
TEMPLE LAW REVIEW

© TEMPLE UNIVERSITY OF THE COMMONWEALTH SYSTEM OF
HIGHER EDUCATION

VOL. 88 NO. 3

SPRING 2016

ARTICLES

HEALTH INSURANCE RATE REVIEW

*John Aloysius Cogan Jr.**

The Affordable Care Act's health insurance rate review process has been touted by government officials and consumer advocates as an effective tool to control rising health insurance premiums. This Article argues that the current rate review process is limited in its ability to lower health insurance costs as it does not address the primary driver of rising premiums—the excessive prices paid by health insurers to healthcare providers. The efficacy of the Act's rate review process is further diminished by two additional factors: (1) a retrospective medical loss ratio requirement that pressures insurers to lower administrative costs prior to rate review, and (2) the limited scope of the new rate review requirements. Nevertheless, this Article does not advocate abandoning health insurance rate review. Instead, this Article contends that health insurance rate review holds great potential to control healthcare costs and hold down premium increases if it is modified from its present form, created to address century-old insurance market defects, to be a more dynamic process that gives state insurance commissioners the authority to correct market failures in the healthcare industry that drive up the prices insurers pay for the healthcare services we consume.

* Associate Professor of Law, University of Connecticut School of Law. This Article has benefited from comments by Michael Fischl, Rick Kay, Brendan Maher, Patricia McCoy, Peter Siegelman, and the insights of numerous commenters at the 2015 Annual Health Law Professors Conference.

TABLE OF CONTENTS

INTRODUCTION.....	413
I. MARKET FAILURE AND PROVIDER PRICES	420
A. <i>Informational Asymmetries</i>	423
1. Information Deficits Related to Diagnosis and Treatment.....	423
2. Information Deficits and the Price of Medical Care	424
3. Information Deficits and the Purchase of Health Insurance.....	424
B. <i>Moral Hazard</i>	425
C. <i>Market Power</i>	426
1. Market Consolidation.....	426
2. Other Factors Contributing to Provider Market Power	428
D. <i>Market Failure and Higher Prices</i>	429
E. <i>Can Costs Be Controlled?</i>	429
II. RATEMAKING AND RATE REVIEW PRIOR TO THE ACA	431
A. <i>Health Insurance Ratemaking</i>	431
B. <i>The Origins of Rate Review</i>	432
1. Property-Casualty Rate Review	432
2. The Rate Review Standard.....	435
C. <i>Health Insurance Rate Review Prior to the ACA</i>	436
1. The Fully Insured Markets	437
a. <i>The Large Group Market</i>	437
b. <i>The Small Group Market</i>	438
c. <i>The Individual Market</i>	440
2. Self-Insured Groups	441
3. All Markets Share the Same High Prices	442
III. HEALTH INSURANCE RATE REVIEW UNDER THE ACA	443
A. <i>The Mechanics of Rate Review Under the ACA</i>	444
1. New Federal Filing Requirements	445
2. Effectiveness of State Review	446
B. <i>The Results: Light, But Not Much Heat</i>	448
IV. THE LIMITS OF RATE REVIEW UNDER THE ACA.....	451
A. <i>Rate Review, Indemnity Insurance, and Direct Payment to Providers</i>	451
1. Two Models of Insurance: Indemnity vs. Direct Provider Payment ..	452
2. Modern Health Insurance and the Direct Provider Payment Model.	453
B. <i>Control of the Loading Charge</i>	455
C. <i>The Limited Scope of Rate Review</i>	456
V. A NEW ROLE FOR RATE REVIEW?	456
A. <i>Rate Review as a Cost Control Mechanism</i>	457
1. Practical Reasons for Using Rate Review.....	458
a. <i>Rate Review Is Flexible</i>	458
b. <i>Existing Infrastructure and Expertise</i>	459
2. Theoretical Reasons for Using Rate Review	460
a. <i>States as Laboratories of Innovation</i>	460

<i>b. Interstate Competition</i>	461
3. Political Reasons for Using Rate Review.....	461
<i>B. A New Rate Review Process</i>	462
1. Point-of-Service Incentives.....	463
2. Increasing Insurer Leverage Through Joint Negotiations.....	464
3. Limiting the Growth of Contracted Prices.....	464
4. Setting Payment Rates.....	465
<i>C. Likely Objections to a New Rate Review Process</i>	468
1. There Would Be Significant Political Obstacles.....	468
2. ERISA.....	469
3. What About Federal Antitrust Laws?.....	469
4. Why Not Fix the Underlying Market?.....	470
CONCLUSION: THE FUTURE OF HEALTH INSURANCE RATE REVIEW.....	471

INTRODUCTION

The new health insurance rate review process is a central, but largely overlooked feature of the Affordable Care Act (ACA).¹ Operating deep in the shadows of the ACA's two most prominent, and heavily litigated, provisions applicable to the private health insurance market—the individual mandate² and the health insurance exchanges³—the ACA's rate review process has significantly expanded the federal government's role in health insurance regulation. Under the ACA, rate review has transitioned from a relatively obscure state-based administrative process into a joint state and federal effort to collect, publish, and scrutinize health insurance rate increase requests.⁴ Moreover, rate review has been touted as an effective tool to control rising

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

2. 26 U.S.C. § 5000A(a)–(b) (2012). The so-called individual mandate requires most Americans to have “minimum essential” health insurance or pay a tax penalty to the Internal Revenue Service. *Id.* The individual mandate was extensively litigated, culminating in the Supreme Court's 2012 decision *National Federation of Independent Business v. Sebelius*, which found the ACA's individual mandate unconstitutional under the Commerce Clause, but upheld the mandate's tax penalties under Congress's Taxing Clause power. 132 S. Ct. 2566, 2600 (2012).

3. 42 U.S.C. § 18031 (2012). The health insurance exchanges—or, more precisely, the premium tax subsidies provided to lower income individuals and families who purchase insurance through the federally run exchanges—were also the subject of litigation culminating in a Supreme Court decision, *King v. Burwell*, which held that federal tax credits are available to individuals in states that have federally established, rather than state established, exchanges. 135 S. Ct. 2480 (2015).

4. Unlike the individual mandate and the health insurance exchanges, the ACA's rate review provisions have not been challenged as unconstitutional or contrary to statute. Indeed, the only lawsuit connected with the ACA's rate review provisions was filed to compel disclosure of Missouri's proposed rate increases for health plans sold on Missouri's federally established exchange. *See* Jodie Jackson Jr., *Health Insurance Rates to Be Published*, COLUM. DAILY TRIB. (May 20, 2015, 2:00 PM), http://www.columbiatribune.com/news/local/health-insurance-rates-to-be-published/article_3453e010-d3f2-521c-b1dd-feafc5c9f2d3.html?comments=focus.

health insurance rates. During the passage and rollout of the ACA, Kathleen Sebelius, a former state insurance commissioner and then-Secretary of the U.S. Department of Health and Human Services (HHS), hailed rate review as a way to prevent insurers from imposing “exorbitant, unexplained premium hikes”⁵ and to “help rein in . . . excessive and unreasonable rate increases that have made insurance unaffordable for many families.”⁶ Consumers Union, one of the most influential consumer advocacy organizations in the United States, argues that rate review “has the potential to not only hold down premiums” but also to “reduce the underlying healthcare cost drivers” of health insurance.⁷ Indeed, in annual reports issued since 2012, HHS has estimated that rate review has reduced health insurance rates by about \$4.7 billion.⁸ Yet, because very few apart from actuaries, insurance experts, and insurance regulators understand the rate review process, how it works, and its limitations, claims about the effectiveness of rate review are difficult to evaluate. Moreover, given the general inaccessibility of the rate review process to those who are not industry or regulatory insiders, it should come as no surprise that little scholarly attention has been paid to health insurance rate review. This Article ventures into the rate review vacuum, explaining the shortcomings of rate review while also revealing its untapped potential to control healthcare costs and contain rising insurance rates.

The central claim of this Article is that the rate review process, as traditionally applied by the states and implemented by the ACA, does not live up to its potential to hold down health insurance rate increases. The primary drivers of healthcare costs, which the current rate review process does nothing to address, are the excessive prices charged by healthcare providers. Health insurance rates are comprised of two basic parts: (1) the medical cost component, and (2) the loading charge. The medical cost component is made up

5. Kathleen Sebelius, *New Rules Protect Consumers from Insurance Industry Abuse*, HUFFPOST POL. (Aug. 31, 2011, 10:05 PM), http://www.huffingtonpost.com/sec-kathleen-sebelius/new-rules-protect-consume_b_944312.html.

6. Robert Pear, *Health Insurers to Be Required to Justify Rate Increases over 10 Percent*, N.Y. TIMES (Dec. 21, 2010), http://www.nytimes.com/2010/12/22/health/policy/22insure.html?_r=1&.

7. *Rate Review*, CONSUMERS UNION, <http://consumersunion.org/topic/health-care/rate-review/> (last visited Apr. 1, 2016).

8. See U.S. DEP'T OF HEALTH & HUMAN SERVS., RATE REVIEW ANNUAL REPORT 8 (2015) [hereinafter 2015 RATE REVIEW REPORT], https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf (reporting savings of approximately \$1.5 billion attributable to rate review); U.S. DEP'T OF HEALTH & HUMAN SERVS., RATE REVIEW ANNUAL REPORT 3 (2014) [hereinafter 2014 RATE REVIEW REPORT], https://aspe.hhs.gov/sites/default/files/pdf/77041/rpt_RateReview.pdf (reporting savings of approximately \$1 billion attributable to rate review); U.S. DEP'T OF HEALTH & HUMAN SERVS., RATE REVIEW ANNUAL REPORT 3 (2013) [hereinafter 2013 RATE REVIEW REPORT], https://aspe.hhs.gov/sites/default/files/pdf/178361/ratereview_rpt.pdf (reporting savings of \$1.2 billion attributable to rate review); see also Ctr. for Consumer Info. & Ins. Oversight, *2012 Annual Rate Review Report: Rate Review Saves Estimated \$1 Billion for Consumers*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 11, 2012), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review/09112012a.html> [hereinafter 2012 Rate Review Report] (reporting estimated savings of \$1 billion attributable to rate review).

of all the payments made to healthcare providers for goods and services covered by the health insurance plan. While many blame overuse of medical services (so-called overutilization) for rising claims costs, overuse is not the most significant problem—high prices are. We simply pay too much for the medical services we consume. These excessive prices, which are primarily responsible for a doubling of health insurance premiums over the last decade and a half,⁹ are the byproduct of market failures in the marketplace for medical services. These market failures—information asymmetries, moral hazard, and excess provider market power—cannot be moderated by the ACA’s rate review process, which is modeled on a rate review process created to address a different set of market failures present in the nineteenth-century property-casualty insurance¹⁰ market. Over a hundred years ago, the property-casualty market, particularly the fire insurance industry, was beset by a boom-and-bust cycle of high profits, followed by an influx of new insurers and intense and reckless rate competition. This dynamic led to inadequate rates and insurer insolvencies. Insurers responded by establishing cartels and collusive rate setting.¹¹ States then implemented rate review to ensure that insurance prices were adequate (to ensure insurer solvency), not excessive (to counter cartel pricing), and not discriminatory (to prevent insurers from offering unwarranted discounts to attract business).¹² Thus, rate review was never concerned with the underlying costs that drove insurance rates, but was instead focused on the marketplace behavior of insurers, specifically their pricing strategies and solvency problems.¹³ Since the states, and now the federal government, apply to health insurance a rate review standard designed to address a set of market failures that existed a hundred years ago for a different insurance product, the health insurance rate review process is simply incapable of controlling the fundamental problems that plague *today’s* health insurance market—the market failures leading to excessive provider prices. As such, rate review can do little to control the medical cost component of health insurance rates. Simply put, there is a mismatch: health insurance rate review uses the wrong tools for the job at hand.

This mismatch is further compounded by two additional aspects of the ACA: (1) a retrospective medical loss ratio (MLR) requirement that pressures insurers to lower administrative costs prior to rate review, and (2) the limited

9. See KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2014 ANNUAL SURVEY 20 (2014) [hereinafter KAISER EMPLOYER BENEFITS REPORT], <https://kaiserfamilyfoundation.files.wordpress.com/2014/09/8625-employer-health-benefits-2014-annual-survey6.pdf> (noting that family health insurance premiums in the group market have more than doubled since 2002).

10. Property-casualty insurance provides protection against losses associated with real or personal property, including businesses, homes, and automobiles, and from legal liability to third parties, resulting from injury or damage to persons or property. See *What is Property and Casualty Insurance?*, ALLSTATE (Nov. 2015), <https://www.allstate.com/tools-and-resources/insurance-basics/property-and-casualty-insurance.aspx>.

