INTRODUCTION

The ACA includes a number of new strategies designed to improve the affordability of health insurance, particularly for individual consumers and small businesses. As one of these strategies, the ACA requires each state, or the federal government on behalf of a state, to review proposed increases in health insurance premiums and determine whether such increases are unreasonable. Rate review is intended to constrain unjustified premium increases through a comprehensive review process that helps ensure that insurers’ rates are based on accurate, verifiable data and realistic projections. The ACA’s rate review provisions were implemented beginning in August 2010, and robust rate review processes are expected to play a critical role in ensuring the success of the ACA’s broader market reforms that go into effect in 2014.

To help states enhance their rate review process, the ACA dedicated up to $250 million in grants for activities that expand the states’ legal authority to review rates, ensure a more robust, data-driven examination of insurers’ filings, and increase transparency and consumer and employer engagement in the rate review process. To date, the U.S. Department of Health and Human Services (HHS) has distributed $152 million in grant funds to 44 states.¹

This paper describes the status of rate review programs in the 10 states participating in the Robert Wood Johnson Foundation’s monitoring and tracking project: Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia. Information is drawn from publicly available sources, state legislation, and site visit interviews in each of the 10 states. We summarize how the 10 case study states have enhanced their rate review authority and processes, increased transparency, and expanded consumer outreach in response to the ACA. Although there has been significant variation, all 10 states took some action to improve their rate review process and ensure that insurers’ proposed rates are justified. To a large extent, the actions taken by these states reflect the diversity of approaches to rate review that exist among states nationwide.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation’s work on coverage, visit www.rwjf.org/coverage.
BACKGROUND

The ACA encourages states to enhance their regulatory review of insurers’ proposed rate increases, and allows HHS to establish minimum standards for the review of unreasonable rate increases.2 Rate review requirements apply to rates in the individual and small group markets and, beginning in 2014, to qualified health plans offered through the exchange. While state departments of insurance (DOIs) continue to have the responsibility for reviewing the rates charged by health insurers, the ACA provides for a federal review of rates when a state fails to meet federal rate review standards.

To meet federal standards for an “Effective Rate Review Program,” a state DOI must receive sufficient data from health insurers to adequately examine whether a proposed rate increase is reasonable. The examination must consider, where applicable, medical cost trends, changes in utilization, benefits and cost sharing, changes in the risk profile of enrollees, reserves, administrative costs, taxes and fees, medical loss ratio, and the insurer’s capital and surplus. The state must also have a standard for determining whether a proposed rate is reasonable, and the DOI must post on its website either rate filings, justifications, or links to the federal government’s posting of rate justifications. States must also provide for a public process to review and comment on proposed rate increases.3 As of February 2012, the Center for Consumer Information and Insurance Oversight (CCIIO), a division within HHS, determined that 44 states and the District of Columbia had effective rate review programs in at least one insurance market. Although the majority of states have an effective rate review program, a significant minority of states do not and are without the authority (or do not exercise the authority) to require some or all insurers to undergo the review process.

As of February 2012, the Center for Consumer Information and Insurance Oversight (CCIIO), a division within HHS, determined that 44 states and the District of Columbia had effective rate review programs in at least one insurance market.

OBSERVATIONS FROM THE 10 STATES

Prior to passage of the ACA, the 10 case study states had varying degrees of authority to review insurers’ proposed rates (exhibit 1). All had prior approval authority over at least one market or entity, yet only Colorado, Minnesota, New Mexico, and Rhode Island had prior approval authority over all health insurance products in the individual, small group and association markets.4 While the ACA has prompted all 10 states to expand the scope and depth of their rate review processes, state variation remains. Some states have statutory authority to review and reject unreasonable rate increases and conduct a comprehensive examination of rate filings and supporting documentation. Others have more limited authority over insurers’ rates or take a less robust approach to rate review. A number of states have made transparency and consumer involvement a high priority while in other states it remains difficult for consumers to access information about their rates or participate in the process.

