approval at $p < .05$.
Prior approval – Rates are reviewed for HMO, PPO, and other plans and do not go into effect immediately.
HMO Prior Approval – Rates are reviewed for HMO plans only. PPO and other plans have file and use requirements only.
File and Use – Carriers file rates and the rates go into effect immediately. In some cases there may be retrospective review.

Similar to 2009 and 2010, in 2011 and 2012, the premium increase rate in both "file and use" and "other" states was significantly lower than in "prior approval" states (Table 17). "Prior approval" and "other" states both saw declines in premium increase rates from 2011 to 2012, but "file and use" states experienced an increase (Table 17). One contributing factor could be our limited sample size of "file and use" and "other" states. In the small group market, we classified only five of the 27 sampled states as "file and use" and four as "other."

Table 17: Average Premium Increase by Regulatory Review, Small Group

State Regulatory Status	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
File and Use	N/R	3.4%*	4.1%*	6.9%*	1.6%*	3.9%*
Prior Approval	11.1%	12.5%	11.5%	8.4%	8.1%	5.5%
HMO Prior Approval	13.6%	14.1%	6.4%*	1.8%*	N/A	N/A
Other	N/A	N/A	N/A	N/A	4.4%*	4.2%*

Note: Entries with fewer than five filings are not reported (N/R).
† Data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from prior approval at $p < .05$.
Prior approval – Rates are reviewed for HMO, PPO, and other plans and do not go into effect immediately.
HMO Prior Approval – Rates are reviewed for HMO plans only. PPO and other plans have file and use requirements only.
File and Use – Carriers file rates and the rates go into effect immediately. In some cases there may be retrospective review.

The lower rates of increase in "file and use" states in 2011 and 2012 could be due to factors outside the scope of this study, and further inquiry would be needed to assess a cause.

Trends by Product Type

We determined that premium increases in the individual market varied by product type, but that this variation was inconsistent.[35] In 2011, HMO products experienced significantly higher premium increases than PPO products. Indemnity products had similar rate increases compared to PPO products in 2011, but

[35] We believe that many plans that filed as indemnity plans are actually PPO plans with an indemnity license given that The Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey estimates indemnity market share in the employer-based market at 1 percent.

significantly lower rate increases in 2012 (Table 18). Cumulative increases in premiums from 2011 to 2012 were significantly higher for HMO products when compared to PPO products, with HMO products having cumulative increases approximately 2.3 percent higher than PPO products. Cumulative increases in premiums from 2011 to 2012 were approximately 4.3 percent lower for Indemnity products than for PPO products.

Our individual market results also show that none of the three product types had consistently high premium rate increases. In the individual market, all three product types had less than double-digit rate increases in both 2011 and 2012 (Table 18). Our results do not show a consistent trend from 2011 to 2012 by product type. HMO and Indemnity products had a decline in premium increase rate from 2011 to 2012, but PPO products had a slight increase. As noted earlier in this report, indemnity products make up a small share of the insurance market; the number of filings associated with each product type is included as Appendix B of this report.

Table 18: Rates of Premium Increase by Product Type, Individual/Conversion

Characteristic	Starting index =100	2008 increase Trends	2009 increase Trends	2010 increase Trends	2011 increase Trends†	Cumulative Increase Trends†	2011 increase SMR	2012 increase SMR	Cumulative Increase SMR
HMO	100	6.9%*	9.1%*	9.8%*	7.1%	137.2*	8.9%*	7.0%	**116.6***
PPO/HDP	100	9.9%	12.3%	12.3%	7.7%	149.4*	6.6%	7.2%	**114.3**
Indemnity	100	11.2%*	9.9%*	11.1%*	10.9%*	150.4*	6.5%	3.7%*	**110.3***
All plans	**100**	**9.9%**	**10.8%**	**11.7%**	**8.6%**	**147.6**	**7.0%**	**7.1%**	**114.6**

† Trends data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from PPO/HDP at $p < .05$.

We identified a clearer relationship between product type and premium increase rate in the small group market. In both 2011 and 2012, Indemnity products had significantly higher premium increase rates than PPO products (Table 19). In 2012, HMO products had a significantly higher premium increase rate than PPO products. In 2011, the HMO product increase rate was lower than the PPO rate, but this difference was not significant. Cumulative increases in premiums from 2011 to 2012 were significantly higher for Indemnity products than for PPO products, but the difference was not statistically significant between PPO and HMO products (Table 19).

In the small group market, HMO products had premium increase rates of less than 6 percent in both 2011 and 2012. However, Indemnity plan types had higher increase rates in both years. All three product types had a decline in premium increase rate from 2011 to 2012, although this decline was small for HMO and Indemnity products (Table 19).

Table 19: Rates of Premium Increase by Product Type, Small Group

Characteristic	Starting index =100	2008 increase Trends	2009 increase Trends	2010 increase Trends	2011 increase Trends†	Cumulative Increase Trends†	2011 increase SMR	2012 increase SMR	Cumulative Increase SMR
HMO	100	7.2%*	10.8%	10.5%*	8.3%*	142.2	5.7%	5.6%*	111.6
PPO/HDP	100	14.4%	11.7%	8.0%	5.7%	145.8	6.1%	4.0%	110.4
Indemnity	100	12.7%	9.5%	9.6%	5.1%	142.2	10.4%*	9.8%*	121.2*
All plans	**100**	**11.2%**	**11.2%**	**8.8%**	**6.7%**	**143.6**	**6.1%**	**4.8%**	**111.2**

† Trends data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from PPO/HDP at p < .05.

Relationships of Carrier Size, Market Concentration, and Premium Increases

In both 2011 and 2012 in the individual market, there were no significant differences in average premium increases between large carriers (the three largest in the state's individual market, using NAIC data) and other carriers. Over the two study years, cumulative premium increases in large carriers were about 1.1 percentage points greater than for smaller carriers (Table 20), although this difference was not statistically significant.

Table 20: Rates of Premium Increase, by Year, by Carrier Size - Individual/Conversion

Carrier Size	Starting index =100	2008 increase Trends	2009 increase Trends	2010 increase Trends	2011 increase Trends†	Cumulative Increase Trends†	2011 increase SMR	2012 increase SMR	Cumulative Increase SMR
Top 3 Carrier	100	11.3%	10.0%	11.4%	8.6%	137.2	7.1%	7.2%	**114.8**
Other Carrier	100	7.5%*	12.6%*	13.2%*	8.9%	149.4*	6.5%	6.8%	**113.7**
All plans	**100**	**9.9%**	**10.8%**	**11.7%**	**8.6%**	**147.6**	**7.0%**	**7.1%**	**114.6**

† Trends data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from Top 3 Carrier at p < .05.