11. See *infra* Part II.B.1.

12. See *infra* Part II.B.2.

13. See *infra* Part II.B.2.

scope of the new rate review requirements. The ACA's MLR requirement affects an insurer's loading charge, which is comprised of the insurer's administrative costs, including its costs of doing business (e.g., rent, wages and benefits, marketing costs, taxes, and fees), profits, and contributions to reserves.¹⁴ The ACA places a hard cap on certain administrative charges that can be included in health insurance rates. The MLR provision works like this: if, at the end of every year, an insurer's administrative costs included in premiums exceed the MLR limit (15% to 20% of total premium charged, depending on the market), the insurer must rebate the overage to its customers. Since rebates are costly to calculate and distribute, and are therefore undesirable to insurers, the ACA's MLR provision pressures insurers to limit administrative charges when rates are first developed by the insurer, before those rates are submitted for rate review. Many believe the MLR requirement is a good thing.¹⁵ However, since the MLR requirement puts pressure on insurers to lower administrative charges prior to rate review, the effectiveness of rate review is dampened with respect to controlling the administrative fees in health insurance premiums.¹⁶

Finally, even if the current rate review process were capable of controlling the rising health insurance rates in a meaningful way, the effectiveness of rate review is nevertheless weakened by the limited scope of the ACA's rate review process: it is limited to only a small fraction of the private health insurance market. Specifically, the ACA's rate review process applies to only approximately 16% of the health insurance market—that is, the small group and individual markets.¹⁷ This limitation leaves rates for 84% of the private health

14. Insurers are required to contribute to and maintain adequate reserves to protect against the possibility of insolvency due to future losses in excess of collected premiums. See KENNETH J. MEIER, *THE POLITICAL ECONOMY OF REGULATION: THE CASE OF INSURANCE* 46–47 (1988). For an overview of insurer solvency and reserve requirements, see KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 113–23 (6th ed. 2015).

15. See, e.g., Michael J. McCue & Mark A. Hall, *Insurers' Responses to Regulation of Medical Loss Ratios*, COMMONWEALTH FUND: ISSUE BRIEF, Dec. 2012, at 1, 1–5, http://www.commonwealthfund.org/~media/files/publications/issuebrief/2012/dec/1634_mccue_insurers_responses_mlr_regulation_ib.pdf (describing how the ACA's MLR requirement benefits consumers). But see Scott E. Harrington, *Medical Loss Ratio Regulation Under the Affordable Care Act*, 50 *INQUIRY* 9, 10 (2013) (suggesting the ACA's MLR requirement could produce unintended consequences, including higher premiums, withdrawal of insurers from some markets, greater market concentration of insurers, and barriers to health system change).

16. See *infra* Part IV.B. As discussed in Part IV.B *infra*, the MLR cap controls an insurer's loading charges on an aggregate basis rather than on an individual insurance product basis. Rate review, unlike the MLR cap, is capable of identifying excessive loading charges for individual insurance products that might not push an insurer over its MLR cap. Thus, while rates for some health insurance products may contain high loading charges, an insurer's aggregate loading charges for products in a given market (e.g., its individual market products in a particular state) will be held down by the MLR cap.

17. The health insurance market is divided into four different segments: the self-insured, large employer group, small employer group, and individual markets. See *infra* Part II.C.1. There are 170,042,900 persons covered by private health insurance in the United States, see *Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/total-population/> (last visited Apr. 1, 2016) [hereinafter *Health Insurance Coverage*] (select "2013" under "Timeframe" bar), with roughly 28 million of those persons in the small group and individual markets,

insurance market unreviewed.¹⁸ Thus, whatever the possible benefits of rate review, those benefits are confined to a very small segment of the private health insurance market; any gains to the overall private health insurance market from rate review will be negligible.

While these arguments make for a compelling case against the efficacy of the ACA's rate review process, this Article does not advocate abandoning rate review for health insurance. The rate review process does indeed provide some benefits to consumers—four to be exact. First, rate review can identify mathematical and other errors in an insurer's rate calculations, leading to a reduction of proposed rate increases.¹⁹ Second, rate review also functions as a regulatory “second opinion” with respect to actuarial assumptions and projections, and the data upon which those assumptions and projections are based, contained within rate filings.²⁰ These second opinions can also lead to reductions or proposed rate increases.²¹ Third, rate review functions as a form of disclosure regulation, providing consumers, consumer advocates, and even competitors with information about the development of an insurer's rates.²² In theory, disclosure promotes both public accountability of insurers and market discipline.²³ Fourth, state insurance regulators can use the rate review process to impose a cap on an insurer's administrative charges or profits.²⁴ However, the

see infra Part II.B.1.b–c.

18. While the ACA does not require rate review of the large employer group market, a few states require some review of large employer group market rates. *See infra* note 155.

19. *See, e.g.,* Duke Helfand, *Aetna Scraps 19% Rate Increase for Individual Policyholders*, L.A. TIMES (June 25, 2010), <http://articles.latimes.com/2010/jun/25/business/la-fi-aetna-rates-20100625> (health insurer rescinded request for rate increase after math errors found in filing); Duke Helfand, *Anthem Blue Cross Withdraws Request for Rate Hikes*, L.A. TIMES (Apr. 30, 2010), <http://articles.latimes.com/2010/apr/30/business/la-fi-0430-anthem-20100430> (same).

20. *See infra* Part II.B.2 for a discussion of how rate review allows an agency to scrutinize premiums to ensure they are “adequate” and “not excessive.”

21. *See, e.g.,* *Golden Rule Ins. Co. v. Ins. Dep't*, 641 A.2d 1255, 1256 (Pa. Commw. Ct. 1994) (state insurance commission rejected requested rate increase based in part on a difference of opinion as to which data should be used to develop rates); *see also* KAISER FAMILY FOUND., RATE REVIEW: SPOTLIGHT ON STATE EFFORTS TO MAKE HEALTH INSURANCE MORE AFFORDABLE 14–15 (2010) [hereinafter SPOTLIGHT ON STATE EFFORTS], <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8122.pdf> (noting that rate filings contain “assumptions and projections that involve nuanced judgment calls” and that rigorous rate review can result in lower rates based on an independent review of those assumptions and projections).

22. *See infra* notes 205–07 and accompanying text for a discussion of how HHS subjects rate increases it finds unreasonable to public scrutiny.

23. *But see* Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. PA. L. REV. 647, 651 (2011) (arguing that mandatory disclosure does not improve consumer decision making).

24. *See, e.g.,* *Anthem Health Plans of Me., Inc. v. Superintendent of Ins.*, 18 A.3d 824, 828 (Me. 2011) (refusing, based on mootness, to overturn state insurance commissioner's decision to limit for-profit health insurer to 0% profit margin for its 2009 rates); *see also* Pinar Karaca-Mandic et al., *States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market in 2010–13*, 34 HEALTH AFF. 1358, 1363 ex.1 (2015) (noting that in 2013 eight states employed a rate review system for individual market products that required a minimum loss ratio of 80% or more as a condition for approval of filed rates).

effect of these four benefits on the overall costs of health insurance is typically small because the lion's share of health insurance rate increases are driven not by mathematical errors, faulty actuarial assumptions, hidden charges, administrative costs, or insurer profits, but by increases in the prices paid by health insurers to healthcare providers. But the outdated health insurance rate review process currently practiced by the states and promoted by the ACA is simply incapable of controlling rising provider prices. Health insurance rate review, however, need not remain a weak vestige of a bygone era.

This Article contends that rate review holds great potential to control healthcare costs and hold down premium increases, but only if the health insurance rate review process is untethered from its antiquated property-casualty origins and refocused on the provider price problem plaguing the health insurance market. This transformation will require two major alterations of the health insurance rate review process. First, rate review must be extended to cover all fully insured health insurance products,²⁵ thereby maximizing rate review's reach on the overall health insurance market. Second, state insurance commissioners must have the ability to condition the approval of rates on an insurer's compliance with certain orders—specifically, those designed to combat health insurance market failures such as excessive provider bargaining power. Such orders could range from inclusion of point-of-service incentives designed to drive consumers to lower cost providers all the way up to setting provider payment rates by linking those rates to Medicare benchmarks.²⁶ To be clear, this reform should take place at the state, not the federal, level. The reasons for state-based, rather than federal-based, reformation of the rate review process are both practical and based on the benefits of federalism. The practical reasons include the availability of expertise and resources in state insurance departments, the willingness of some state insurance departments to take steps to control healthcare costs, and the unlikelihood of additional federal health insurance legislation anytime in the foreseeable future.²⁷ From a federalist perspective, a state-based approach to controlling healthcare costs through rate review allows for both experimentation by states and localized regulation to address local conditions. While escalating healthcare costs are a problem throughout the United States, every state has its own healthcare landscape, with its own levels of provider and insurer market concentration, and its own unique set of healthcare

25. See *infra* Part II.C.1–2 for a discussion comparing the fully insured market to self-insured groups. This is not meant to suggest that self-funded plans, regardless of whether they are covered by the Employee Retirement Income Security Act of 1974 (ERISA), should be subject to rate review. However, there would be a spillover effect from a more effective rate review if it is imposed on the entire fully insured private health insurance market. See *infra* Part V.B.

26. See *infra* Part V.B for a discussion of suggested mechanisms to address price-related market failures.

27. Indeed, the political and legal battles over the ACA still rage and show no sign of abating. See, e.g., Sarah Kliff, *The Latest Anti-Obamacare Lawsuit, and Why It Might Succeed, Explained*, VOX (Aug. 21, 2015, 8:00 AM), <http://www.vox.com/2015/8/21/9183809/obamacare-lawsuit-republicans> (describing a pending lawsuit filed by Republicans in the House of Representatives challenging the legality of cost-sharing subsidies provided to insurance companies).

pricing problems. Finally, state insurance commissioners have traditionally been given wide discretion to apply broad statutory authority to regulate their home insurance markets.²⁸ In this respect, reforming the rate review process by state legislatures to give insurance commissioners the authority to address the underlying cost drivers of health insurance would simply continue existing practice.

This Article proceeds in five parts. Section I describes the causes of market failure in the marketplace for healthcare services, including information asymmetries, moral hazard, and excess provider market power. It then explains how these factors drive up the prices charged by healthcare providers and why regulatory action is needed. Section II provides an overview of health insurance ratemaking, the origins of rate review, its property-casualty roots, and the application of rate review to health insurance prior to the ACA. Section III then describes the new ACA rate review process. Part IV clarifies why the current state-based rate review process and the expansion of rate review under the ACA can do little to mitigate the market failures that drive up the prices for healthcare services. It also explains how rate review's ability to control administrative costs is dampened by the MLR requirement, and how rate review is limited to only a small fraction of the private health insurance market. Finally, Section V provides four examples of how the rate review process could be adapted to give state insurance commissioners the authority needed to address the market failures that drive up health insurance rates. This Article discusses four possible conditions to rate approval: (1) obligating insurers to include in their plans consumer point-of-service incentives, such as tiered cost sharing and reference pricing, in order to steer consumers to lower-priced providers and stimulate greater price competition among providers; (2) requiring insurer participation in joint negotiations with each medical care provider possessing excess market power to level the insurer-provider playing field; (3) requiring insurers to limit annual provider price increases to the same percentage increases in Medicare prices; and (4) requiring insurers to pay all providers uniform prices for a given geographic area by pegging prices to Medicare rates (or some multiple thereof). These are not the only approaches that can be used, but instead illustrate the range of increasing regulatory control that a state insurance commissioner could bring to bear to correct market failures that contribute to the high cost of health insurance. Section V also considers possible objections to this the new rate review process.

While the ACA expanded coverage to millions of Americans, it did very little to address the rising costs of private health insurance. Without effective regulatory interventions, health insurance premiums will continue their steady rise, rendering health insurance again unaffordable and unavailable to those who only recently gained access through the ACA. Using rate review to address health insurance market failures is compatible with both the ACA²⁹ and

28. See *infra* Part V.A.3 for a discussion of the deference afforded to the states' regulation of insurance markets.

29. These suggestions would require no federal changes to the ACA, as the ACA sets a floor

traditional notions of state-based insurance regulation, and does not run afoul of the Employee Retirement Income Security Act of 1974 (ERISA)³⁰ or other federal laws. It is also adaptable to changing market conditions. As such, states would have the flexibility to address local problems while also addressing the overarching concern of rising healthcare costs.

I. MARKET FAILURE AND PROVIDER PRICES

Health insurance rates in the United States have been increasing dramatically. This is news to no one. In 2013, for example, private health insurance premiums in the United States reached \$961.7 billion, representing about one-third of the \$2.9 trillion in total U.S. health spending.³¹ That same year, nearly 6% of the total U.S. economy was devoted to spending on health insurance premiums.³² Closer to home, annual premiums for employer-sponsored family health coverage reached an average of \$16,834 in 2014.³³ While up only 3% from 2013, family premiums have increased 69% since 2004 and have more than doubled since 2002.³⁴ To make matters worse, the cost-sharing component of most health insurance plans—the deductibles, copays, and coinsurance—have increased as well.³⁵ This means total cost increases borne by American families for their health coverage are even greater than reflected by premium increases alone.