Nearly All States Have Fully or Partially Effective Rate Review Processes

Of the 10 states, six were found to have an effective rate review process for all markets, while three had a partially effective rate review process (exhibit 1). Only one state, Alabama, currently lacks authority to review rates for all
insurers in the individual and small group markets and was found not to have an effective rate review program (exhibit 1). Of the three states with partially effective rate review programs, Oregon and Rhode Island do not require all insurers that sell plans through associations to file their rates with the DOI. In many states, when insurance is sold through a group purchasing arrangement (such as an association or purchasing coalition), the policies are subject to fewer regulatory requirements than traditional insurance products, including the requirement to undergo rate review. In Rhode Island, for example, the state DOI has authority to review rates for insurers selling coverage through associations, but does not currently review rates for those insurers domiciled in another state. Oregon also has authority over associations, but state law exempts certain associations from rate review requirements so long as they meet specified requirements. Because federal rate review requirements encompass any coverage sold to individuals and small groups, including coverage marketed through an association, states that do not review rates for association products cannot receive a fully effective designation. Virginia received only a partially effective designation: although insurers are required to file their rates prior to use, the Bureau of Insurance (BOI) does not have the statutory authority to review rates for HMOs in the individual and small group markets, or for small group or association group business.

Exhibit 1. Pre- and Post-ACA Authority to Review Rates

<table>
<thead>
<tr>
<th>State</th>
<th>Effective Rate Review Program**</th>
<th>Pre-ACA Authority</th>
<th>Post-ACA Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>No</td>
<td>No review authority over commercial insurers</td>
<td>No change</td>
</tr>
<tr>
<td>Colorado</td>
<td>Yes</td>
<td>Prior approval</td>
<td>Expanded data collection requirements</td>
</tr>
<tr>
<td>Maryland</td>
<td>Yes</td>
<td>No review authority over out-of-state individual market associations</td>
<td>Gained new authority to review out-of-state individual market associations;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Allow public disclosure of filings</td>
</tr>
<tr>
<td>Michigan</td>
<td>Yes</td>
<td>File and use authority for non-commercial insurers; No review of rates of commercial insurers</td>
<td>Began to exercise previously unused authority to require commercial insurers to submit rate filings and review commercial rates</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Yes</td>
<td>Prior approval (unless insurer can guarantee lifetime loss ratio of 65%)</td>
<td>No change</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Yes</td>
<td>Prior approval</td>
<td>Expanded data collection requirements; Gained new authority to publicly disclose rate filings; Created consumer input process</td>
</tr>
<tr>
<td>New York</td>
<td>Yes</td>
<td>File and use</td>
<td>Gained prior approval authority</td>
</tr>
<tr>
<td>Oregon</td>
<td>Yes (partial)**</td>
<td>Prior approval</td>
<td>No change</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Yes (partial)***</td>
<td>Prior approval</td>
<td>No change</td>
</tr>
<tr>
<td>Virginia</td>
<td>Yes (partial)****</td>
<td>Review authority over rates in the individual market, with the exception of HMO and association business. HMO, group association and small group rates are required to be filed</td>
<td>No change</td>
</tr>
</tbody>
</table>

*Source: CCIIO, as of February 2012.
**Oregon does not have authority to review individual association products or exempt small group association products.
***Rhode Island does not currently review rates for out-of-state insurers selling coverage through an association.
****Virginia does not have statutory authority to review HMO, small group and group association rates in the individual market.
Post-ACA Changes to State Rate Review Authority

States took many efforts to enhance the comprehensiveness of their rate review process, for example by expanding the number of filings reviewed, conducting a more in-depth examination of insurers' data and projections, and broadening the scope of review to include an assessment of insurers' financial health. In doing so, half of the states changed their legal authority to review rates while the other half made changes to their rate review practices.

Five of the 10 states changed their legal authority to review rates and collect data from insurers in response to the ACA (exhibit 1). Three of these states—New York, Maryland, and Michigan—expanded authority to review rates in an additional market or for an additional product. In New York, the legislature passed a law in 2010 to grant the Department of Financial Services (DFS) authority to approve, disapprove, or modify individual and small group rates. Regulators previously had this authority, but it was taken away during an era of deregulation in the 1990s. In Maryland, legislation passed in 2012 granted the Maryland Insurance Administration (MIA) with authority to review rates for out-of-state association plans while Michigan regulators extended rate review requirements to the commercial market by asserting authority that had previously gone unexercised. Michigan regulators noted: “We had a history of exempting commercial market policy holders [from rate review]. Our bulletin re-established our authority over [the commercial market].” In addition to reviewing commercial rates, regulators report that they are giving the filings more scrutiny and asking for more supporting information than they have in the past, which has resulted in the collection of additional detail from carriers and more “thoroughly filed” forms.