We found a similar result in the small group market, in which there were no significant differences in average premium increase between large and other carriers in either of the study years. Over the two study years, the cumulative increase for the top three carriers was about 1.0 percentage point less than the cumulative increase for other carriers (Table 21), although this difference was not statistically significant.

Table 21: Rates of Premium Increase, by Year, by Carrier Size – Small Group

Carrier Size	Starting index =100	2008 increase Trends	2009 increase Trends	2010 increase Trends	2011 increase Trends†	Cumulative Increase Trends†	2011 increase SMR	2012 increase SMR	Cumulative Increase SMR
Top 3 Carrier	100	9.2%	12.6%	8.9%	4.3%	142.2	5.8%	4.8%	**110.9**
Other Carrier	100	14.4%*	9.4%*	8.7%	10.5%*	145.8	6.7%	4.9%	**111.9**
All plans	**100**	**11.2%**	**11.2%**	**8.8%**	**6.7%**	**143.6**	**6.1%**	**4.8%**	**111.2**

† Trends data for 2011 are incomplete (see Methods section).
* Estimate is significantly different from Top 3 Carrier at p < .05.

In the individual market, states with medium market concentration – those in which the largest carrier accounts for 50-79 percent of the member-months in the market – had significantly higher premium increases in 2011 than states with high concentration, in which the largest carrier holds 80 percent or more of the market. This difference was not statistically significant in 2012. Over the two-year study period, premium increases for carriers in medium-concentration states increased about 6.3 percent more than in states with high concentration (Table 22). This difference was statistically significant.

Our comparison of medium and low market concentration states produced more equivocal results. States with low concentration had significantly lower premium increases than medium-concentration states in 2011. However, in 2012, low-concentration states had significantly higher premium increases than medium-concentration states. Over the two-year study period, premium increases for carriers in medium-concentration states increased about 2.1 percent more than in low-concentration states (Table 22). This difference was statistically significant.

Table 22: Rates of Premium Increase, by Year, by Market Concentration - Individual/ Conversion

Market Concentration	Starting index =100	2008 increase Trends	2009 increase Trends	2010 increase Trends	2011 increase Trends†	Cumulative Increase Trends†	2011 increase SMR	2012 increase SMR	Cumulative Increase SMR
Low	100	9.6%*	10.2%*	10.9%*	8.6%*	137.2*	6.3%*	8.1%*	114.9*
Medium	100	11.5%	11.5%	12.4%	9.6%	149.4*	10.3%	6.1%	117.0
High	100	8.2%*	10.6%	11.8%	6.5%*	150.4*	5.3%*	5.1%	110.7*
All plans	**100**	**9.9%**	**10.8%**	**11.7%**	**8.6%**	**147.6**	**7.0%**	**7.1%**	**114.6**

Note: Entries with fewer than five filings are not reported (N/R).

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from Medium Market Concentration at $p < .05$.

In the small group market, states with medium market concentrations had significantly lower premium increases in 2011 and 2012 than states with low or high-concentrations. Over the two-year study period, premium rates for carriers in low-concentration states increased about 9.0 percent more than in medium-concentration states. Premiums increased for carriers in high-concentration states about 7.9 percent more than in medium-concentration states. Both differences were statistically significant (Table 23).

Table 23 also shows the trend from 2011 to 2012 for low, medium and high-concentration states. High- and medium-concentration states saw premium growth rates increase in this period, but low-concentration states saw premium growth rate decline. Appendix A provides data for each state in the sample on the level of market concentration for the individual and small group markets including its concentration classification.

Table 23: Rates of Premium Increase, by Year, by Market Concentration – Small Group

Market Concentration	Starting index =100	2008 increase Trends	2009 increase Trends	2010 increase Trends	2011 increase Trends†	Cumulative Increase Trends†	2011 increase SMR	2012 increase SMR	Cumulative Increase SMR
Low	100	10.2%	11.1%	9.3%	7.1%*	142.2	7.9%*	5.3%*	113.6*
Medium	100	14.5%	11.8%	7.4%	4.7%	145.8	1.8%	2.7%	104.6
High	100	N/R	N/R	N/R	2.6%	142.2	3.9%*	N/R	112.5*
All plans	**100**	**11.2%**	**11.2%**	**8.8%**	**6.7%**	**143.6**	**6.1%**	**4.8%**	**111.2**

Note: Entries with fewer than five filings are not reported (N/R).

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from Medium Market Concentration at $p < .05$.

Approval Rates of State Regulators

Many filings in prior approval states record both the carrier's initial proposed rate increase and the increase ultimately enacted. In most cases proposed rate increases were approved without modification by the state's regulatory agency. For the purposes of these analyses, rate increases from filings submitted in states with "prior approval" or "other" regulatory authority (see Table 1) that were approved with or without modification are considered "approved." Those that were denied or withdrawn by the carrier are not. Filings from "file and use" states are excluded from these analyses (Tables 24 to 30). Although some filings from "file and use" states may be reviewed retrospectively, the state's decision to approve or disapprove the filing increase is not always consistently captured.

In the individual market, the approval rate increased significantly from 77.0 percent in 2011 to 84.1 percent in 2012, as shown in Table 24 below. We did not observe a higher percentage of disapprovals after implementation of the ACA rate review than in the pre- review period. Conversely, small group approval ratings decreased from 79.7 percent in 2011 to 75.9 percent in 2012, although this decrease was not statistically significant and both rates were similar to pre-review years.

Table 24: Percentage of Premium Increases Approved, by Year and Market

Carrier Size	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Individual/Conversion	76.9%	79.3%*	83.1%*	74.8%	77.0%	84.1%*
Small Group	84.4%*	64.0%	68.6%	69.7%	79.7%	75.9%

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from 2011 at $p < .05$.

Note: Percentage is calculated as the percentage of filings with an "approved" status among the filings for which the regulatory disposition was known. Filings from "file and use" states are not included in the analysis.

One caution that applies to both markets is that state procedures for archiving disapproved or withdrawn filings are inconsistent. In some states, files on proposed rate increases that are rejected by the regulator are kept open until a compromise rate increase can be arrived at; in others, the carrier appears to re-file at

a later date under a separate tracking number. Furthermore, it is unclear whether disapproved or withdrawn filings were made available on publicly-accessible web portals to the same extent as approved rate increases.

Relationship of Carrier Size, Product Type, and Market Concentration on Approval Rates

As shown in Table 25 below, in the individual market, we found that larger carriers had significantly higher approval rates than smaller carriers in 2011, with larger carriers obtaining approval for 78.8 percent of premium increases compared to only 69.2 percent approved for smaller carriers. However, larger carriers had lower approval rates (83.2 percent of premium increases approved) than smaller carriers in 2012 (87.2 percent of premium increases approved), although this difference is not significant.