What factors drive these increases? Most discussions of healthcare cost drivers, as if responding to Captain Louis Renault's famous line in the film *Casablanca*, typically "round up the usual suspects." The list of cost drivers usually includes some or all of a wide-ranging list of potential culprits, including "[f]ee-for-service reimbursement," "[f]ragmented delivery of care," "[a]dministrative burdens on providers," population health factors, "advances in medical technology," the tax treatment of health insurance, "insurance benefit design," a "[l]ack of cost and quality transparency," medical care market consolidation, the high prices of medical goods and services, medical malpractice premiums, fraud and abuse, and the structure and supply of the medical care workforce.³⁶ While many of these suspects can certainly be implicated in rising

for rate review while allowing states to impose stricter standards. The ACA's preemption clause states that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d) (2012).

30. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2012).

31. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2013 HIGHLIGHTS (2014), https://www.heartland.org/sites/default/files/national_health_expenditures_highlights.pdf.

32. *Id.*

33. KAISER EMPLOYER BENEFITS REPORT, *supra* note 9, at 1.

34. *Id.* at 20.

35. *Id.* at 2–4.

36. BIPARTISAN POLICY CTR., WHAT IS DRIVING U.S. HEALTH CARE SPENDING? AMERICA'S UNSUSTAINABLE HEALTH CARE COST GROWTH 6–7 (2012), <http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20Health%20Care%20Cost%20Drivers%20Brief%20Sept%202012.pdf>.

premiums, some are more blameworthy than others. But one in particular is the most culpable of all: the prices charged for medical services.

Medical care prices, rather than population age, utilization levels, defensive medicine, or any other factor,³⁷ are the most important variable driving increases in medical care costs.³⁸ Indeed, the prices charged by hospitals and physicians to health insurers are excessive.³⁹ Compared to their peers in other wealthy, developed nations, U.S. medical care providers charge significantly higher prices.⁴⁰ But the quality of care we receive is no better, and is in many ways worse, than the care provided in other countries where prices are lower than

37. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 90 (2003); Robert Berenson, *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust*, 40 J. HEALTH POL., POL'Y & L. 711, 711–12 (2015) [hereinafter Berenson, *Pricing Power*]; see Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing Our Health Care Appetite*, 13 NEV. L.J. 822, 832 (2013) (citing an economic analysis that suggests the aging population accounts for 2%, defensive medicine accounts for 0%, and supplier-induced demand accounts for 0% of rising healthcare costs); David A. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, COMMONWEALTH FUND: ISSUES INT'L HEALTH POL'Y, May 2012, at 1, 2, http://www.commonwealthfund.org/~media/files/publications/issue-brief/2012/may/1595_squires_explaining_high_hlt_care_spending_intl_brief.pdf (relying on OECD data to conclude that higher U.S. healthcare spending cannot be attributed to higher income, an older population, or greater supply or utilization of hospitals and doctors).

38. See COMMONWEALTH OF MASS. OFFICE OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS 35–37 (2010) [hereinafter 2010 MASSACHUSETTS AG REPORT], <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf> (finding that price increases, not utilization, caused most of the increase in healthcare costs over the study period); PAUL B. GINSBURG, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 16, HIGH AND RISING HEALTH CARE COSTS: DEMYSTIFYING U.S. HEALTH CARE SPENDING 11 (2008), <http://www.rwjf.org/content/dam/farm/reports/reports/2008/rwjf32703> (noting empirical studies that point to technology and price as driving growth in healthcare spending); HEALTH CARE COST INST., 2013 HEALTH CARE COST AND UTILIZATION REPORT 1 (2014), <http://www.healthcostinstitute.org/files/2013%20HCCUR%2012-17-14.pdf> (noting that higher prices for medical care and brand name prescriptions, rather than increases in utilization, drove increases in healthcare spending in 2013); Hamilton Moses III et al., *The Anatomy of Health Care in the United States*, 310 JAMA 1947, 1949 (2013); Squires, *supra* note 37, at 2. Technology is implicated in higher costs, but technology and price are not completely independent cost drivers. Providers incorporating newer technology command higher prices and benefit from higher reimbursement rates associated with the new technology. DIANA FARRELL ET AL., MCKINSEY GLOBAL INST., ACCOUNTING FOR THE COST OF US HEALTH CARE: A NEW LOOK AT WHY AMERICANS SPEND MORE 101–04 (2008), http://www.mckinsey.com/insights/health_systems_and_services/accounting_for_the_cost_of_us_health_care. Likewise, administrative costs are significant but are also largely linked to the U.S. pricing structure and fragmented payment system. See David U. Himmelstein et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 HEALTH AFF. 1586, 1586 (2014) (finding hospital administrative costs linked to complex, market-oriented payment schemes accounted for 25.3% of total U.S. hospital expenditures); James G. Kahn et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals*, 24 HEALTH AFF. 1629, 1629 (2005) (estimating that billing and insurance-related functions represent 20% to 22% of privately insured spending in California acute care settings).

39. See Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 92 (2015) (noting that “[h]ealth care prices in the United States are excessive and inexplicable”).

40. See Anderson et al., *supra* note 37, at 90–91.

those charged in the United States.⁴¹

But what causes these higher prices? One factor is income. The United States has a higher per capita income compared to other countries. Indeed, higher national income—as expressed in Gross Domestic Product (GDP) per capita—explains some, but not all, of the difference in spending between the United States and its peer countries.⁴² If GDP per capita were the only factor responsible for the spending difference between the United States and other Organisation for Economic Co-operation and Development (OECD) countries, however, we would be spending roughly 72% of what we spend now.⁴³

What, then, is responsible for the remaining price difference between the United States and its peer nations? Market failure. The U.S. healthcare market is plagued by widely recognized market failures⁴⁴ that undermine consumer welfare,⁴⁵ and justify government intervention in the market.⁴⁶ The three most prominent market failures leading to excessive provider prices appear to be

41. See KAREN DAVIS ET AL., COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY 26 (2014), http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf (“Although the U.S. spends more on health care than any other country . . . survey findings indicate that from the patients’ perspective, and based on outcome indicators, the performance of American health care is severely lacking.”).

42. See Uwe E. Reinhardt, *Why Does U.S. Health Care Cost So Much? (Part I)*, N.Y. TIMES: ECONOMIX (Nov. 14, 2008, 7:30 AM), http://economix.blogs.nytimes.com/2008/11/14/why-does-us-health-care-cost-so-much-part-i/?_r=0 (noting “there exists a very strong relationship between the G.D.P. per capita of [OECD] countries (roughly a measure of ability to pay) and per-capita health spending”).

43. *Id.* But, even if GDP per capita explained the difference in price, the difference still would not be justified, given the fact that the United States does not enjoy any greater benefit from the higher prices it pays. See DAVIS ET AL., *supra* note 41, at 7.

44. The term “market failure” is widely used, but rarely explained. Market failure has its roots in microeconomic theory and describes a situation in which a distribution of goods and/or services is not efficient from a societal perspective. The first fundamental theorem of welfare economics holds that the economy is Pareto optimal (when it is not possible to improve the well-being of any one person without making others worse off) only under certain conditions, including, but not limited to, perfectly competitive markets, no externalities, low transaction costs, and perfect information. When one or more of these conditions is absent, a market can fail and government intervention may be justified to promote efficiency. JOSEPH E. STIGLITZ, *ECONOMICS OF THE PUBLIC SECTOR* 77–84 (3d ed. 2000). Kenneth J. Arrow provides the seminal treatment of healthcare market imperfections. See generally Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). For a more recent discussion of healthcare market imperfections, see David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, in 1B HANDBOOK OF HEALTH ECONOMICS 1093, 1095–96 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000). For a discussion of market failure specific to hospital pricing, see Brown, *supra* note 39, at 88.

45. See Arrow, *supra* note 44, at 947 (“The failure of one or more of the competitive preconditions has as its most immediate and obvious consequence a reduction in welfare below that obtainable from existing resources and technology, in the sense of a failure to reach an optimal state in the sense of Pareto.”).

46. See STIGLITZ, *supra* note 44, at 77 (explaining that the government can adopt market correcting interventions in response to market failures).

informational asymmetries, moral hazard, and the excessive market power of providers.⁴⁷

A. *Informational Asymmetries*

Information problems are pervasive in the healthcare market and are present not only during medical encounters between patients and physicians, but also when consumers purchase health insurance.

1. Information Deficits Related to Diagnosis and Treatment

Consumers lack information about their medical conditions and therefore must rely on medical care providers with superior knowledge. As Kenneth Arrow noted, information asymmetry in the healthcare market results from two basic facts of medical treatment: “the existence of uncertainty in the incidence of disease and in the efficacy of treatment.”⁴⁸ While a consumer may know she is ill, she will likely have limited (or no) information about her illness, its severity, or whether treatment is needed. Even if needed, there is also significant uncertainty in medical treatment. Medical information is highly technical, diagnoses are complex, the availability or efficacy of alternative treatments is not always clear, and the potential for complications is always present. Furthermore, patients cannot readily assess the quality of medical care providers.⁴⁹ These factors make it difficult for patients—and insurers, who typically finance treatment—to assess the necessity, value, and quality of medical services prior to a patient’s treatment. These uncertainties mean that the price paid for a particular medical treatment may not be an accurate signal of its value.⁵⁰ This not only makes it much easier for patients (and their insurers) to pay too much for treatment,⁵¹ it makes it easier for providers to provide costly but not optimal,

47. *But see* Brown, *supra* note 39, at 85–86 (including principal-agent problems among the list of market failures affecting hospital pricing); Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, 865 (2004) (noting that “agency relationships, which pervade health markets, are highly influential in health care transactions”).

48. *See* Arrow, *supra* note 44, at 941.

49. Indeed, there are few reliable sources of information on the quality of providers. *See* Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 65–66 (2006) [hereinafter Reinhardt, *Chaos*] (noting that information on price and quality are rarely available to the patient).

50. Medical services exhibit credence attributes, which means that the quality of such services cannot be fully determined even after the services have been rendered. *See* Michael R. Darby & Edi Karni, *Free Competition and the Optimal Amount of Fraud*, 16 J.L. & ECON. 67, 68–69 (1973) (“Credence qualities are those which, although worthwhile, cannot be evaluated in normal use.”); Wolfgang Pesendorfer & Asher Wolinsky, *Second Opinions and Price Competition: Inefficiency in the Market for Expert Advice*, 70 REV. ECON. STUD. 417, 417 (2003) (noting that credence services are plagued by information problems because they are “not easily or objectively measurable”).

51. *See* Gillian K. Hadfield, *The Price of Law: How the Market for Lawyers Distorts the Justice System*, 98 MICH. L. REV. 953, 968–69 (2000) (noting that “[t]heoretical work on markets for credence goods predicts that markets for credence goods may be characterized by fraud (billing for unnecessary services or services not performed) and a price mark-up over cost” (citing Asher Wolinsky, *Competition in Markets for Credence Goods*, 151 J. INSTITUTIONAL & THEORETICAL ECON. 117

or even ineffective, treatment.⁵²

2. Information Deficits and the Price of Medical Care

Consumers also lack information about the cost of medical services they receive. As Paul Starr has aptly noted, the informational “fog . . . hangs thick and low in the healthcare market.”⁵³ Not only are patients hampered in their ability to judge the value of medical services they receive, it is also difficult to obtain the prices paid for their medical services.⁵⁴ Unlike many other countries, prices for medical services in the United States are not readily available at the point of service for consumers.⁵⁵ Hospitals and other medical care providers typically do not post their prices or offer any way of comparing their prices with the prices of other providers.⁵⁶

3. Information Deficits and the Purchase of Health Insurance

Finally, health insurance erects yet another barrier between consumers and the costs of medical care. Information about the costs of medical care, as reflected in insurance premiums, is obscured. Nearly half of all Americans—about 49%—receive their health insurance through an employer.⁵⁷ The employment-based insurance system has long obscured the total costs of health insurance from employees. First, until recently, employees rarely knew how much their employers contributed to their insurance premiums. Now employer contribution must be shown on an employee’s W-2,⁵⁸ although it is not entirely clear that all employees fully understand or even notice this information. Second, an employee receives a tax subsidy since his insurance is purchased with pretax

(1995); then citing Winand Emons, *Credence and Fraudulent Experts*, 28 RAND J. ECON. 107 (1997)).

52. See Henry J. Aaron, *To Find the Answer, One Must Know the Question: Health Economics and Public Policy*, in INCENTIVES AND CHOICE IN HEALTH CARE 21, 30 (Frank A. Sloan & Hirschel Kasper eds., 2008) (“[I]f physicians are willing to do more of certain things when paid well to do them, it is hard to see why the idea that physicians might induce demand was ever controversial.”). Indeed, there is a moral hazard problem when a consumer relies on the advice of an expert—the medical care provider—in order to choose among an array of possible treatments. See *infra* Part I.B. for a discussion of moral hazard in the context of consumer choices.

53. Paul Starr, *Law and the Fog of Healthcare: Complexity and Uncertainty in the Struggle over Health Policy*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 213, 215 (2013).

54. See Kanu Okike et al., *Survey Finds that Few Orthopedic Surgeons Know the Costs of the Devices They Implant*, 33 HEALTH AFF. 103 (2014); Reinhardt, *Chaos*, *supra* note 49, at 57–58.