The other two states that adopted additional legal authority—Colorado and New Mexico—had prior approval authority before the ACA, but expanded their existing rate review requirements. In Colorado, the state DOI issued a regulation expanding the scope of information insurers must disclose as part of their rate filing. And, in 2011, New Mexico passed legislation exceeding the ACA's standards for an effective rate review process. The new legislation grants the DOI the authority to expand data submission requirements and allows public web access to insurance rate filings with a 30-day public comment period. New Mexico regulators indicated that the law has empowered the DOI to request broader disclosures from insurers, noting “it’s phenomenal what we’ve been able to do with it…proposed increases are 20 percent of what they were before and we know what the insurers are doing now.”

Five states—Alabama, Michigan, Oregon, Rhode Island, and Virginia—did not amend their rate review authority, although most made significant changes to their rate review practices, as discussed below. Of these states, Alabama and Virginia have historically adopted a largely hands-off approach to the regulation of rates. Alabama, for example, currently has no authority to review rates for commercial insurers in the individual or small group market. While regulators expected rate review legislation to be enacted in 2012, no bill was introduced. Industry representatives in Virginia noted that the BOI has “historically been very laissez faire related to rates,” which they predicted is unlikely to change. Regulators note that their review of individual market rates is “active” and “robust,” but acknowledged that they would need broader authority and an enhanced, up-front review process if they want to run a state-based exchange or conduct plan management in a federally-facilitated exchange. In Alabama, federal regulators are reviewing all individual and small group market rate filings that request an increase of 10 percent or more. They are doing the same for all small group, individual HMO and association filings in Virginia.

Leveraging Federal Funds to Enhance State Rate Review Processes

The largest impact of the ACA in the 10 states is likely through the provision of federal funding to support enhanced rate review processes. A number of states reported that, prior to the ACA, resource constraints limited the state’s ability to carry out a comprehensive, transparent, and inclusive rate review process. Many did not have sufficient numbers of trained staff, including actuaries, to conduct an independent review. For example, in a 2010 study, Colorado regulators reported...
that they often had to “triage” rate filings and were able to thoroughly review only 25 percent of filings.\textsuperscript{14}

Regardless of their statutory authority to regulate rates, all 10 states applied for and received rate review grants and reported improvements to the quality of the rate review process as a result. Seven of the 10 states applied for and received two grants under Cycle I and Cycle II funding opportunities (exhibit 2). Alabama and Virginia received a Cycle I grant, but did not apply for Cycle II funding, while Minnesota did not apply for Cycle I funding, but did receive a Cycle II grant. According to respondents, these states did not apply for both sources of funding because they did not need the additional funding or did not want to rely on federal funds. Regulators in Virginia, for example, reported that the state decided not to pursue a Cycle II rate review grant because they felt they had already completed all of their proposed projects with Cycle I funding.

To date, the grants have supported a range of activities. Nine of the ten states—Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia—used the grants to establish websites that provide information for consumers and opportunities for public input. Eight of the states—all but Alabama and Virginia\textsuperscript{15}—used grant funds to hire or contract with additional staff, including health actuaries, to enable a more comprehensive examination of insurers’ assumptions about cost trends and better market analysis. For example, the MIA contracted with a health actuarial firm, which issued a report on how the rate review process could be enhanced. The MIA is currently in the process of implementing those recommendations. Additionally, MIA staff are working with the Maryland Health Care Commission and Maryland Health Services Cost Review Commission to determine how shared data can or will be useful in the rate review process. The MIA has also created several new rate review staff positions from the grant funds.\textsuperscript{16} Minnesota’s DOI also reported its intent to hire two new actuaries, an assistant, and a consultant to help the Department improve its rate review process.