Table 25: Percentage of Premium Increases Approved, by Year, by Carrier Size - Individual/Conversion

Carrier Size	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Top 3 Carrier	100.0%	92.1%	84.7%	87.2%	78.8%	83.2%
Other Carrier	39.8%*	54.0%*	76.1%*	37.7%*	69.2%*	87.2%

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from Top 3 Carrier at $p < .05$.

Note: Percentage is calculated as the percentage of filings with an "approved" status among the filings for which the regulatory disposition was known. Filings from "file and use" states are not included in the analysis.

In the small group market, shown below in Table 26, smaller carriers had significantly higher approval rates in 2011, with smaller carriers approving 92.3 percent of premium increases, compared to 74.4 percent approved for larger carriers. However, while larger carriers also had a lower approval rate in 2012 (74.2 percent vs. 79.2 percent for smaller carriers), the difference between the two was not statistically significant.

Table 26: Percentage of Premium Increases Approved, by Year, by Carrier Size - Small Group

Carrier Size	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Top 3 Carrier	94.5%	88.7%	74.3%	64.1%	74.4%	74.2%
Other Carrier	70.4%*	33.2%*	55.3%*	80.4%*	92.3%*	79.2%

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from Top 3 Carrier at $p < .05$.

Note: Percentage is calculated as the percentage of filings with an "approved" status among the filings for which the regulatory disposition was known. Filings from "file and use" states are not included in the analysis.

We also analyzed the observed differences in approval rates by product type. In the individual market, shown in Table 27, we found that Indemnity plans had significantly higher approval rates than PPO plans

in 2011. However, in 2012, both HMO and Indemnity plans differed significantly from PPO plans in approval rates. HMO plans were significantly lower, approving 72.2 percent, compared to 85.6 percent approved for PPO. Indemnity plans also had a significantly lower approval rate, 72.9 percent, compared to 85.6 percent approved for PPO.

Table 27: Percentage of Premium Increases Approved, by Year, by Product Type - Individual/Conversion

Product Type	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
HMO	25.6%*	53.8%*	62.4%*	39.2%*	78.1%	72.2%*
PPO/HDP	91.4%	80.8%	86.3%	80.1%	72.2%	85.6%
Indemnity	86.6%	87.3%*	90.1%	90.3%*	91.4%*	72.9%*

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from PPO/HDP at $p < .05$.

Note: Percentage is calculated as the percentage of filings with an "approved" status among the filings for which the regulatory disposition was known. Filings from "file and use" states are not included in the analysis.

In the small group market, shown in Table 28, there were few differences in approval ratings across product types. In 2011, there were no significant differences between the three types, although HMO plans had slightly lower approval rates (74.9 percent vs. 80.1 percent for PPO) as did Indemnity plans (73.5 percent vs. 80.1 percent for PPO). In 2012, only Indemnity plans were significantly different, approving increases at a rate of 91.0 percent compared to only 76.1 percent for PPO. There were no significant differences between HMO and PPO plans in the small group market.

Table 28: Percentage of Premium Increases Approved, by Year, by Product Type – Small Group

Product Type	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
HMO	87.1%	40.7%*	76.7%*	70.6%	74.9%	74.9%
PPO/HDP	82.8%	78.0%	65.4%	69.6%	80.1%	76.1%
Indemnity	79.3%	97.7%*	63.4%	56.9%	73.5%	91.0%*

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from PPO/HDP at $p < .05$.

Note: Percentage is calculated as the percentage of filings with an "approved" status among the filings for which the regulatory disposition was known. Filings from "file and use" states are not included in the analysis.

We additionally explored the association between market concentration (see Appendix A for the classification of each state's market concentration) and percentage of rate requests approved. In the individual market (Table 29), higher-market concentration states had the highest approval ratings in both 2011 and 2012, significantly higher than medium-concentration states both years. In 2011, low-

concentration states also had a significantly higher approval rate, approving 79.6 percent compared to 61.2 percent for medium-concentration states, and high-concentration states approving 89.4 percent of premium increases. In 2012, high-concentration states had significantly higher approval ratings than medium-concentration states, approving 99.0 percent of premium increases compared to only 81.1 percent for medium-concentration states. In the small group market (Table 30), there were no significant differences between states of different market concentrations in either of the study years.

Table 29: Percentage of Premium Increases Approved, by Market Concentration, by Year - Individual/Conversion

Market Concentration	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Low	77.7%*	80.3%*	75.9%*	85.2%*	79.6%*	81.7%
Medium	62.1%	72.1%	88.1%	45.5%	61.2%	81.1%
High	100.0%*	99.6%*	100.0%*	100.0%*	89.4%*	99.0%*

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from medium concentration at p < .05.

Note: Percentage is calculated as the percentage of filings with an “approved” status among the filings for which the regulatory disposition was known. Filings from “file and use” states are not included in the analysis.

Table 30: Percentage of Premium Increases Approved, by Market Concentration, by Year – Small Group

Market Concentration	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Low	90.5%	71.7%*	76.7%*	73.9%*	80.2%	79.7%
Medium	67.5%	42.8%	43.7%	52.2%	83.6%	75.8%
High	N/R	N/R	N/R	N/R	52.9%	N/R

Note: Entries with fewer than five filings are not reported (N/R).

† Data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from medium concentration at p < .05.

Note: Percentage is calculated as the percentage of filings with an “approved” status among the filings for which the regulatory disposition was known. Filings from “file and use” states are not included in the analysis.

Modification of Proposed Premium Increases by State Regulators

We also analyzed the proportion of filings approved without modification as compared with those changed as a result of interactions with state regulatory agencies (Table 31). This analysis is based on a subset of 1,253 filings from all states (regardless of regulatory review authority) that list both a proposed and an approved rate, which differs slightly from the criteria used in other sections of this report. Filings that were disapproved by regulators or withdrawn list a proposed rate, but do not list an implemented

rate.[36] In some cases filings obtained from state summary documents did not contain a proposed rate, but by publicly releasing them the state implies their approval. Conversely, some filings from file and use states did not include enough information to give us confidence that the rate was not changed through retrospective review. As a result, discussion of modified rates is limited to the subset of filings for which review is known.

For most of these filings, the regulator approved the initial proposed rate. As shown below in Table 31, we found 240 filings from 2011 and 2012 that had premium increase modifications, with 142 of them in the individual market and 98 in the small group market. Filings with rate modifications accounted for 24.4 percent of all reviewed filings in the individual market and 14.6 percent of all reviewed filings in the small group market. In both study years, the percentage of filings with rate modifications was higher in the individual market than the small group market.