55. See Starr, *supra* note 53, at 217 (“It is one of the ironies of the supposedly market-oriented American system that healthcare prices are much harder to discover in the United States than they are in many countries where prices for physicians’ services are negotiated annually, posted publicly, and easily available.”); see, e.g., Jaime Rosenthal et al., *Availability of Consumer Prices from US Hospitals for a Common Surgical Procedure*, 173 JAMA INTERNAL MED. 427, 428 (2013) (finding that only 16% of hospitals studied could provide a full price quote for a total hip replacement).

56. Starr, *supra* note 53, at 215.

57. See *Health Insurance Coverage*, *supra* note 17 (select “2014” under “Timeframe” bar and select “United States” under the “Location” bar).

58. This changed in 2012 when an employee’s W-2 was required to show the employer’s contribution to his insurance. 26 U.S.C. § 6051(a)(14) (2012).

dollars.⁵⁹ Finally, the cost of the employer's share of the health insurance is largely viewed as borne by its workers in the form of foregone wages.⁶⁰

B. Moral Hazard

The mere presence of health insurance can also result in market failure. Individuals will consume more medical care, and more expensive medical care, than they would if they had to bear the full costs of such care, thereby dampening market pressures on the price of healthcare services.⁶¹ This phenomenon is known as moral hazard.⁶² Moral hazard takes two forms. First, ex ante moral hazard occurs when an insured reduces the precautions she takes for risks covered by insurance. The second form, ex post moral hazard, is more relevant to health insurance. Under this type of moral hazard, an insured consumes more covered healthcare services than she would have in the absence of insurance.⁶³ And, the aforementioned tax subsidy⁶⁴ makes the problem even worse because employees can buy more insurance than they would have been willing to buy with post-tax dollars.⁶⁵ Yet, while moral hazard can be somewhat mitigated through cost sharing, such as copays, coinsurance, or deductibles,⁶⁶ insureds are likely to be insensitive to costs—and therefore the prices charged—once they hit their cost-sharing limit.⁶⁷ And, price-insensitive consumers cannot

59. Section 106 of the Internal Revenue Code excludes employer-provided health insurance from employees' income. *Id.* § 106(a). On the other hand, individuals who purchase health insurance directly from an insurance company must pay for their insurance with after-tax dollars.

60. While employees may view health insurance as a perquisite of employment, economists maintain that employees pay for their coverage. See Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177, 178 (1989); see also James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2623 (2001) ("Although economists maintain that employer contributions to health insurance would have been added to wages and salaries, employees view insurance contributions as a supplement to, rather than a substitute for, cash compensation." (footnote omitted)). It has also been suggested that the preferential tax treatment of health insurance premiums has caused moral hazard, that is, the purchase of too much health insurance. See Mark V. Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 J. ECON. LITERATURE 629, 641 (1986) [hereinafter Pauly, *Taxation*] ("The effect of a tax subsidy then is to push the market away from even a second best optimum, and make the extent of moral hazard (and welfare loss) greater than would occur if coverage were not subsidized.").

61. See Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 533–34 (1968) [hereinafter Pauly, *Economics of Moral Hazard*].

62. For a general and highly insightful discussion of the concept of moral hazard, see Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996).

63. See Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251, 258–59 (1987) (finding that people are more likely to consume healthcare services when their health insurance coverage provides for lower out-of-pocket expenditures); Pauly, *Economics of Moral Hazard*, *supra* note 61, at 535 ("[T]he response of seeking more medical care with insurance than in its absence is a result not of moral perfidy, but of rational economic behavior. Since the cost of the individual's excess usage is spread over all other purchasers of that insurance, the individual is not prompted to restrain his usage of care.").

64. See *supra* Part I.A.3 for a discussion of this tax subsidy.

65. Pauly, *Taxation*, *supra* note 60, at 641.

66. Pauly, *Economics of Moral Hazard*, *supra* note 61, at 534.

67. See James C. Robinson & Kimberly MacPherson, *Payers Test Reference Pricing and Centers*

be expected to hold provider prices down. As Kenneth Arrow noted, “Insurance removes the incentive on the part of individuals, patients, and physicians to shop around for better prices for hospitalization and surgical care.”⁶⁸ Since consumers are insensitive to provider prices above cost sharing, prices are generally hidden from consumers, and since health insurance is usually subsidized by employers and through tax treatment, excess prices charged by providers are neither a concern to consumers when they receive covered medical care nor a consideration when they purchase health insurance.⁶⁹

C. Market Power

The third contributor to market failure is the market power of providers. Organized physician groups, large medical centers, and other powerful providers wield considerable market clout when negotiating with health insurers, leading to highly favorable payment rates⁷⁰ that then push up insurance rates.⁷¹ Much of this market power is the result of consolidation in the medical industry. Other factors contribute to this market power as well. Regardless of the reason behind the market power, the bottom line is this: providers with market power command supracompetitive prices, and the higher prices demanded by providers account for a significant portion of the increases in health insurance premiums.

1. Market Consolidation

Since the 1990s, U.S. hospital markets have become significantly more concentrated,⁷² with nearly half of all hospital markets considered “highly concentrated,” as measured by the Herfindahl-Hirschman Index (HHI).⁷³

of Excellence to Steer Patients to Low-Price and High-Quality Providers, 31 HEALTH AFF. 2028, 2029 (2012).

68. Arrow, *supra* note 44, at 962.

69. See ANN TYNAN ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE, RESEARCH BRIEF NO. 7, A HEALTH PLAN WORK IN PROGRESS: HOSPITAL-PHYSICIAN PRICE AND QUALITY TRANSPARENCY 4 (2008), <http://www.hschange.com/CONTENT/1008/1008.pdf>; Robinson & MacPherson, *supra* note 67.

70. E.g., Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 699–701, 703–04 (2010) [hereinafter Berenson et al., *Provider Clout*] (noting that in California some large and powerful physician groups can “demand fee increases on the order of double digits annually” (quoting a health plan executive)).

71. Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012) [hereinafter Berenson et al., *The Growing Power*] (emphasizing that “hospital and physician payment rate increases that outpace the rate of cost increases are major contributors to rising premiums for employer-sponsored insurance”).

72. William B. Vogt, *Hospital Market Consolidation: Trends and Consequences*, EXPERT VOICES (Nov. 2009), http://www.nihcm.org/pdf/EV-Vogt_FINAL.pdf. Provider consolidation appears to have been a response to the financial pressures of managed care, but a causal link has not been firmly established. *Id.* The path for hospital consolidations was paved by a string of antitrust court decisions unfavorable to the federal government and a lapse in antitrust enforcement beginning in the 1990s. Greaney, *supra* note 47, at 857.

73. David Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1966 (2013). The HHI is a commonly used measure of market concentration. See U.S.

Indeed, most large metropolitan areas have highly concentrated hospital markets.⁷⁴ Unsurprisingly, hospitals in concentrated markets charge significantly higher prices and earn significantly higher margins from private insurers than hospitals in competitive markets.⁷⁵

Likewise, physicians in concentrated markets also charge higher prices.⁷⁶ Although the overall market for physicians is not concentrated, certain markets for physician services are very concentrated. For example, “markets for specialists are fairly to highly concentrated.”⁷⁷ Also, physician practices are much more concentrated in some areas of the country than in others.⁷⁸ This is no accident. “[H]ospitals and physicians have become increasingly sophisticated in developing organizational forms primarily to increase their negotiating clout with health plans.”⁷⁹ As a result, hospitals and physicians can command greater prices from health insurers since those providers can threaten to walk away from an insurer’s network, which could cause significant harm to the profitability of the health insurer.⁸⁰ The increases they can demand are significant, sometimes

DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES § 5.3 (2010), <http://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf>; Neil B. Cohen & Charles A. Sullivan, *The Herfindahl-Hirschman Index and the New Antitrust Merger Guidelines: Concentrating on Concentration*, 62 TEX. L. REV. 453, 459–60 (1983).

74. Stephen Zuckerman & John Holahan, *Despite Criticism, The Affordable Care Act Does Much to Contain Costs*, URB. INST. HEALTH POL’Y CTR., Oct. 2012, at 1, 2, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412665-Despite-Criticism-The-Affordable-Care-Act-Does-Much-to-Contain-Health-Care-Costs.PDF> (noting that 88% of hospital markets in large metropolitan areas are highly concentrated).

75. See AM.’S HEALTH INS. PLANS, DATA BRIEF: IMPACT OF HOSPITAL CONSOLIDATION ON HEALTH INSURANCE PREMIUMS 4–5 (2015), <https://www.ahip.org/Epub/Impact-of-Hospital-Consolidation/> (providing empirical evidence showing a positive correlation between health insurance premiums and the degree of hospital concentration); James C. Robinson, *Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology*, 17AM. J. MANAGED CARE e241, e241 (2011) (finding that hospitals in concentrated markets charge significantly higher prices and earn significantly higher margins from private health insurers than their counterparts in competitive markets).

76. Abe Dunn & Adam Hale Shapiro, *Do Physicians Possess Market Power?*, 57 J.L. & ECON. 159, 186 (2014) (finding that physicians in the most highly concentrated markets will charge fees that are 14% to 30% higher than physicians in the least concentrated markets). However, physician service prices are affected “by the relative degree of bargaining power between physicians and insurance carriers.” *Id.* at 161–62.

77. Martin Gaynor et al., *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235, 241 (2015).

78. E.g., John E. Schneider et al., *The Effect of Physician and Health Plan Market Concentration on Prices in Commercial Health Insurance Markets*, 8 INT’L J. HEALTH CARE FIN. & ECON. 13, 21, 23 (2008) (finding that most counties in California have highly concentrated markets for physician organizations).

79. See Berenson et al., *Provider Clout*, *supra* note 70, at 701.

80. See *id.*; see also WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 9, HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 4 (2006), <https://folio.iupui.edu/bitstream/handle/10244/520/no9researchreport.pdf?sequence=2> (noting a strong correlation between hospital market concentration and rising costs of health insurance). Some insurers have even acceded to oppressive (and ultimately illegal) payment terms due to a hospital system’s market power. See, e.g., Blue Cross &

20% to 50%.⁸¹

2. Other Factors Contributing to Provider Market Power

Even in unconcentrated markets, so-called “must-have” providers can command higher prices. Must-have providers are hospitals and physician groups that insurers must include in their provider network in order to attract and retain customers. These must-have providers have market leverage over health insurers for reasons other than their size or the level of market concentration. For example, providers that offer specialized services or possess sterling reputations can often demand higher prices.⁸² Also, factors unrelated to any specific provider can sometimes create must-have providers. These factors include the presence of “any willing provider” laws,⁸³ the unwillingness of consumers to accept narrow networks, and a dwindling supply of hospital beds and physicians in some markets.⁸⁴ As a result, health insurers cannot exclude must-have

Blue Shield of R.I., OHIC-2011-5 ¶ 4.a. (R.I. Health Ins. Comm’r Oct. 11, 2011) (final admin. order) [hereinafter Blue Cross Final Order], <http://www.ohic.ri.gov/documents/Targeted-Market-Conduct-Exam-Order-BCBS-and-Care-New-England.pdf>. In the Blue Cross Final Order, the Rhode Island Health Insurance Commissioner accepted a market conduct examination report regarding BCBS. *Id.* ¶¶ 3–5. In doing so, the Commissioner noted that the hospitals in the Care New England system had

the bulk of the state’s maternity beds, provide high risk pregnancy and neonatal services not otherwise available in Rhode Island, employ many obstetricians and gynecologists in the Blue Cross network, and operate the state’s only general psychiatric hospital. These factors appear to have combined to give Care New England a significant level of bargaining power in its negotiations with Blue Cross. As a result, Blue Cross simply could not walk away from the Agreements

Id. ¶ 4.a. Portions of the agreements were found to be illegal. *Id.* ¶¶ 6, 12–14, 21. The author of this Article coauthored the examination report.

81. See MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., SYNTHESIS REPORT UPDATE, THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE 2 (2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261 (“The magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent.”); Berenson et al., *Provider Clout*, *supra* note 70, at 702 (recognizing these demanded increases); Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088, 1089 (2014) (“Hospital mergers that create a dominant system can lead to very large price increases, even as high as 40–50 percent.”).

82. These specialized services include level one trauma centers, burn centers, organ transplant facilities, and children’s hospitals, which in most markets do not have effective competition for their specialized services. Berenson, *Pricing Power*, *supra* note 37, at 721; see, e.g., Blue Cross Final Order, *supra* note 80, ¶ 4.a. (administrative adjudication involving a must-have provider that offered the state’s only high risk pregnancy and neonatal services).