Other states, including those that did not expand their existing authority, also hired staff to conduct a more comprehensive review of rate filings. For example, Oregon regulators noted no changes to state practice as a result of the ACA because the state already had strong rate review authority and a practice of comprehensive review. However, the federal grant support allowed them to hire eight new staff, including two new health actuaries and a market analyst, so they can more critically examine all of the supporting documentation in each rate filing.

Funding for additional staff has been critical to state rate review efforts. For example, the insurance division in New Mexico used federal grant funding to hire consulting actuaries to ensure a critical review of rate requests, and representatives from the insurance industry report that the DOI has become much tougher on rates since passage of the ACA. As one respondent from a major insurer noted, “the [DOI] made it clear that whatever rate is submitted will go through the process and they will fight you every step of the way. The [insurer] may win but the DOI will make you prove it.”
## Exhibit 2. Federal Rate Review Grants*

<table>
<thead>
<tr>
<th>State</th>
<th>Cycle I</th>
<th>Award</th>
<th>Primary Activities</th>
</tr>
</thead>
</table>
|Alabama    | Cycle I   | $1,000,000  | • Initiate review of certain rate filings  
                           • Stakeholder meetings                      |
|           | Cycle II  | N/A         |                                                                                      |
|Colorado   | Cycle I   | $1,000,000  | • Hire staff  
                           • Expand data collection and analysis  
                           • Enhance IT  
                           • Consumer engagement                      |
|           | Cycle II  | $4,031,188  |                                                                                      |
|Maryland   | Cycle I   | $1,000,000  | • Hire staff  
                           • Improve transparency  
                           • Consumer engagement                      |
|           | Cycle II  | $3,961,072  |                                                                                      |
|Michigan   | Cycle I   | $1,000,000  | • Issued bulletins expanding rate filing requirements  
                           • Hire staff  
                           • Consumer engagement  
                           • Improve IT                      |
|           | Cycle II  | $3,994,728  |                                                                                      |
|Minnesota  | Cycle I   | N/A         | • Introduce legislation to enhance authority  
                           • Standardize rate filing requirements  
                           • Consumer engagement  
                           • Hire staff  
                           • Improve IT                      |
|           | Cycle II  | $3,900,899  |                                                                                      |
|New Mexico | Cycle I   | $1,000,000  | • Legislation to increase transparency  
                           • Hire staff  
                           • Consumer engagement  
                           • Improve IT  
                           • Consult with outside actuaries           |
|           | Cycle II  | $3,000,000  |                                                                                      |
|New York   | Cycle I   | $1,000,000  | • Hire staff  
                           • Expand review  
                           • Consumer engagement  
                           • Improve IT                      |
|           | Cycle II  | $4,469,996  |                                                                                      |
|Oregon     | Cycle I   | $1,000,000  | • Hire staff  
                           • Consumer engagement  
                           • Public hearings  
                           • Improve IT                      |
|           | Cycle II  | $4,040,777  |                                                                                      |
|Rhode Island| Cycle I   | $1,000,000 | • Hire staff  
                           • Expand analysis of rates  
                           • Upgrade IT  
                           • Public meetings  
                           • System affordability improvements      |
|           | Cycle II  | $3,724,651  |                                                                                      |
|Virginia   | Cycle I   | $1,000,000  | • Targeted rate reviews  
                           • Enhance transparency  
                           • Premium trend analysis of individual and small group markets  
                           • Hire health actuary                      |
|           | Cycle II  | N/A         |                                                                                      |

*Sources: HHS and state officials

### Maintaining State Authority

Even in states with a historically laissez faire approach to rate review, policymakers reported that insurers had a different stance on rate review than they had prior to the ACA, primarily because they preferred state regulation over federal oversight. In some cases, carriers’ concerns about federal regulation translated into support for new state authority over rates. As a Virginia regulator noted, “our industry would prefer to see the regulation from us and not the Feds.” Similarly, regulators in New Mexico reported that insurers pushed back “some” on the legislation passed in 2011 to expand the state’s rate review authority, but, in the end, they “would rather be regulated by the state than the federal government.” And, when Michigan regulators recently re-established rate review authority in the commercial market, Michigan insurers were generally cooperative. As one official put it:
“[The carriers] prefer just ‘one stop’ for their rate filings. They want to avoid a ‘second stop’ at HHS.”