Table 31: Number and Percentage of Filings with Premium Increase Modifications, by Year and Market

	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	Trends Total†	SMR 2011	SMR 2012	SMR Total
Number of Filings with Premium Increase Modifications								
Individual	32	61	85	63	241	55	87	142
Small Group	1	0	13	14	28	32	66	98
All	33	61	98	77	269	87	153	240
Percentage of Filings with Premium Increase Modifications, as a % of all reviews								
Individual	13.7%	14.2%	20.9%	20.6%	17.5%	20.5%	27.8%	24.4%
Small Group	2.0%	0.0%	10.0%	10.4%	7.1%	14.9%	14.5%	14.6%

† - Trends data from 2011 are incomplete (see Methods section).

Note: Percentage is calculated based on the subset of filings with complete rate information – both proposed and approved premium increases.

In the individual market, rate modification did not have a significant impact on rate increases in 2011, but it did have a significant impact in 2012, reducing the magnitude of rate increases by 1 percentage point (Table 32). Similarly in the small group market (Table 33 below), rate modification had a significant effect in 2012, reducing the magnitude of rate increases by 1.6 percentage points.

[36] However, carriers may in some cases file a new application (under a separate tracking number) during the next or even the same quarter, or may aggregate plans differently in subsequent filings. We cannot therefore conclude that policyholders covered by disapproved filings were not subject to a rate increase.

Table 32: Rates of Premium Increases, Proposed and Approved, by Year - Individual/Conversion

Rate Modification	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Proposed Rate Increase	11.6%	11.3%	13.1%	10.7%	6.3%	7.9%
Approved Rate Increase	11.3%	10.3%*	11.2%*	8.8%*	5.6%	6.9%*

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from Proposed Rate Increase at $p < .05$.

Note: Calculated based on the subset of filings with complete rate information – both proposed and approved premium increases

Table 33: Rates of Premium Increases, Proposed and Approved, by Year – Small Group

Rate Modification	Trends 2008	Trends 2009	Trends 2010	Trends 2011†	SMR 2011	SMR 2012
Proposed Rate Increase	12.8%	12.5%	7.3%	5.0%	5.6%	6.7%
Approved Rate Increase	12.5%	12.5%	6.7%	4.5%	5.2%	5.1%*

† Trends data for 2011 are incomplete (see Methods section).

* Estimate is significantly different from Proposed Rate Increase at $p < .05$.

Note: Calculated based on the subset of filings with complete rate information – both proposed and approved premium increases

The effects of premium increase modification on state-level estimates (for filings with complete rate information) for the individual and small group markets are shown below. In the individual market (Table 34), 17 states in 2011 and 23 states in 2012 had complete rate information and reportable levels of enrollment. Of these states, 11 out of 17 states in 2011 and had rate modifications and 11 out of 23 states in 2012 had rate modifications. In the small group market (Table 35), 15 states in 2011 and 21 states in 2012 met criteria for reporting data. Of these, four out of 15 states in 2011 and eight out of 21 states in 2012 had rate modifications.

Table 34: Rates of Premium Increases, Proposed and Approved, by State for the Individual Market, 2008-2012

	Individual/ Conversion Trends 2008 Proposed	Individual/ Conversion Trends 2008 Approved	Individual/ Conversion Trends 2009 Proposed	Individual/ Conversion Trends 2009 Approved	Individual/ Conversion Trends 2010 Proposed	Individual/ Conversion Trends 2010 Approved	Individual/ Conversion Trends 2011† Proposed	Individual/ Conversion Trends 2011† Approved	Individual/ Conversion SMR 2011 Proposed	Individual/ Conversion SMR 2011 Approved	Individual/ Conversion SMR 2012 Proposed	Individual/ Conversion SMR 2012 Approved
AL	-	-	-	-	9.2%	9.2%	-	-	7.7%	7.7%	7.1%	7.1%
AR	N/R	N/R	N/R	N/R	N/R	N/R	10.0%	7.2%	11.2%	8.5%	-	-
CA	-	-	-	-	-	-	-	-	8.3%	8.3%	9.3%	8.6%
CO	N/R	N/R	N/R	N/R	16.4%	16.4%	10.9%	10.9%	2.0%	1.2%	10.6%	10.1%
CT	-	-	20.1%	20.1%	N/R	N/R	11.5%	8.2%	1.7%	1.6%	11.0%	6.1%
DC									N/R	N/R	(4.7)%	(4.7)%
FL	11.4%	11.4%	8.9%	8.8%	17.0%	13.6%	10.1%	9.9%	-	-	-	-
HI	-	-	-	-	-	-	-	-				
IA	2.9%	2.8%	7.6%	7.3%	19.6%	18.4%	11.6%	10.2%	7.3%	6.5%	7.1%	7.1%
ID	-	-	-	-	-	-	-	-				
IL	14.4%	14.4%	10.4%	10.4%	9.6%	9.6%	-	-	N/R	N/R	-	-
IN	13.5%	13.5%	15.1%	15.1%	10.7%	8.2%	N/R	N/R	7.3%	4.9%	10.8%	3.3%
KS	-	-	-	-	-	-	-	-	N/R	N/R	8.6%	8.4%
KY	8.9%	8.1%	7.1%	7.1%	5.5%	5.5%	2.8%	2.8%	N/R	N/R	5.4%	5.4%
MA	-	-	-	-	-	-	-	-				
MD	-	-	-	-	-	-	-	-				
ME	N/R	N/R	18.5%	11.0%	15.6%	11.1%	7.5%	5.2%	7.7%	4.9%	4.1%	3.5%
MI	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	6.8%	6.8%	N/R	N/R
MN	N/R	N/R	10.7%	10.7%	7.2%	7.2%	7.3%	7.3%	-	-	2.6%	2.6%
NC	N/R	N/R	N/R	N/R	13.9%	11.6%	6.2%	4.9%	4.5%	3.7%	3.7%	3.7%
NE	-	-	-	-	21.8%	21.8%	15.9%	15.0%	N/R	N/R	11.5%	11.5%
NJ	-	-	4.1%	4.1%	10.8%	10.8%	12.7%	12.7%	-	-	9.8%	9.8%
NV									(12.0)%	(12.1)%	9.0%	6.8%
NY									N/R	N/R	17.5%	8.6%
OH	-	-	N/R	N/R	N/R	N/R	N/R	N/R				
OK	-	-	-	-	-	-	-	-	10.0%	10.0%	5.6%	5.6%
OR	12.8%	12.2%	16.3%	15.2%	19.8%	14.9%	13.4%	9.0%	13.0%	9.0%	8.1%	6.2%
PA	N/R	N/R	N/R	N/R	16.4%	8.6%	8.1%	6.9%	4.5%	3.9%	7.4%	7.2%
RI	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	-	-	N/R	N/R
SD	N/R	N/R	14.1%	14.1%	17.5%	16.2%	-	-				
TN									N/R	N/R	8.0%	8.0%
VA	-	-	13.8%	13.8%	8.7%	8.7%	-	-	11.8%	11.8%	10.6%	10.6%
WA	N/R	N/R	N/R	N/R	14.1%	13.9%	11.9%	10.6%	11.7%	11.4%	9.0%	7.0%
WI	7.3%	7.3%	-	-	-	-	-	-	9.1%	9.1%	10.5%	10.5%
MEAN US	**11.6%**	**11.3%**	**11.3%**	**10.3%**	**13.1%**	**11.2%**	**10.7%**	**8.8%**	**6.3%**	**5.6%**	**7.9%**	**6.9%**

† - Trends data from 2011 are incomplete (see Methods section).