83. “Any willing provider” statutes prohibit health insurers from excluding providers from the insurer’s provider networks, so long as a provider is willing and able to meet the insurer’s conditions of network participation. Ashley Noble, *Any Willing or Authorized Providers*, NAT’L CONF. ST. LEGISLATORS (Nov. 5, 2014), <http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx>. Currently, twenty-seven states have “any willing provider” statutes. *Id.* Many of these statutes apply only to pharmacies, pharmacists, or allied professionals, including chiropractors, optometrists, psychologists, and social workers. *Id.* However, fourteen states apply the statute to physicians, hospitals, or both. *Id.*

84. See *id.*

providers without risking a loss of customers.⁸⁵ And, if an insurer cannot exclude certain providers from its network because of customer demands, the insurer loses its ability to resist those providers' demands for higher payment rates.

D. *Market Failure and Higher Prices*

These market failures have clear consequences. U.S. hospitals charge higher prices for most services than do hospitals in peer countries. Likewise, physician fees and incomes are substantially higher in the United States than in peer countries for both primary care physicians and specialists.⁸⁶ Private payers in the United States pay 70% higher fees to U.S. primary care physicians for office visits and 120% more to orthopedic physicians for hip replacements than private payers in peer countries.⁸⁷ Primary care and orthopedic physicians also earn higher incomes (\$186,582 and \$442,450, respectively) than their foreign counterparts,⁸⁸ with this higher income a function of higher prices charged rather than increased use of services.⁸⁹ And, despite these higher prices, health outcomes in the United States are no better, and in many cases worse, than those in peer countries where the prices of healthcare goods and services are lower.⁹⁰

All of these factors confound the ability of the market to control medical care prices, and, as a result, health insurance rates.⁹¹

E. *Can Costs Be Controlled?*

The asymmetries of information associated with healthcare services, including the difficulty of identifying prices, the moral hazard associated with insurance, and the market power of providers vis-à-vis insurers together form a potent recipe for market failure and excessive provider prices. But, these causes of market failure in the healthcare marketplace are difficult to correct, even in the long run. Asymmetric information is an intractable problem in healthcare.

85. See Berenson et al., *Provider Clout*, *supra* note 70, at 702.

86. See Miriam J. Laugesen & Sherry A. Glied, *Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries*, 30 HEALTH AFF. 1647, 1650–51 (2011) (comparing physicians' fees paid by public and private payers for primary care office visits and hip replacements in Australia, Canada, France, Germany, the United Kingdom, and the United States).

87. *Id.* at 1647.

88. *Id.* at 1652–53.

89. *Id.* at 1654 (“[H]igher US incomes do not appear to be due to a higher volume of services. . . . This relationship suggests that higher fees, rather than higher practice costs, volumes, or tuition expenses, are the main driver of higher US spending in these two areas.”).

90. See DAVIS ET AL., *supra* note 41, at 25 (citing studies that find “that the U.S. lags in health outcomes despite spending so much more than other countries on health care”).

91. See, e.g., 2010 MASSACHUSETTS AG REPORT, *supra* note 38 (finding that “[p]rice increases, not increases in utilization, caused most of the increases in health care costs . . . in Massachusetts”); VOGT & TOWN, *supra* note 80, at 4 (noting a strong correlation between hospital market concentration and rising costs of health insurance); Berenson et al., *Provider Clout*, *supra* note 70, at 704 (finding that provider market power has pushed California health insurance premium trends upward); Berenson et al., *The Growing Power*, *supra* note 71, at 973 (arguing that “hospital and physician payment rate increases that outpace the rate of cost increases are major contributors to rising premiums for employer-sponsored insurance”).

Even if more information about prices and quality measures were made available to consumers, information problems related to diagnoses and the variety and efficacy of available treatments would still exist. Also, employer-based health insurance will continue to obscure the real costs of health insurance due to employer premium contributions and the preferential federal tax treatment afforded health insurance benefits. The moral hazard associated with insurance can be reduced only partially by cost sharing. Insureds will remain indifferent to the price of healthcare services above cost-sharing limits. To the extent that providers have already consolidated, more robust antitrust enforcement going forward will not undo existing concentrated markets.⁹² And, must-have and specialty providers will be able to command higher prices, regardless of the level of provider concentration. All of this suggests that some form of regulatory action is needed to correct for the upward price distortions in the market for medical services.⁹³ There is, in fact, a growing chorus of legal scholars, health policy scholars, and economists who suggest that some form of price-setting may be the best response to high prices.⁹⁴ The approach typically suggested is an independent, Maryland-style, all-payer, price-setting commission that sets hospital prices for all payers—private insurers, Medicare, and Medicaid.⁹⁵ But, there is another alternative that is never discussed: a more robust health insurance rate review process, updated from its antiquated property-casualty origins to counteract market failures that afflict the contemporary marketplace for health insurance.⁹⁶

There are many reasons why using rate review to accomplish this goal is more preferable than simply price setting. Using rate review would be more flexible than an across-the-board price-setting approach. It could be configured to address local market problems and could adapt to changing conditions. It would also be more efficient insofar as it could leverage the existing state administrative apparatuses and the expertise of state insurance departments. No

92. Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 27–28 (2014); Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 871 (2011).

93. See STIGLITZ, *supra* note 44, at 77 (explaining that the government can adopt market correcting interventions in response to market failures).

94. See, e.g., Brown, *supra* note 39, at 138 (concluding that price regulation “must be a central part of any policy strategy to control health care spending”); Cutler & Morton, *supra* note 73, at 1969 (“A third approach, if there is no other way to obtain good care except through monopoly organizations, is for policy makers to regulate prices or total spending.”); Theodore Marmor et al., *The Obama Administration’s Options for Health Care Cost Control: Hope Versus Reality*, 150 ANNALS INTERNAL MED. 485, 486–87 (2009); Joseph P. Newhouse, *Assessing Health Reform’s Impact on Four Key Groups of Americans*, 29 HEALTH AFF. 1714, 1723 (2010) (“Despite all of the substantive and political problems of price setting, some sort of all-payer regulatory regime may be the only feasible alternative.”); Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125, 2129 (2011).

95. For a brief overview of the Maryland price-setting system, see ANNA S. SOMMERS ET AL., NAT’L INST. FOR HEALTH CARE REFORM, POLICY ANALYSIS NO. 9, ADDRESSING HOSPITAL PRICING LEVERAGE THROUGH REGULATION: STATE RATE SETTING 2–4 (2012), <http://www.nihcr.org/1t192>.

96. See *infra* Part II.B for a discussion of the rate review process’s property-casualty origins.

new state agency would need to be created.⁹⁷ But, in order to understand the capacity of rate review to address health insurance market failures related to the prices of medical goods and services, it is first necessary to understand how health insurance rates are developed, the origins (and limitations) of rate review, and the ACA's expanded rate review process.

II. RATEMAKING AND RATE REVIEW PRIOR TO THE ACA

A. Health Insurance Ratemaking

Health insurance rates, like all other insurance rates, are only estimates. An insurance product is unlike most other products offered for sale because the cost of insurance is not known in advance, but can be determined only after all claims have been paid.⁹⁸ Because future claims costs cannot be known at the time future rates (that is, rate increases) are developed, health insurance rate increases are determined through an exceedingly complex process in which healthcare trend factors and other rating factors are projected onto past claims experience (the insured pool's past claims information). Healthcare trend factors reflect the annual rate of change in the price and utilization of various healthcare goods (such as pharmaceuticals) and services (such as physician and hospital inpatient services).⁹⁹ These trend factors represent the underlying medical cost of health insurance and are typically responsible for the largest part of rate increases.¹⁰⁰

A host of other factors also affect rate increases. These include benefit design changes (such as changes to covered benefits and cost sharing), changes in the covered population (such as an increase in average age or expected morbidity¹⁰¹), the impact of legislative and regulatory changes (such as regulatory fees, taxes, and new mandated health benefits¹⁰²), changes to provider networks,¹⁰³ as well as other factors unrelated to the cost of healthcare, such as

97. See *infra* Section V for a deeper analysis of whether or not rate review requires the creation of new state agencies.

98. GEOFF WERNER & CLAUDINE MODLIN, CAS. ACTUARIAL SOC'Y, BASIC RATEMAKING 1 (4th ed. 2010), http://www.casact.org/library/studynotes/Werner_Modlin_Ratemaking.pdf.

99. AON HEWITT, 2011 HEALTH INSURANCE TREND DRIVER SURVEY 5–6 (2011), http://www.aon.com/attachments/thought-leadership/2011_Health_Insurance_Trend_Driver_Survey.pdf.

Healthcare trend represents the underlying medical cost component of a health insurance premium increase. *Id.* The trend is also affected by changes in the underlying makeup of the covered group. *Id.*

100. *Id.* Due to differences in the price, delivery, and consumption of healthcare services, trend can vary across market segments, across regions of the United States, and across different provider networks. *Id.*

101. Changes in age (average claims costs increase with age), *id.* at 6–7, and expected morbidity (the expected instances of illness or injury for a given group over a given period) affect rates by increasing or decreasing expected claims costs.

102. Mandated health benefits, typically enacted under state law, refer to medical services that “must be covered by a health insurance policy” or medical providers that must be reimbursed under a health insurance policy. Amy B. Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 145.

103. MARK NEWSOM & BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41588,

an insurer's need to increase its contribution to reserves,¹⁰⁴ its investment income,¹⁰⁵ and adjustments for prior inadequate rates.¹⁰⁶

Yet, while the actual process of developing health insurance rates is highly complicated, one need not be an actuary to understand the fundamental components of health insurance rates. Indeed, health insurance ratemaking is conceptually simple. Health insurance rates result from actuarial estimates of the expected cost of covering a particular pool of individuals under a contract for certain health benefits for a particular period of time. In general, health insurance rates represent the estimated amount that would be required to cover two major cost components: (1) the expected medical claims cost (typically 80% to 90% of the rate), which I will refer to as the medical cost component;¹⁰⁷ and (2) the administrative costs of providing the coverage (including a profit margin).¹⁰⁸ The second component is generally referred to as the loading charge.¹⁰⁹

Insurance rates, however, have not always been developed using highly technical methods. In the 1800s, insurance rates, particularly fire insurance rates, were often developed haphazardly,¹¹⁰ resulting in financial instability for the insurance industry.¹¹¹ This instability led directly to rate review.

B. *The Origins of Rate Review*

1. Property-Casualty Rate Review

Rate review¹¹² arose not as a way to ensure lower insurance rates, but instead as a response to collective market action in the late 1800s and early 1900s

PRIVATE HEALTH INSURANCE PREMIUMS AND RATE REVIEWS 5 (2011), http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1793&context=key_workplace; AON HEWITT, *supra* note 99, at 6–9.

104. See MEIER, *supra* note 14, at 45.

105. See *id.* at 189 n.4 (providing an example of investment income as a percentage of premium for various lines of insurance).

106. See AON HEWITT, *supra* note 99, at 8.

107. The medical cost component may be thought of as the actuarial cost of providing health insurance. Paul J. Feldstein & Thomas M. Wickizer, *Analysis of Private Health Insurance Premium Growth Rates: 1985–1992*, 33 MED. CARE 1035, 1036 (1995).

108. *Id.*; WERNER & MODLIN, *supra* note 98, at 204.

109. See Feldstein & Wickizer, *supra* note 107, at 1036–42.

110. See Spencer L. Kimball & Ronald N. Boyce, *The Adequacy of State Insurance Rate Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 MICH. L. REV. 545, 547–48 (1958) (describing the history of local and regional ratemaking boards, the creation of the National Board of Fire Underwriters, and local compacts).

111. *Id.* at 548.

112. Scholarly treatments and court decisions generally refer to the review of filed insurance rates as “rate regulation.” *E.g.*, *German All. Ins. Co. v. Lewis*, 233 U.S. 389, 414–18 (1914). The ACA uses the term “rate review” to describe the process of reviewing health insurance rates. I have adopted this term to distinguish the process by which insurance regulators review health insurance rates from other types of regulatory controls over rates, such as restrictions on ratemaking, which place restrictions on the variables insurers can use when determining rates.

in the property-casualty industry, particularly the market for fire insurance.¹¹³ Cartels, industry associations, and ratemaking bureaus formed to combat market failure due to a destructive boom-and-bust cycle in the fire insurance industry.¹¹⁴ When there were no fires, the business of fire insurance was very profitable. This profitability spurred competition from new market entrants, which pushed premiums downward. This problem was exacerbated by the use of independent agents to sell policies.¹¹⁵ With little incentive to avoid bad risks, agents freely issued policies to increase their commissions. As a result, insurers were saddled with insufficient premiums and bad risks.¹¹⁶ When large local fires occurred,¹¹⁷ fire insurers without sufficient reserves were unable to pay the losses they incurred from claims.¹¹⁸ Consequently, insurers developed a strategy of collusion to address the problem of inadequate rates.¹¹⁹ Although this strategy was not wholly successful due to defections by some insurers who undercut established prices,¹²⁰ this collusion led to the first rate review law in 1909, when Kansas granted its insurance commissioner the authority to order changes in excessive or unjust rates.¹²¹

The Kansas law and those that followed typically gave state insurance commissioners the power to order changes in insurance rates or ratemaking practices, but also allowed insurers to engage in cooperative ratemaking through the use of rating bureaus or associations.¹²² The result was “regulated

113. The early property-casualty market in the United States was limited mainly to fire insurance. MEIER, *supra* note 14, at 50.