Maintaining state authority over rate review—and keeping the federal government out—may continue to drive states to take action. For example, when Alabama was not deemed to have an effective rate review program, state officials predicted that legislators would be amenable to providing the department with the requisite authority, if only to halt a “federal takeover” of rate review. Officials suggested insurers in the state would accept such legislation because they do not want to be regulated by two authorities.

At the same time, the dual layer of federal regulation helped strengthen regulators’ hands in at least one state. In New York, insurers initially protested the state’s efforts to make rate filings more transparent. The DOI and a coalition of consumer advocates pushed for greater disclosure, and their efforts were boosted by federal requirements that insurers publicly post essentially the same information they were resisting disclosing in New York. Eventually most of the insurers in New York withdrew their objections to greater transparency.

**Improved Transparency and Consumer Engagement**

Perhaps the most significant long lasting change ushered in by the ACA will be improvements to the transparency and inclusiveness of the rate review process in the 10 states. Prior to the ACA, respondents in most states reported that it was very difficult for consumers to access the information in rate filings or provide input on rates. In response to the ACA’s new rate review requirements, the majority of states took action to provide consumers with greater information about rates, the rate review process, and the drivers of rate increases. Many have also provided consumers with better mechanisms for commenting on proposed rates.

Across the 10 states, a number of respondents expressed the strong belief that transparency is essential to the success of the rate review process. In Rhode Island, for example, all rate decisions are publicly posted online and made available to the press. Rhode Island is also contracting with a community organization to receive input from consumers and businesses in the rate review process. This community partner is focusing particularly on educating small business employers about what drives rising health care costs and providing a platform for them to engage in the rate review process.17

Colorado is enhancing its website to allow complete rate filings to be publicly posted, and consumers can now request email alerts when their insurance carrier files a rate change. New York has begun posting all rate filings on the web, and instituted a public comment period. One New York official reported that, “As far as ACA is concerned, public disclosure has been a big benefit for rate review.” Michigan officials similarly applauded greater transparency: “In the past,” they observed, “you had to travel here to get copies of the filings, or file a [Freedom of Information Act request]. Now anyone can go in and pull up a filing.”

Perhaps no state has done more to engage consumers in the rate review process than Oregon. The Insurance Division instituted a public comment period for rate filings, contracted with a consumer advocacy group to weigh in on rate filings on behalf of consumers, and initiated public hearings. It has also invested heavily in consumer education about the factors driving premium rate increases, including the development of a consumer-friendly video to explain rates to consumers and a guide to increase understanding about the contents of a rate filing. While a national trade association of insurers has objected to insurance departments contracting with consumer groups to engage in rate review, respondents in Oregon report that the program is working well, and the state remains committed to a transparent and inclusive public process for the review of rates. Despite these improvements, greater transparency has not been without challenges, the department’s leadership noted: “Even with additional staff, transparency is a lot of work. It’s the right thing to do but it does create delay.”

States are also finding that their rate review process can be leveraged to improve public education in other ways. For example, Oregon used its rate review authority to analyze, respond to, and correct inaccuracies in insurers’ communications with enrollees. According to state regulators, insurers were sending customers correspondence suggesting that their entire rate increase was attributable to the ACA’s early market reforms, which went into effect in 2010. Using rate review, regulators were able to ascertain that the early market reforms had
a negligible impact on premiums and began requiring carriers to submit their draft correspondence with enrollees, to be checked for accuracy.

Using Rate Review to Address the Underlying Costs of Care

A few states view the rate review process as part of a much broader state strategy to address the rising cost of health care and help keep coverage affordable for consumers, as well as state purchasers. These states are using their authority over rates to hold insurers accountable for some of the underlying drivers of premium increases and, in particular, the reimbursements insurers pay to health care providers.

Oregon and New York are exploring how to use rate review to support their delivery system reform efforts. In Oregon, the Insurance Division and the Oregon Health Authority (OHA), which purchases insurance coverage for state employees, teachers and Medicaid, are working together to encourage the implementation of delivery system reforms. As envisioned by state officials, the OHA will delineate best practices for higher-quality, more efficient care, and the Insurance Division will use its rate review authority to encourage insurance companies to incorporate the same best practices—and accompanying reimbursement incentives—into their provider contracts. One insurance regulator noted, “Our hospital providers have such a monopoly and they can demand reimbursement increases. As much as our carriers don’t like regulation, they’ve told me we can be very helpful if we say ‘no’ to the hospital.” The DOI also commissioned a study by an actuarial firm to assess how to use the rate review process to influence claims costs. New York officials are in the initial stages of assessing how they can use rate review to support insurers’ efforts to “bend the medical cost curve” through New York’s multi-payer medical home pilot, as well as other delivery system reforms.