Note: Approved rates differ from those in Table 16 because this Table is restricted to filings with complete rate information – both proposed and approved premium increases. Some estimates are not reportable (N/R) because the proportion of state member months represented in the sub-sample is less than 50%. Missing values for states included in the study are denoted with a dash.

Table 35: Rates of Premium Increases, Proposed and Approved, by State for the Small Group Market, 2008-2012

	Small Group Trends 2008 Proposed	Small Group Trends 2008 Approved	Small Group Trends 2009 Proposed	Small Group Trends 2009 Approved	Small Group Trends 2010 Proposed	Small Group Trends 2010 Approved	Small Group Trends 2011† Proposed	Small Group Trends 2011† Approved	Small Group SMR 2011 Proposed	Small Group SMR 2011 Approved	Small Group SMR 2012 Proposed	Small Group SMR 2012 Approved
AL	8.4%	8.4%	-	-	-	-	-	-	3.9%	3.9%	N/R	N/R
AR	-	-	-	-	-	-	-	-				
CA	-	-	-	-	-	-	-	-	7.3%	7.2%	5.3%	5.3%
CO	-	-	5.4%	5.4%	8.8%	8.8%	3.8%	3.8%	0.1%	0.1%	6.3%	6.3%
CT	-	-	-	-	15.3%	15.2%	N/R	N/R	5.1%	3.9%	11.1%	7.6%
DC									N/R	N/R	7.5%	7.5%
FL	19.2%	19.2%	16.4%	16.4%	13.1%	10.9%	7.2%	7.2%	-	-	-	-
HI	-	-	-	-	-	-	-	-				
IA	-	-	-	-	-	-	-	-	N/R	N/R	N/R	N/R
ID	-	-	-	-	-	-	-	-				
IL	-	-	-	-	-	-	-	-	-	-	-	-
IN	N/R	N/R	21.0%	21.0%	-1.1%	-1.2%	1.7%	1.7%				
KS	-	-	-	-	-	-	-	-	2.6%	2.6%	1.2%	1.2%
KY	-0.4%	-0.4%	3.7%	3.7%	5.4%	5.4%	6.1%	6.1%	(1.0)%	(1.0)%	3.4%	3.4%
MA	-	-	-	-	-	-	-	-				
MD	-	-	-	-	-	-	-	-				
ME	-	-	-	-	N/R	N/R	6.7%	6.7%	10.2%	9.9%	10.5%	7.1%
MI	-	-	-	-	-	-	-	-	2.6%	2.6%	5.9%	5.9%
MN	N/R	N/R	N/R	N/R	0.1%	0.1%	-1.2%	-1.2%	-	-	(0.6)%	(0.6)%
NC	40.0%	40.0%	-	-	-	-	9.0%	9.0%	10.1%	10.1%	6.4%	6.4%
NE	-	-	-	-	-	-	N/R	N/R	N/R	N/R	N/R	N/R
NJ	-	-	-	-	-	-	-	-	-	-	5.2%	5.2%
NV									0.2%	0.2%	1.9%	1.6%
NY									16.1%	14.4%	15.6%	8.9%
OH	-	-	N/R	N/R	4.3%	4.3%	-0.4%	-0.4%				
OK	-	-	-	-	-	-	-	-	N/R	N/R	1.5%	1.0%
OR	4.7%	4.7%	5.9%	5.9%	13.1%	12.7%	7.4%	6.0%	7.3%	6.1%	5.3%	4.2%
PA	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	-	-	2.6%	2.6%
RI	-	-	-	-	2.0%	1.3%	14.3%	11.6%	-	-	5.7%	4.0%
SD	-	-	-	-	-	-	-	-				
TN									(2.4)%	(2.4)%	(2.5)%	(2.5)%
VA	-	-	-	-	-	-	-	-	(1.1)%	(1.1)%	3.1%	3.1%
WA	-	-	-	-	4.2%	4.2%	N/R	N/R	13.2%	13.2%	4.9%	3.0%
WI	-	-	-	-	-	-	-	-	N/R	N/R	3.7%	3.7%
MEAN US	**12.8%**	**12.5%**	**12.5%**	**12.5%**	**7.3%**	**6.7%**	**5.0%**	**4.5%**	**5.6%**	**5.2%**	**6.7%**	**5.1%**

† - Trends data from 2011 are incomplete (see Methods section).

Note: Approved rates differ from those in Table 16 because this Table is restricted to filings with complete rate information – both proposed and approved premium increases . Some estimates are not reportable (N/R) because the proportion of state member months represented in the sub-sample is less than 50%.

Trends Before and After the Start of "Unreasonable" Rate Review

As of September 1, 2011, rate increase requests of 10 percent or more are shared with the Center for Consumer Information and Insurance Oversight (CCIIO), which is a part of DHHS, as part of the "unreasonable" rate review program.[37] In addition to being reviewed by state or federal regulators, these filings are made available to the public through an online portal (healthcare.gov). We used the data collected from this study to compare rate increases and approval rates during the times periods before and immediately after the implementation of reasonable rate review.

We analyzed all the filings in our study that had rate modifications to see if filings that met the threshold for public disclosure, with a proposed rate increase of 10 percent or more, were subject to a larger percentage of modifications by state regulators than those that did not. While in general, larger requested rate increases should be more likely to be modified because they will draw greater scrutiny, the public disclosure of the larger-magnitude rate filings may cause carriers and regulators to treat publicly-disclosed filings differently. Of course an increase in reviews and modifications by state regulators may also be due to increased regulatory activity overall, as funded by the Cycle I and II rate review grants (also described in the Introduction) or by other factors not addressed in our analysis.

In the individual market (Table 36), filings with a requested increase of greater than 10 percent in both 2011 and 2012 were modified significantly more often than those with a requested rate increase of less than 10 percent. In 2011, 34.5 percent of filings with requested rates above 10 percent were modified, compared to only 18.3 percent of requested rates below 10 percent. This difference was even more apparent in 2012, with 42.1 percent of all requested rates above 10 percent modified, compared to only 20.2 percent of requested rates below 10 percent.