114. Although insurance price-fixing began in the early 1800s, it did not become widespread until after the Civil War. See Kimball & Boyce, *supra* note 110, at 548–49 (describing the history of local and regional rate making boards, the creation of the National Board of Fire Underwriters, and local compacts). For an overview of the early history of the U.S. fire insurance industry, see F. C. Oviatt, *Historical Study of Fire Insurance in the United States*, 26 ANNALS AM. ACAD. POL. & SOC. SCI. 155 (1905).

115. MEIER, *supra* note 14, at 52.

116. *Id.* at 51–52.

117. Large urban fires were common in the 1800s. See Marc Schneiberg & Tim Bartley, *Regulating American Industries: Markets, Politics, and the Institutional Determinants of Fire Insurance Regulation*, 107 AM. J. SOC. 107, 112 (2001) (noting that “[n]early every U.S. city burned from 1820 to 1915, yielding 40 major conflagrations, like the burning of New York in 1835 and the great Chicago fire of 1871”).

118. See MEIER, *supra* note 14, at 51–52.

119. *Id.*

120. *Id.* at 52.

121. Tim Bartley & Marc Schneiberg, *Rationality and Institutional Contingency: The Varying Politics of Economic Regulation in the Fire Insurance Industry*, 45 SOC. PERSP. 47, 58 (2002). These laws followed a wave of anti-compact laws passed mainly in Midwestern states, but also a few elsewhere, from the 1890s to 1910, that represented an effort to block collusion by insurers. *Id.* at 53–54. Almost immediately after passage of the Kansas law, the state’s superintendent of insurance ordered a rate reduction. *Id.* at 58. This prompted a legal challenge that resulted in the U.S. Supreme Court decision *German Alliance Ins. v. Lewis*, 233 U.S. 389 (1914). *Id.* The Supreme Court ruled that because fire insurance was “affected with a public interest,” states had the right to regulate insurance rates. *Lewis*, 233 U.S. at 408. The decision effectively endorsed the “regulated cooperation” approach to insurance rate collusion. Bartley & Schneiberg, *supra* note 121, at 58.

122. See Bartley & Schneiberg, *supra* note 121, at 58–59.

cooperation,” through which insurers collectively set rates that were subject to state oversight.¹²³ By 1930, thirty-three states had enacted some form of rate review in the property-casualty market.¹²⁴ Rate review and regulated cooperation also ushered in the use of objective and generally accepted rating standards,¹²⁵ leading to the development of statistically sound rates based on reliable claims and cost data.¹²⁶ This more rigorous approach to ratemaking allowed state regulators to evaluate rates objectively.¹²⁷

This mode of regulation continued until 1944, when the federal government entered the field of insurance regulation. Prior to 1944, the business of insurance had been considered outside the scope of interstate commerce and therefore was not subject to federal regulation, including antitrust laws.¹²⁸ In 1944, however, the Supreme Court, in *United States v. South-Eastern Underwriters Ass'n*,¹²⁹ found the Sherman Antitrust Act¹³⁰ applicable to insurance. In response to *South-Eastern Underwriters*, Congress enacted the McCarran-Ferguson Act (MFA) in 1944, granting insurers a partial exemption to allow continued pooling of claims data and joint premium development,¹³¹ conditioned on state oversight of the insurance industry.¹³² Thereafter, nearly every state enacted a form of rate

123. *See id.*

124. *Id.* at 48.

125. *Id.* at 59.

126. The principle of “regulated cooperation” emerged during an unprecedented shift in the insurance market:

Even as the principle of regulated cooperation emerged, its viability hinged on firms’ and regulators’ ability to set and judge rates according to an objective and generally accepted set of standards. Absent such a system, companies could not justify their rate-making practices, regulators could not evaluate rate conflicts, and consumers lacked the reliable safeguards necessary for them to endorse rate making by company associations.

Id.

127. *Id.* at 59–60.

128. *See Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183–85 (1868) (holding that Congress’s power to regulate interstate commerce did not include insurance, thereby precluding action against insurance companies under antitrust law enacted pursuant to Congress’s authority to regulate interstate commerce), *overruled in part by United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944).

129. 322 U.S. 533 (1944), *superseded by statute*, McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (1945), *as recognized in Barnett Bank of Marion Cty., N.A. v. Nelson*, 517 U.S. 25 (1996). According to the indictment, the South-Eastern Underwriters Association controlled 90% of fire and other insurance markets in six southern states, fixed and maintained arbitrary and noncompetitive premium rates in those markets, and maintained an illegal monopoly. The case focused on whether or not insurance was a type of interstate commerce that should fall under the Commerce Clause and the Sherman Antitrust Act. *South-Eastern Underwriters*, 322 U.S. at 534.

130. 15 U.S.C. §§ 1–7 (2012).

131. *See Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 222 (1979) (noting that the MFA was meant to protect “intra-industry cooperative or concerted activities” related to risk).

132. As it turns out, however, state regulation did not have to be effective. *See Sylvia A. Law & Barry Ensminger, Negotiating Physicians’ Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 63 (1986) (“While the history of the [McCarran-Ferguson] Act might have supported a requirement that state regulation be effective, the Court declined to impose such a limit and affirmed the Act’s broad deference to state regulation of insurance, whatever form it

review legislation.¹³³

2. The Rate Review Standard

The rate review standard that developed post-MFA is still the standard widely used today, for both property-casualty and health insurance. Insurance rates are generally reviewed to ensure they are adequate, not excessive, and not unfairly discriminatory.¹³⁴ The requirement for “adequate” rates is rooted in the history of fire insurance in the 1880s and fears that insurers will charge inadequate premiums to gain business. This standard requires that premiums be sufficiently high to ensure the solvency of an insurer that experiences a high level of claims.¹³⁵ The “not excessive” requirement was designed to blunt the ability of insurers to set supracompetitive rates, given continued rate setting cooperation among property-casualty insurers.¹³⁶ The “unfairly discriminatory” standard was intended to promote equity among insureds by ensuring that rates reflected actual risk, rather than other factors such as unjustified discounts. In other words, similar risks must be charged similar rates.¹³⁷ Thus, the “adequate, not excessive, and not unfairly discriminatory” standard reflects governmental concerns about the property-casualty insurance rating practices of a century ago and embeds those concerns in current insurance regulation. Rate review focuses

took.” (citing *FTC v. Nat’l Cas. Co.*, 357 U.S. 560, 564 (1958))). The ACA attempts to change this approach to state regulation by imposing its own effectiveness standards—albeit weak effectiveness standards—on the rate review process. *See infra* Part III.A.2.

133. *See* MEIER, *supra* note 14, at 72–76 (describing the development and adoption of model rate review laws by the National Association of Insurance Commissioners and the adoption of rate review laws by the states). Illinois was the only state that did not enact rate regulation. Stephen P. D’Arcy, *Insurance Price Deregulation: The Illinois Experience*, in *DEREGULATING PROPERTY-LIABILITY INSURANCE: RESTORING COMPETITION AND INCREASING MARKET EFFICIENCY* 248, 248 (J. David Cummins ed., 2002).

134. *See, e.g.*, CONN. GEN. STAT. ANN. § 38a-481(b) (West 2016) (health insurance); *see also State Approval of Health Insurance Rate Increases*, NAT’L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/health-insurance-rate-approval-disapproval.aspx> (last updated Aug. 2015) (“[Health insurance rate review] statutes typically grant authority similar to Connecticut’s example: ‘The commissioner may refuse such approval if he finds such amounts to be excessive, inadequate or discriminatory.’”).

135. Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 482–83 (1961). In light of modern solvency requirements imposed on insurers by state insurance regulators, the requirement for “adequate” rates is viewed by some as “a historical relic.” *E.g.*, ABRAHAM & SCHWARCZ, *supra* note 14, at 117. *But see* Blue Cross Blue Shield of R.I., OHIC-2015-1, 2 (R.I. Health Ins. Comm’r Aug. 19, 2015) (amended order), <http://www.ohic.ri.gov/documents/DirectPay2015-Amended-Order-and-Decision-20150819.pdf> (approving higher rates to ensure the insurer adequately contributes to reserves).

136. Kimball, *supra* note 135, at 491.

137. *Id.* at 495. To the extent that insurers base premiums on the riskiness of each insured, insurers will always discriminate in terms of price. Insurers do so to avoid adverse selection and moral hazard problems. ABRAHAM & SCHWARCZ, *supra* note 14, at 133–34. The requirement that rates not be unfairly discriminatory, however, is designed to ensure that rate discrimination is based on information about an insured’s characteristics that correlate with expected losses. *Id.* at 134. Judgments about unfairly discriminatory rates can also involve consideration of social values. *Id.* at 135.

on past claims experience (as well as changes to the cost of claims over time due to inflation) to confirm that an insurer's proposed rates will cover expected losses and administrative costs, keep the insurer solvent, and prevent it from charging arbitrary rates. Rate review typically does not concern itself with any other nonactuarial factors or market conditions, including those that drive underlying claims costs. In essence, it is a regulatory "second opinion" about the judgments and data used by an insurer to develop its rates and a review of the insurer's rate calculations.¹³⁸

C. *Health Insurance Rate Review Prior to the ACA*

Although the rate review standard ("adequate, not excessive, and not unfairly discriminatory") was historically the same for property-casualty and health insurance, that standard has never been uniformly applied to all segments of the health insurance market. The ACA continues this practice. In order to understand why rate review has not been uniformly applied in the health insurance market, it is first necessary to understand the geography of the health insurance market.¹³⁹ The U.S. private health insurance market is hyperfragmented; there are not only divisions within and across states, but also divisions created by federal law. These divisions establish the boundaries for rate review by segregating purchasers of health insurance by risk, by law, and by jurisdiction.

First, every state constitutes a separate market, governed by its own insurance laws (although there is some level of uniformity due to adoption of model laws promulgated by the National Association of Insurance Commissioners¹⁴⁰ and federal laws, such as the Health Insurance Portability and Accountability Act of 1996¹⁴¹) and subject to oversight by its own insurance department, with its own resource constraints and practices. Contained within each state market are three fully insured¹⁴² submarkets: the large group, small group, and individual markets. Each of these submarkets represents different classes of risk, and each is governed by different economic considerations and

138. See *supra* notes 20–21 and accompanying text.

139. For a description of the regulatory landscape of the highly fragmented health insurance market in terms of its "geography," see Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries*, 19 HEALTH AFF. 173, 173 (2000).

140. For an overview of the role of the National Association of Insurance Commissioners (NAIC) in developing model insurance laws, see Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 640–60 (1999).

141. Pub. L. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of U.S.C. 29). For a brief overview of the major pre-ACA federal laws governing health insurance, see TIMOTHY STOLTZFUS JOST, *THE REGULATION OF PRIVATE HEALTH INSURANCE* 25–30 (2009), https://www.nasi.org/usr_doc/The_Regulation_of_Private_Health_Insurance.pdf.

142. An employer health plan is fully insured if the employer purchases a health insurance policy from a licensed health insurer. In exchange for a premium payment by the employer, the insurer bears the full risk for all claims covered by the health insurance policy.

regulations.¹⁴³ There are also self-insured employer groups, which do not purchase health insurance from an insurance company but instead provide an insurance-like plan to their employees by directly bearing (at least some of) the cost of the medical goods and services consumed by those employees.¹⁴⁴ Most, but not all, self-insured plans are exempt from state regulation.¹⁴⁵ Each of these different markets is more fully discussed below.

1. The Fully Insured Markets

- a. *The Large Group Market*

The large group market,¹⁴⁶ which covers employers with more than fifty employees,¹⁴⁷ is the largest segment of the fully insured market, covering about 48 million employees and their dependents.¹⁴⁸ Large groups “enjoy economies of scale and purchasing power,” which results in very low administrative costs.¹⁴⁹ The size of the group also provides some protection against rate volatility. In other words, one or two very sick employees (or covered dependents) will not significantly affect future costs for the group because of the group’s size.¹⁵⁰ Finally, large groups, with their dedicated human resources staff (i.e., a company’s human resources department) are perceived as sophisticated and able

143. Hall, *supra* note 139, at 173.

144. This contractor is also known as a third-party administrator, or TPA.

145. See *infra* Part II.C.2 for a discussion of self-insured employer groups.

146. Although some commenters combine fully insured and self-insured large groups for the purposes of discussion, I treat these groups separately, following state insurance codes. See, e.g., 27 R.I. GEN. LAWS ANN. §§ 27-18.6-1 to -12 (West 2016) (covering only fully insured large groups).

147. Prior to the ACA, the large employer group market consisted of employers with fifty-one or more employees, and the small employer group market consisted of employers with fifty or fewer employees. Although the ACA amended these definitions to enlarge the small employer group market to include employers with up to 100 employees as of January 1, 2016, Congress later amended the ACA to retain the original definitions of large and small group employers. Protecting Affordable Coverage for Employees Act, Pub. L. 114-60, 129 Stat. 543 (2015) (codified in scattered sections of 42 U.S.C.). For the reasons behind the change, see Timothy Jost, *PACE and EACH Acts Pass House; CMS Addresses Consumers Enrolled in Multiple Plans (Updated)*, HEALTH AFF. BLOG (Sept. 29, 2015), <http://healthaffairs.org/blog/2015/09/29/implementing-health-reform-pace-and-each-acts-pass-house-cms-addresses-consumers-enrolled-in-multiple-plans/>.