Rhode Island has moved forward the most rapidly, largely stemming from its broad authority to address health care cost drivers through rate review. In 2010, the Office of the Health Insurance Commissioner (OHIC) released a set of “Affordability Standards” for insurers, which direct insurers to improve the affordability of coverage by:

- Expanding and improving the primary care infrastructure in the state—with limitations on insurers’ ability to pass on associated costs in premiums;
- Spreading the adoption of the chronic care model-style medical home;
- Standardizing electronic medical record incentives; and
- Working toward comprehensive payment reform across the delivery system.18

OHIC further uses the rate review process to evaluate insurers’ contracts with hospital providers, and requires them to include six conditions, which include payments for services that encourage efficient use of resources, incentives for quality improvement, administrative simplification, and better care coordination, among others. The Commissioner has used also his authority to modify rate increases fueled by onerous terms in the hospitals’ contracts with the carriers. For example, one hospital chain was requiring the private carriers to make up any shortfall in reimbursement from public health programs like Medicare and Medicaid. OHIC ultimately ruled that these contract terms were not in the public interest, and caused them to be eliminated. State officials noted, “We police the outliers and let hospitals know we’re watching them.”

CONCLUSION

In the 10 states studied, we found considerable variability in the culture, authority and practice of rate review. While all of the states made some effort to improve their rate review authority or practices as a result of the ACA, these efforts ranged from minimal to robust. A few state officials and stakeholders saw value in expanding rate review primarily because it would keep the federal government out. But the majority of respondents appear to view the ACA’s rate review provisions as a welcome opportunity to hold insurers more accountable for rates, educate the public about the factors underlying rate increases, and make the rate review process more transparent and inclusive for consumers. And a few states are using the new resources provided by the ACA to take rate review into uncharted waters, exploring its use as one mechanism to help improve the affordability and quality of health care at the delivery system level.
About the Authors and Acknowledgements
Sabrina Corlette, Kevin Lucia and Katie Keith are research professors and project directors at the Georgetown University Health Policy Institute’s Center on Health Insurance Reforms. The authors are grateful for the comments they received from Linda Blumberg and Sally McCarty. Support for this paper was provided by a grant from the Robert Wood Johnson Foundation. The authors benefited from the state reports and interview notes developed from 10 site visits conducted under the auspices of this project. Aside from themselves, these site visits were conducted by Urban Institute colleagues, including: Fiona Adams, Linda Blumberg, Randall Bovbjerg, Vicki Chen, Brigette Courtot, Teresa Coughlin, Stan Dorn, Ian Hill, John Holahan, and Shanna Rifkin.

About the Robert Wood Johnson Foundation
The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation’s largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter www.rwjf.org/twitter or Facebook www.rwjf.org/facebook.

About Georgetown University’s Health Policy Institute—Center on Health Insurance Reforms
The Center on Health Insurance Reforms at Georgetown University’s Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.
ENDNOTES


2. Patient Protection and Affordable Care Act (ACA) § 1003, adding Public Health Service Act (PHSA) § 2794.

3. 45 C.F.R. § 154.301(b).

4. Some states, such as Rhode Island, may also have rate review authority in the large group market.

5. Alabama has authority to prior approve initial rates for Blue Cross Blue Shield (BCBS) products and HMOs, but not for commercial carriers.


7. For example, an association in Oregon must limit premium variation to no more than 50% among its small groups and retain 95% or more of its employers in order to qualify as exempt from rate review. Ore. Stat. § 743.734.


9. NY Ins. §3231. The law also extended the DFS’ prior approval authority to HMO and Medicare Supplemental plan rates.


15. Virginia used federal grant funds to contract with an actuary for the duration of the grant period, which ended July 30, 2012.