Table 36: Percentage of Filings with Rate Modifications, for Filings in which the Proposed Rate Increase was Greater than or Equal to 10%, Individual/Conversion

Requested Rate	SMR 2011	SMR 2012
Less Than 10%	18.3%	20.2%
Greater Than / Equal to 10%	34.5%*	42.1%*

* Estimate is significantly different from filings with a requested rate of less than 10% at $p < .05$.

Calculated based on the subset of filings with complete rate information – both proposed and approved premium increases

[37] As described in this report's Introduction section, reviewed filings are classified as "reasonable" or "unreasonable," although regulators' ability to deny or reduce proposed rates was not affected by the initiative – in some states, carriers may still implement "unreasonable" rate increases.

In the small group market (Table 37), a significant difference in rate modifications was found between filings requesting an increase greater than 10 percent and those that requested an increase of less than 10 percent in both 2011 and 2012. While both years showed a significant difference, this difference was much larger in 2012. In 2011, 15.4 percent of filings with requested rates above 10 percent were modified, compared to 8.4 percent of requested rates below 10 percent. In 2012 78.5 percent of all filings with a requested rate increase of greater than 10 percent were modified in 2012, compared to only 11.7 percent of those that had a request of less than 10 percent.

Table 37: Percentage of Filings with Rate Modifications, for Filings in which the Proposed Rate Increase was Greater than or Equal to 10%, Small Group

Requested Rate	SMR 2011	SMR 2012
Less Than 10%	8.4%	11.7%
Greater Than / Equal to 10%	15.4%*	78.5%*

* Estimate is significantly different from filings with a requested rate of less than 10% at $p < .05$.

Calculated based on the subset of filings with complete rate information – both proposed and approved premium increases

Another approach to analyzing before and after implementation of the new rules on public disclosure and "excessive" rate review is to compare all filings submitted before the September 1, 2011 deadline with all those submitted after. The estimates in the remainder of this section are not directly comparable to others in this report – because the September 1 cutoff applies based on when a filing is submitted, rather than the date it takes effect, the year with which a filing is associated in the rest of the report (based on the effective date) is not necessarily how it will be identified for the purposes of this analysis. Note that few filings appear in the last months of 2012 because of the delay between when a filing is initially submitted and when it takes effect – most filings submitted in October 2012 and later take effect in early 2013, and are outside the scope of this study. Additionally, 362 filings in the data set are missing a value for the date submitted to the state, and are omitted from this analysis. While these filings have other dating information roughly contemporaneous with submission date, such as the date they were approved or went into effect, this analysis is concerned with behavior around a specific cut-point, and so classifying these filings by assumption could introduce error into our calculations.

Table 38 presents the number of filings that had a proposed rate that were submitted during each month of the study. The table also denotes the number of filings per month based on whether the proposed rate (as opposed to the final implemented rate) was greater than or less than 10 percent. There is a clear increase in activity during August 2011, just prior to the beginning of public rate review and disclosure, as more filings were submitted in that month than any other during the study period. Additionally, rate filings

requesting an increase of 10 percent or more comprise 39.5 percent of the filings submitted prior to the deadline (103 of 261) and just 20.2 percent of those submitted after (50 of 248).

Table 38: Number of Filings Submitted, in which the Proposed Rate Increase was Greater than or Equal to 10%, by Month, Individual/Conversion

Month	Individual, less than 10%	Individual, 10% or more	All Individual Filings
2010 July	.	18	18
2010 August	5	3	8
2010 September	6	5	11
2010 October	17	10	27
2010 November	7	6	13
2010 December	5	4	9
2011 January	7	2	9
2011 February	9	10	19
2011 March	19	11	30
2011 April	26	5	31
2011 May	15	6	21
2011 June	17	18	35
2011 July	18	12	30
2011 August	**47	**39	**86
2011 September	16	.	16
2011 October	21	3	24
2011 November	11	3	14
2011 December	12	4	16
2012 January	21	2	23
2012 February	19	1	20
2012 March	22	4	26
2012 April	21	14	35
2012 May	19	1	20
2012 June	15	6	21
2012 July	10	4	14
2012 August	6	3	9
2012 September	2	3	5
2012 October	3	2	5
2012 November	.	.	.
2012 December	.	.	.

Note: Month and year designation is determined by the date the filing was filed by the carrier (and not the effective date of the filing). Cells highlighted in blue** indicate the month when the greatest number of filings was submitted.

Table 39 examines the same rate for the small group market. Any effect of the deadline for the excessive rate review program is hard to discern from this data. While 56 filings were submitted in August 2011 as compared with September, 61 filings were submitted in October 2011, and there is more month-to-month variation generally. Similarly, the ratio of filings requesting larger-magnitude increases to all submitted filings is roughly the same for filings submitted before and after the deadline, less than 20 percent in both cases.

Table 39: Number of Filings Submitted, in which the Proposed Rate Increase was Greater than or Equal to 10%, by Month, Small Group

Month	Small Group, less than 10%	Small Group, 10% or more	All Small Group Filings
2010 July	.	1	1
2010 August	.	.	.
2010 September	1	4	5
2010 October	7	5	12
2010 November	3	.	3
2010 December	4	1	5
2011 January	7	2	9
2011 February	7	.	7
2011 March	26	2	28
2011 April	41	8	49
2011 May	19	5	24
2011 June	7	8	15
2011 July	25	8	33
2011 August	47	**9	56
2011 September	16	2	18
2011 October	53	8	**61
2011 November	23	4	27
2011 December	25	2	27
2012 January	34	1	35
2012 February	26	2	28
2012 March	45	.	45
2012 April	**54	4	58
2012 May	45	4	49
2012 June	27	2	29
2012 July	26	8	34
2012 August	15	1	16
2012 September	11	5	16
2012 October	3	3	6
2012 November	1	.	1
2012 December	.	.	.

Note: Month and year designation is determined by the date the filing was filed by the carrier (and not the effective date of the filing). Cells highlighted in blue** indicate the month when the greatest number of filings was submitted.

It is also possible to compare the mean proposed and implemented premium increases for filings submitted before and after September 1, 2011; the results are presented below in Table 40. As noted earlier, for analytic purposes the final implemented rate includes both the increases that are reviewed and approved by state regulators, and the cases of filings where an approved rate is not available (and there is no clear indication that the filing was disapproved by the state or withdrawn by the carrier) so the proposed rate is used. The implemented increase in the individual market was hardly affected by the change, with an average rate of increase of 7.0 percent before the review program began and 7.0 percent afterward. However, the proposed rate increase in the individual market dropped from 8.1 percent before the review program began to 7.5 percent afterward. This suggests that the rate review program may have exerted a downward pressure on proposed rate increases in this market. In the small group market, the

mean proposed rate increase also dropped following implementation of the rate review program from 4.7 percent to 3.1 percent. A contrast also appears to be present in the mean implemented increase in the small group market, but issues of item non-response bias (filings where a filed date was not present) may be the cause. Filings with a submission date prior to September 1, 2011 show an average implemented rate increase of 4.3 percent, those with a submission date after September 1 show one of 3.1 percent, and the 199 small group filings missing information on a submission date show an average increase of 9.5 percent (data not shown in Table).