148. U.S. GOV’T ACCOUNTABILITY OFF., GAO-15-101R, PRIVATE HEALTH INSURANCE: CONCENTRATION OF ENROLLEES AMONG INDIVIDUAL, SMALL GROUP, AND LARGE GROUP INSURERS FROM 2010 THROUGH 2013, at 10 (2014), <http://www.gao.gov/assets/670/667245.pdf> (2013 figures). The GAO measured enrollment in fully insured health insurance plans by measuring covered “life-years, which represent the average number of lives insured . . . on a pre-specified day over the [twelve] months in the reporting year.” *Id.* at 3 n.14.

149. Hall, *supra* note 139, at 174. Large group plans have high medical loss ratios (MLRs), typically in the high eighties or low nineties. *Id.* In other words, the percentage of premium dollars used to pay claims was usually in the high eighties to low nineties. For an overview of the MLR statistic and its use in the ACA, see *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, KAISER FAMILY FOUND. (Feb. 29, 2012), <http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/>.

150. See Allison K. Hoffman, *An Optimist’s Take on the Decline of Small-Employer Health Insurance*, 98 IOWA L. REV. BULL. 113, 118 (2013).

to bargain effectively with insurers.¹⁵¹ As a result, large groups, especially if they are very large (i.e., they have 500 or more employees) are typically experience rated.¹⁵² This means that the group's own prior medical claims experience is used to project rate increases using current trend factors.¹⁵³ For these reasons, the large group market was (and still is) generally viewed as well functioning¹⁵⁴ and was subject to few legal restrictions. Thus, the majority of states conducted no rate review of large group rates.¹⁵⁵

b. The Small Group Market

The small group market typically consists of employer groups with fifty or fewer employees.¹⁵⁶ An estimated 17 million are insured in the small employer market.¹⁵⁷ Prior to the ACA there was a "fair degree of uniformity" in state regulation of the small group market due to state and federal reform efforts in the 1990s.¹⁵⁸ In the small group market, health insurance was offered in all states on a guaranteed issue basis, meaning that any small employer could obtain health insurance for its employees.¹⁵⁹ Rates were typically calculated based on the characteristics of the specific employer group, such as age, gender, and the number of employees.¹⁶⁰ Small group rates were also subject to a health status

151. *See id.* at 124.

152. John Bertko, Adjunct Staff, RAND Corp., Health Insurance Market Practices, Testimony Presented Before the Senate Finance Committee (Sept. 23, 2008) [hereinafter Bertko Testimony], http://www.rand.org/content/dam/rand/pubs/testimonies/2008/RAND_CT315.pdf. By insuring a large number of independent risks, the experience of the entire group becomes more stable and can be more accurately predicted. This is the basis for experience rating. For other insured groups, however, the volume of data used for overall ratemaking may not always be fully sufficient to produce accurate and stable rates, and the actuary must supplement existing data with additional information. WERNER & MODLIN, *supra* note 98, at 216.

153. Bertko Testimony, *supra* note 152, at 3–4. If, on the other hand, a group's experience is not credible, then the group's rate is projected based on a blended average of the employer group's claims experience and manual rates. *Id.* Manual rates determined for an entire block of business are applied in cases where the experience of a group is not credible. *See* Kristi Bohn, Jay Ripps & Richard S. Wold, *Pricing of Group Insurance*, in *GROUP INSURANCE* 501, 508–09 (William F. Bluhm ed., 6th ed. 2013). Credibility is the predictive value an actuary ascribes to a particular body of claims data. ACTUARIAL STANDARDS BD., ACTUARIAL STANDARD OF PRACTICE NO. 25, CREDIBILITY PROCEDURES APPLICABLE TO ACCIDENT AND HEALTH, GROUP TERM LIFE, AND PROPERTY/CASUALTY COVERAGES 1 (1996), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop025_051.pdf. Claims data for a particular employer group may not be credible for a variety of reasons, including the size of the employer, changes to the size or makeup of the employees, and insufficient claims data.

154. *See* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 *YALE J. HEALTH POL'Y, L. & ETHICS* 23, 30–31 (2001).

155. Rate Increase Disclosure and Review, 75 Fed. Reg. 81004, 81006 (proposed Dec. 23, 2010) (codified at 45 C.F.R. pt. 154) [hereinafter Rate Increase Disclosure and Review Proposal] (noting that only eighteen states have authority to review rates for some or all of the large group market).

156. The definition of the small employer group was recently amended. *See supra* note 147.

157. 2014 RATE REVIEW REPORT, *supra* note 8, at 5.

158. *See* Hall, *supra* note 139, at 175.

159. *See* Bertko Testimony, *supra* note 152, at 3.

160. *Id.*

factor.¹⁶¹ This meant that a small employer group's rates could be adjusted based on the health status of its employees. However, rates in the small group market were often constrained by rating band limitations, which limited the variation of health insurance rates that could be charged.¹⁶²

The pre-ACA small group market was plagued by high administrative costs and rate volatility. The average cost of insurance coverage was much higher for small employers than for large employers because insurers incurred higher administrative costs covering small employers.¹⁶³ Also, small employer group rates were more volatile. Since the costs of one very sick employee could affect the rates charged to the small employer group, a small group's rates could increase significantly if even one employee incurred high healthcare costs.¹⁶⁴ For these reasons, small group rates were subject to a much greater level of regulation than the large group market; most states (and the District of Columbia) had some form of rate review for the small group market just prior to the ACA.¹⁶⁵ Although this fact may give the impression that small group rates were closely reviewed, this was not the case.

In the years leading up to the enactment of the ACA, there was substantial variation among states with respect to health insurance rate review in the small group market. Some states conducted careful reviews while others conducted no review at all. Some states "only require[d] insurers to file an 'actuarial certification' attesting that their rates were in compliance with state law, without providing any underlying documentation."¹⁶⁶ Even in states that conducted rate review, there was wide variation in the types of insurers subject to rate review and the type of review applied. For instance, some states applied rate review only to Blue Cross and Blue Shield (BCBS) insurers and exempted Health Maintenance Organizations (HMOs) and commercial insurers¹⁶⁷ from review, while other states did the opposite—they exempted BCBS insurers and reviewed the rates of HMOs or commercial insurers.¹⁶⁸ There was also wide variation in

161. *Id.* A few states also applied adjusted community ratings, under which insurers could not vary rates by health status or other factors. *Id.*

162. KAISER FAMILY FOUND., HEALTH INSURANCE MARKET REFORMS: RATE RESTRICTIONS 2 (2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf>.

163. MLRs in the small group market are usually in the high seventies to mid-eighties. Hall, *supra* note 139, at 174.

164. Hoffman, *supra* note 150, at 118.

165. BRENT D. FULTON & RICHARD M. SCHEFFLER, HEALTH INSURANCE PREMIUM RATE REVIEW REGULATION: CASE STUDIES TO INFORM CALIFORNIA 14 tbl.1 (2012), <http://petris.org/wp-content/uploads/2013/02/CPAC-Fulton-Scheffler-rate-review-study-F.pdf>.

166. SPOTLIGHT ON STATE EFFORTS, *supra* note 21, at 4, 19 app.A; Adele M. Kirk & Deborah J. Chollet, *State Review of Major Medical Health Insurance Rates*, 20 J. INS. REG. 3, 7–10 (2002). In some states, aggressive rate regulation was not considered necessary because no carrier had a large percentage of the market, and price competition was assumed to hold rates down. SPOTLIGHT ON STATE EFFORTS, *supra* note 21, at 4.

167. State insurance laws often distinguish between BCBS, HMO, and commercial health insurers. *See, e.g.*, R.I. GEN. LAWS ANN. §§ 27-19-1, 27-19.2-1, 27-2-1 (West 2016) (BCBS); *id.* §§ 27-41-1 to -85 (HMOs); *id.* §§ 27-18-1 to -81 (commercial insurers).

168. *See* Kirk & Chollet, *supra* note 166, at 7–10.

how rate review was conducted. In states that required rates to be filed, any number of rate review processes could have been applied, including filing for informational purposes only; a “file and use” system that allowed an insurer to use rates upon filing, subject to subsequent scrutiny by the state;¹⁶⁹ prior approval; and prior approval with a provision deeming rates approved if not promptly reviewed (usually within sixty days).¹⁷⁰ States even applied these rate-filing processes differently, with some engaged in a much more active rate review process than others. There was also wide variation in what was considered an acceptable rate and what triggered review.¹⁷¹ As a result, most states reduced rates less than one-third of the time.¹⁷² Many states never reduced rates.¹⁷³

c. The Individual Market

The individual (or nongroup) market covers health insurance purchased directly from an insurer, typically by the self-employed, unemployed, or those who do not get health insurance through an employer. Roughly 11 million people get private health insurance directly from an insurer.¹⁷⁴ Prior to the ACA, the individual market was regulated almost entirely by the states, with significant regulatory variation between the states.¹⁷⁵ Medical underwriting of individual applicants was commonplace.¹⁷⁶ Rates typically differed based on factors such as age, gender, and health status. As a result, rates varied significantly. High-risk or high-cost individuals would be charged very high rates or denied coverage altogether.¹⁷⁷ Consequently, a high number of applicants for individual market insurance could not get (or could not afford) coverage in the individual market.¹⁷⁸ While some states had so-called high risk pools that were available to cover those who could not obtain insurance in the individual market, premiums in these pools were typically much more expensive than premiums in the individual market.¹⁷⁹ In addition, administrative costs in the individual market were very high, due in part to underwriting and marketing expenses.¹⁸⁰

169. This is a form of retrospective rate regulation that often relies on consumer complaints to indicate a problem. SPOTLIGHT ON STATE EFFORTS, *supra* note 21, at 4.

170. See Kirk & Chollet, *supra* note 166, at 7; SPOTLIGHT ON STATE EFFORTS, *supra* note 21, at 5.

171. See Kirk & Chollet, *supra* note 166, at 15.

172. See *id.* at 12.

173. *Id.*; see also Fulton & Scheffler, *supra* note 165, at 14 tbl.1 (noting extreme variation among states in the percentage of small group rates disapproved, withdrawn, or lowered following review).

174. See 2014 RATE REVIEW REPORT, *supra* note 8, at 3 (2013 figures).

175. See Hall, *supra* note 139, at 175.

176. See *id.*

177. See *id.*

178. See SARA R. COLLINS ET AL., COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 4 (2006), www.commonwealthfund.org/usr_doc/Collins_squeezedrisinghlthcare_costs_953.pdf?section=4039.

179. Bertko Testimony, *supra* note 152, at 3.

180. See Hall, *supra* note 139, at 175. MLRs for the individual market were typically in the sixties to mid-seventies. *Id.*

As was the case in the small group market, individual market rates were also subject to review in most states and the District of Columbia prior to the ACA.¹⁸¹ The basis for rate review for individual market rates was typically the “adequate, not excessive, and not unfairly discriminatory” standard. And, much like the small group market, rate review in the individual market was very inconsistent. States employed different filing requirements and each state imposed its own filing requirements for different types of insurers.¹⁸² As a result, in 2010, on average, fewer than a quarter of reviewed filings were disapproved, withdrawn, or resulted in lower rates.¹⁸³

2. Self-Insured Groups

In contrast to fully insured employer groups, self-insured employer groups do not purchase health insurance from an insurance company. Instead, they bear the risk, at least partially,¹⁸⁴ of the medical expenses of their employees (and the dependents of the employees) through an insurance-like employee benefit plan. Self-insured employer groups typically contract with a third-party administrator, usually a health insurer,¹⁸⁵ that provides the same type of administrative services, provider networks, and other administrative features of a health insurance policy provided by a fully insured employer group. Thus, in many ways, self-insured and fully insured employer groups are indistinguishable.¹⁸⁶ There are, however, two critical differences. First, as noted above, an employer offering its employees coverage through a self-insured plan bears the risk of paying the medical claims of its employees. Second, most, but not all,¹⁸⁷ self-insured plans are governed by ERISA and are exempt from state regulation.¹⁸⁸ As such, state-based rate review does not apply to self-insured plans. Very few small employer groups are self-insured, so large employer groups make up the bulk of self-insured plans.¹⁸⁹

181. See Fulton & Scheffler, *supra* note 165, at 14 tbl.1. Thirty-four states required some form of prior approval, fourteen employed a file and use system, and three states conducted no review of individual market rates. *Id.*

182. Kirk & Chollet, *supra* note 166, at 13; see also Fulton & Scheffler, *supra* note 165, at 14 tbl.1 (noting extreme variation among states in the percentage of small group rates that were disapproved, withdrawn, or lowered following review).