Table 40: Rates of Premium Increases, Proposed and Approved, in the Individual and Small Group Markets, by whether Filing was Submitted before or after September 1, 2011

Market	Date Submitted	Number of Filings	Mean Proposed Increase	Mean Final Implemented Increase
Individual/ Conversion	Before Sept 1, 2011	347	8.1%	7.0%
	After Sept 1, 2011	248	7.5%	7.0%
Small Group	Before Sept 1, 2011	247	4.7%	4.3%
	After Sept 1, 2011	450	3.6%	3.1%

Note: Month and year designation is determined by the date the filing was filed by the carrier (and not the effective date of the filing). The Mean Proposed Increase is calculated using the subset of filings that include a proposed rate. The Mean Final Implied Increase is the average rate of premium increase used elsewhere in the report – when the approved rate is available, it is calculated using the approved rate, otherwise the proposed rate is used.

Limitations

This report presents descriptive analysis of the trends in rate increases in periods before and after ACA rate review, but there is no way of knowing what would happen absent the ACA, as its provisions apply to all states. NORC did not conduct multivariate analyses to test the impact of factors unrelated to the ACA that may affect premium increases.

In both the individual and small group markets, we cannot explain why the number of fillings sometimes fluctuates dramatically from year to year for a given state.

For some data fields in some filings, data were either missing or seemingly implausible. For example, some filings were missing either requested premium increases or approved rate increases; in these cases, we were unable to assess whether state regulators modified the rate originally proposed by the carrier, and so these observations had to be omitted from analysis of that question. In other instances, available data seemed implausible. For example, in some cases the total reported enrollment in multiple filings from the same year by a single carrier summed to a figure much greater than that carrier's entire enrollment listed in the NAIC April Supplemental Report, suggesting that some enrollees may have been double-counted in the filings. Where enrollment data is missing or implausible, the weighting methodology we use employs the data from NAIC on state insurer enrollment in the small group and individual markets to cap the maximum possible weight such filings can receive. From sensitivity testing conducted for a prior ASPE study of similar data, we believe that measures of central tendency in this report are robust to the particulars of the weighting method used.

Another limitation is the comparability of the current study's findings to the findings from the Trends study, as the study sample and data collection methods differed. The current study includes a modified panel of states, with six states that were included in the Trends study sample replaced by five states with publicly available websites. The six states replaced did not have public websites. For each state included in this study, NORC did not extract data for insurers outside of the carrier sample (sampled carriers were either those with at least one percent market share in the state or the five largest carriers, with the more inclusive rule applying, as described in this report's Methods section) for 2011 and 2012, unlike the Trends study. Some fluctuations in the number of filings for individual states may be attributable to the different sampling rules for the Trends study and "State Market Reforms." As a result, the number of fillings sometimes fluctuates dramatically from year to year for a given state, but differences in sampling methods only explain some of the results. For example, data collection efforts for Pennsylvania in the individual market from the Trends study resulted in 16 plan filings in 2008, 30 in 2009, 24 in 2010, and

35 in 2011, with 22 different insurance carriers represented. In comparison, for the current study there were 15 carriers in Pennsylvania's individual market included in the sample, yielding 10 filings in 2011, and 32 in 2012.

Finally, it is important to note that state procedures for posting filings in their public portal and their process for reviewing filings vary, even among states that have the same regulatory authority (file and use or prior approval). For example as noted previously, in some states files on proposed rate increases that are rejected by the regulator are kept open until a compromise rate increase can be arrived at while in other states in response to a rejection from the regulator the carrier may re-file a new rate at a at a later date under a separate tracking number. Although use of the SERFF portal and the SERFF file template did improve the consistency of the information presented in filings, in some cases sections of the template were left blank or could only be found in the correspondence attached to the filing. As such, while the completeness of the filing documentation submitted by carriers has improved since the beginning of the Trends study, the data presented in this report is subject to the limitations of its sources.

Conclusion

In 2011, two provisions of the ACA that relate to the review of health care insurance policy rates went into effect. First, starting at the beginning of the plan year, if carriers in the small group and individual markets had medical loss ratios below 0.80, a provision required carriers to rebate the "excess" to subscribers. Second, beginning on September 1, carriers with premium increases of 10 percent or more in 2011 and 2012 were to submit justification for those increases to state and/or federal regulators. In addition, 35 and 30 states now have prior approval authority in the individual and small group insurance markets, respectively. Prior approval requires insurance department approval before new premium rates go into effect.

To analyze trends in pre- and post-ACA premiums, this study examined publicly available data from 2011 and 2012 and presented findings alongside findings from NORC's earlier study for ASPE, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011." NORC extracted data from 24 states that were included in the Trends study that had public websites, and five additional states that were not included in the Trends study but that had public websites.

In calculating state and national averages, we have used separate weights for the small group and individual markets that reflect enrollment in the plan and carrier. Composite weights for each state are based on the estimated number of persons with coverage in the small group and individual market. Our analyses examine trends in two critical measures – premium increases and approval of rates by state regulators -- in the periods before and after the ACA rate review provisions went into effect.

Our major finding is that premium increases slowed substantially since the time that ACA rate regulations went into effect in 2011 compared to the prior period in the states included in this research. In the Individual market, premium increases fell from 11.7 percent in 2010 to 7.1 percent in 2012. In the small group market, premium increases declined from 8.8 percent in 2010 to 4.8 percent in 2012. In both the individual and small group markets, premium increases for each post-rate review period were lower than for any pre-rate review period.

The slowing of premium increases has two dimensions. First, insurers' requested smaller premium rate increases in both individual and small group markets. Second, regulators reduced requested premiums of insurers more extensively after ACA rate review provisions went into effect. In 2012 state regulators approved about 83.6 percent of rate requests in the individual and 73.2 percent in the small group market, but the average reduction in requested premiums was 12.7 and 23.9 percent respectively. In the pre-rate

review years, data from the Trends study shows rate reductions were never as much as 10 percent in the small group market. In the individual market, rate reductions of 10 percent or more occurred only in 2010. Over the period of the two studies, the number of filings in the study sample grew continuously in the small group market from 124 in 2008 to 569 in 2012. In the individual market the number of filings collected varied significantly from year to year, with 395 found for 2012; these fluctuations occurred on the level of individual states.

Appendix A: Large Carriers and Market Concentration in Each State

Table A1: Market Concentration and Number of Carriers for the Individual Health Insurance Market, by State

State	Number of Carriers in Sample	Largest Carrier (by market share, as a % of premiums)	Market Share - Largest Carrier	Market Share - Top 3 Carriers
High Market Concentration (80% or More of Market Share by Largest Carrier)				
Alabama	5	BCBS of Alabama	88.67%	95.03%
Iowa	5	Wellmark, Inc.	83.23%	91.65%
North Carolina	6	BCBS of North Carolina	82.85%	89.86%
Rhode Island	5	BCBS of Rhode Island	94.71%	98.48%
Medium Market Concentration (50-<80% of Market Share by Largest Carrier)				
Arkansas	6	USAble Mutual Insurance Co. (Arkansas BCBS)	79.07%	91.21%
District of Columbia	8	Group Hospitalization and Med. Svc. (CareFirst, Inc.)	51.06%	78.02%
Illinois	10	Health Care Service Corporation	65.77%	78.17%
Indiana	10	Anthem Insurance Companies, Inc. (WellPoint)	53.57%	78.47%
Kentucky	5	Anthem Health Plans of Kentucky (WellPoint)	79.11%	95.92%
Michigan	11	BCBS of Michigan	53.68%	73.78%
Minnesota	7	BCBS of Minnesota	62.68%	84.37%
Nebraska	6	BCBS of Nebraska	65.56%	87.02%
New Jersey	8	Horizon Healthcare Services, Inc. (BCBS of NJ)	54.86%	80.10%
Oklahoma	9	Health Care Service Corporation	58.64%	75.91%
Virginia	7	Anthem Health Plans of Virginia (WellPoint)	74.73%	86.05%
Low Market Concentration (<50% of Market Share by Largest Carrier)				
California**	9	Anthem Blue Cross (WellPoint)*	48.22%	82.13%
Colorado	12	Rocky Mountain Hosp. and Med. Serv., Inc (WellPoint)	32.01%	52.62%
Connecticut	8	Anthem Health Plans, Inc. (WellPoint)	48.54%	84.17%
Delaware	9	Highmark BCBS of Delaware	46.85%	82.10%
Florida	11	BCBS of Florida	49.20%	70.02%
Kansas	9	BCBS of Kansas	43.76%	75.56%
Maine	5	Anthem Health Plans of Maine (WellPoint)	44.86%	92.45%
Nevada	10	Rocky Mountain Hosp. and Med. Serv., Inc. (WellPoint)	33.57%	67.81%
New York	15	Empire HealthChoice HMO (WellPoint)	17.08%	43.81%
Oregon	9	Regence BCBS of Oregon	35.28%	64.82%
Pennsylvania	15	Highmark, Inc.	31.59%	55.15%
Tennessee	7	TRH Health Insurance Group	36.69%	79.77%
Washington	11	LifeWise Health Plan (Premera Blue Cross)	33.80%	83.04%
Wisconsin	14	Wisconsin Physician Services Ins. Corp.	18.43%	46.14%

Table A2: Market Concentration and Number of Carriers for the Small Group Health Insurance Market, by State

State	Number of licensed carriers	Largest Carrier (by market share, as a % of premiums)	Market Share - Largest Carrier	Market Share - Top 3 Carriers
High Market Concentration (80% or More of Market Share by Largest Carrier)				
Alabama	5	BCBS of Alabama	97.21%	99.58%
Medium Market Concentration (50-<80% of Market Share by Largest Carrier)				
Delaware	5	Highmark BCBS of Delaware	57.11%	87.31%
Illinois	10	Healthcare Service Corporation	54.29%	75.64%
Iowa	10	Wellmark, Inc.	51.77%	77.16%
Kansas	10	BCBS of Kansas	59.23%	74.83%
Kentucky	5	Anthem Health Plans of Kentucky (WellPoint)	71.77%	93.57%
North Carolina	7	BCBS of North Carolina	63.33%	87.68%
Oklahoma	8	HealthCare Services Insurance Corp.	51.76%	73.29%
Rhode Island	5	BCBS of Rhode Island	73.75%	98.16%
Tennessee	7	BCBS of Tennessee	69.37%	84.82%
Low Market Concentration (<50% of Market Share by Largest Carrier)				
California**	12	Kaiser Foundation Health Plan	25.51%	55.79%
Colorado	8	UnitedHealthcare Ins. Co.	29.23%	77.37%
Connecticut	7	Anthem Health Plans,Inc. (WellPoint)	31.00%	70.31%
District of Columbia	8	Group Hosp. and Med. Serv., Inc. (CareFirst)	47.04%	86.91%
Florida	12	UnitedHealthcare Ins. Co.	27.42%	67.97%
Maine	6	Anthem Health Plans of Maine (WellPoint)	49.88%	91.11%
Michigan	14	BCBS of Michigan	38.18%	70.91%
Minnesota	8	BCBS of Minnesota	36.40%	82.39%
Nebraska	9	BCBS of Nebraska	43.07%	80.98%
Nevada	14	Rocky Mountain Hosp. and Med. Serv., Inc. (WellPoint)	23.38%	56.98%
New Jersey	8	Horizon Healthcare (BCBS of New Jersey)	31.00%	69.76%
New York	15	Oxford Health Insurance (UnitedHealth)	22.91%	49.18%
Oregon	8	Regence BCBS of Oregon	21.41%	60.31%
Pennsylvania	11	HM Health Ins. Co. (Highmark)	19.30%	44.09%
Virginia	13	Anthem Health Plans of Virginia (WellPoint)	32.58%	59.38%
Washington	11	Premera Blue Cross	33.15%	68.39%
Wisconsin	21	UnitedHealthcare Ins. Co.	26.85%	46.09%

Appendix B: Number of Filings with a Given Characteristic, by Year and Market

Table B1: Number of Filings by Independent Variable, by Year - Individual/Conversion

Characteristic	SMR 2011	SMR 2012	SMR Total
Total	363	395	758
File and Use	88	62	150
Prior Approval	248	282	530
Other	27	51	78
HMO	82	79	161
PPO/HDP	209	249	458
Indemnity	24	29	53
No Product Type Available	48	38	86
Top 3 Carrier	146	179	325
Other Carrier	217	216	433
Low Concentration States	269	257	526
Medium Concentration States	72	115	187
High Concentration States	22	23	45

Table B2: Number of Filings by Independent Variable, by Year – Small Group

Characteristic	SMR 2011	SMR 2012	SMR Total
Total	327	569	896
File and Use	76	197	273
Prior Approval	209	273	482
Other	42	99	141
HMO	169	246	415
PPO/HDP	122	271	393
Indemnity	9	23	32
No Product Type Available	27	29	56
Top 3 Carrier	143	239	382
Other Carrier	184	330	514
Low Concentration States	253	445	698
Medium Concentration States	69	122	191
High Concentration States	5	2	7