183. Fulton & Scheffler, *supra* note 165, at 13.

184. Self-insured plans typically buy stop-loss insurance to cover excess claims. This has the effect of moderating an employer’s risk by capping its liability. Hall, *supra* note 139, at 173–74.

185. See Russell Korobkin, *The Battle over Self-Insured Health Plans, or “One Good Loophole Deserves Another,”* 5 YALE J. HEALTH POL’Y L. & ETHICS 89, 95 (2005).

186. See *id.* (noting that “most employees in self-insured EHBPs [employee health benefit plans] submit claim forms to and have their covered medical expenses paid by an entity other than their employer, oblivious to the distinction that the TPA is paying claims with the employer’s money rather than with its own”).

187. Exceptions include, among others, state and local government plans and church plans. 29 U.S.C. § 1003(b)(1)–(2) (2012).

188. *Id.* § 1144(a), (b)(2). For a brief but highly accessible explanation of ERISA’s preemption of state laws, see Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 666–68 (2014).

189. See Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm*

Sixty-one percent of U.S. workers are covered by self-insured plans.¹⁹⁰

3. All Markets Share the Same High Prices

Despite the considerable economic, legal, and structural differences between the aforementioned health insurance markets, and despite the varying applicability of rate review to those markets, they all share one significant, but widely overlooked, common feature: they all use the same provider payment arrangements. Regardless of whether a plan is fully insured or self-insured, whether it is in the large group, small group, or individual markets, all plans insured or administered by the same insurer (regardless of whether it is a BCBS, HMO, or commercial insurer) are all subject to the same provider prices. In other words, when a health insurer contracts for payment rates for providers in its network, the prices contained in those contracts are paid by the insurer for all claims for medical services made by anyone covered by the insurer's fully insured plans (large group, small group, individual markets), as well as those covered by a self-insured plan for which the insurer acts as an administrator.¹⁹¹ Thus, while some markets, such as the self-insured and fully insured large group plans, are viewed as "well functioning," from an administrative and risk-spreading perspective,¹⁹² those market segments are subject to the exact same underlying price pressures as their less well-functioning cousins, the small group and individual markets. This means that the price of medical care is the same for all markets. From this perspective, the self-insured and fully insured large group markets function no better than the individual and small group markets—they are all subject to the same market failures and the same high provider prices.¹⁹³ Thus, the health insurance market divisions and risk segmentation discussed

Size, NOTES (Emp. Benefits Research Inst., Washington, D.C.), Nov. 2012, at 2, 4 (2011), http://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-12.Slf-Insrd1.pdf.

190. KAISER EMPLOYER BENEFITS REPORT, *supra* note 9, at 174.

191. See, e.g., RECTOR & ASSOC., INC., BLUE CROSS & BLUE SHIELD OF RHODE ISLAND: REPORT ON HOSPITAL PARTICIPATION AGREEMENTS WITH THE CARE NEW ENGLAND HEALTH SYSTEM 5–6, (2010), <http://www.ohic.ri.gov/documents/Targeted-Market-Conduct-Exam-Report-BCBS-and-Care-New-England-Jan-2009.pdf> (market conduct examination report noting that reimbursement contracts between BCBS of Rhode Island and hospitals in the Care New England health system covered all "Commercial Subscribers," which included individual, fully insured groups, and self-funded groups). The author of this Article was an examiner for this report.

192. See *infra* Part II.C.1 for a discussion of these markets and their perceived functionality.

193. This largely unnoticed and rarely discussed aspect of the health insurance cost equation is key to understanding why most health insurance market reforms will not stem rising health insurance premiums. No matter how the various markets could be reconfigured (e.g., expanding the small group market to include groups of 100 or more employees or merging the small group and individual markets), such market reconfigurations will have no effect on the underlying costs of medical care, which is the largest component of health insurance premiums and the reason why premiums are skyrocketing. While rearranging the market could alter the expected morbidity of a particular pool of insureds and could raise or lower the administrative burden borne by insurers, both of which would affect premiums, such market reconfigurations will never alter the balance of market power between providers and insurers. Providers will still be able to demand and receive high prices. Thus, any reconfiguration of the market, while addressing equity concerns among highly segmented insured populations, will not affect the increasing cost of health insurance.

above that are so often the focus of debate and reform efforts ultimately make no difference when it comes to the underlying cost of medical care. Large fully insured and self-insured groups may be in a better position than small groups or individuals to haggle with an insurer over the administrative charges included in a rate or the terms of an insurance plan's coverage provisions, but those large groups have no more input in the payment terms embedded in the contracts between an insurer and the providers in its network than an individual who purchases a single health insurance policy directly from an insurer.

III. HEALTH INSURANCE RATE REVIEW UNDER THE ACA

In response to increasing health insurance rates¹⁹⁴ and unevenly applied rate review processes by the states,¹⁹⁵ the ACA included a rate review provision that sought to do two things: (1) bring nationwide uniformity to the review of health insurance rates, and (2) improve rate review at the state level through \$250 million in federal grants.¹⁹⁶

In some ways, the ACA's expansion of rate review is quite remarkable. For the first time in any consumer insurance market (e.g., health, property-casualty, life),¹⁹⁷ the federal government can substitute its judgment for that of state

194. Congress included the ACA's rate review process in the Act as a response to double-digit premium increases. See Timothy Jost, *HR 3962: The Affordable Health Care for Americans Act*, HEALTH AFF. BLOG (Oct. 30, 2009), <http://healthaffairs.org/blog/2009/10/30/hr-3962-the-affordable-health-care-for-americans-act/> (characterizing the ACA's rate review provision as apparent congressional "push back" against insurers' demand for double-digit premium increases"). Its inclusion also responded to perceived price gouging by insurers. *Id.* Rate review first appeared in a 2009 health reform debate before the U.S. House of Representatives. See Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 104 (1st Sess. 2009) (requiring insurers to justify increases in premiums through a rate review process implemented by the federal and state governments).

195. See *supra* Part II.C for a discussion of states' inconsistent application of the rate review process.

196. See Ctr. for Consumer Info. & Ins. Oversight, *State Effective Rate Review Programs*, CTRS. FOR MEDICARE & MEDICARE SERVS., https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html (last visited Apr. 1, 2016) [hereinafter *State Effective Rate Review Programs*] ("The Affordable Care Act makes \$250 million available to States to take action against insurers seeking unreasonable rate hikes. To date, 43 States and the District of Columbia are using \$250 million in grants provided by HHS to help them improve their oversight of proposed health insurance rate increases."); see also 42 U.S.C. § 300gg-94(c) (2012) (describing the ACA's rate review process). Grants could be used to help states carry out rate review, including reviewing requests for rate increases, providing information to HHS, and establishing centers to analyze rate information. See *id.* § 300gg-94(c)(1). In all, forty-three states and the District of Columbia were awarded rate review grant funds. Ctr. for Consumer Info. & Ins. Oversight, *Rate Review Grants*, CTRS. FOR MEDICARE & MEDICARE SERVS., <http://www.cms.gov/CCIIO/Resources/Rate-Review-Grants/index.html> (last visited Apr. 1, 2016). States generally used grants to hire additional staff, increase the scope of review to cover products in the small group and individual market not previously reviewed, increase transparency of the review process, and upgrade technology. *Id.*

197. To be clear, there are insurance programs run entirely by the federal government. One example is the National Flood Insurance Program (NFIP). The NFIP, however, is fundamentally different from typical state-based insurance. The NFIP is a public-private partnership in which the federal government underwrites the risk and private insurers sell the policies in exchange for a commission. Jennifer Wriggins, *Flood Money: The Challenge of U.S. Flood Insurance Reform in a*

regulators with respect to a core function of state insurance regulation—assessing the reasonableness of insurance rates offered to the public—in cases where the federal government has determined that a state’s rate review process is not “effective.” While this change to the post-MFA insurance regulatory landscape appears seismic in nature, the effect is much less dramatic. Rate review has changed little under the ACA. While the ACA shines more light on health insurance rate increases through greater disclosure, little heat accompanies that light. The ACA neither compels the reduction of unreasonable rates nor addresses market failures that lead to high prices.

A. *The Mechanics of Rate Review Under the ACA*

The ACA’s rate review process, which took effect in 2011,¹⁹⁸ mirrors existing state practice in critical ways. It consists primarily of an evaluation of actuarial assumptions and underlying rate filing data, which can identify computational errors and reveal unjustified assumptions.¹⁹⁹ And, consistent with pre-ACA state practice, the ACA’s rate review provisions apply only to rate increases²⁰⁰ in the small group and individual markets.²⁰¹ Rates charged in the large group market,²⁰² by grandfathered plans,²⁰³ and by self-funded plans are

Warming World, 119 PENN ST. L. REV. 361, 381 n.100 (2014). The NFIP did not establish a situation where the government usurped state authority over insurance, but rather, one in which the government essentially became the insurer.

198. 42 U.S.C. § 300gg-94(a)(1).

199. See *supra* notes 19–20 and accompanying text for a brief summary of rate review’s efficacy as an error detector in determining proper health insurance rates.

200. Although the ACA directed HHS to establish a process to review “unreasonable increases in premiums,” 42 U.S.C. § 300gg-94(a)(1), the review process actually applies to “rates” charged by an insurer for a particular insurance product rather than to the premium charged to a particular policy (that is, the price charged to a particular policyholder based on that policyholder’s characteristics, such as smoking status). Since state review of an insurer’s request to increase its premiums has typically focused on an actuarial review of the underlying methods and data used to develop the “rate” to be charged for a specific insurance product, HHS has focused its review process on the data and methods underlying rate increases, rather than the price charged any particular insured. As such, HHS’s practice is consistent with rate reviews conducted by the states. See Rate Increase Disclosure and Review Proposal, *supra* note 155, at 81004–05, 81009; Nat’l Ass’n of Ins. Comm’rs & Ctr. for Ins. Policy & Research, Comment Letter on Proposed Regulations Regarding Section 2794 of the Public Health Service Act *passim* (May 12, 2010), http://www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf (comparing the proposed rate review to state practice). Thus, while a product’s rate increase could fall below the 10% review threshold, because a rate increase is calculated through a weighted average of premium increases, any particular customer could nevertheless be charged a premium increase in excess of 10%. See Timothy Jost, *Implementing Health Reform: The Premium Review Regulation*, HEALTH AFF. BLOG (Dec. 22, 2010), <http://healthaffairs.org/blog/2010/12/22/implementing-health-reform-the-premium-review-regulation/> [hereinafter Jost, *Implementing Health Reform*] (observing that “the regulation does not necessarily capture all unreasonable ‘premium’ increases”).

201. 45 C.F.R. § 154.103(a) (2016). The ACA does not alter or limit the extent or manner that states can review rates charged for products and markets not governed by the ACA’s rate review process. Thus, existing state rules regarding the review of rates outside of the small group and individual markets remain unchanged.

202. Although the statutory provision establishing rate review applies to all group health

not covered. However, the ACA differs from state-based practice in one critical respect: disclosure. The ACA attempts to promote greater insurer accountability through heightened disclosure requirements applicable to all individual and small group rate increases in all states.

1. New Federal Filing Requirements

Under the ACA review process, all proposed rate increases for nongrandfathered products sold in the small group and individual markets must be filed with HHS.²⁰⁴ If the proposed rate increase is 10% or more,²⁰⁵ insurers

insurance coverage, which includes insurance offered in the small and large group markets, HHS has, through regulations, limited application of the rate review provision to the individual and small group markets. 45 C.F.R. § 147.102; *see also* Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 77 Fed. Reg. 70584-01, 70589 (proposed Nov. 26, 2012) (codified at 45 C.F.R. § 147.102) (footnotes omitted). HHS gave three reasons for its decision not to apply rate review to the large group market. First, only about one-third of states have the authority to review large group rates. Thus, applying rate review requirements in the large group market “would result in a process that is not closely aligned with most State processes upon which the regulation is modeled.” Rate Increase Disclosure and Review Proposal, *supra* note 155, at 81006. Second, many insurers “are not accustomed to submitting proposed rate increases” for the large group market. *Id.* Third, “purchasers in the large group market have greater leverage than those in the individual and small group markets, and therefore may be better able to avoid imposition of unreasonable rate increases.” *Id.* The first two justifications are simply different versions of the same reason—large group rates are typically not reviewed by the states. The widely held assumption underlying the hands-off approach to large group rates is that these groups are sophisticated and have sufficient bargaining power to protect their own interests. *E.g.*, Hyman & Hall, *supra* note 154, at 30–35. Yet there is no empirical evidence to support the notion that large groups can wholly protect themselves from unreasonable rates, and there is at least some evidence to the contrary. *See, e.g.*, Press Release, Office of the Health Ins. Comm’r of R.I., Health Insurance Commissioner Finds Blue Cross Blue Shield of Rhode Island Engaged in Improper Rating and Underwriting Practices (Sept. 28, 2012), <http://www.ri.gov/press/view/19085> (explaining that the Rhode Island Health Commissioner found that BCBS of Rhode Island had engaged in illegal, discriminatory and abusive rating practices in the large group market during the period of 2007 to 2009). The author of this Article coauthored the examination report.

203. 45 C.F.R. § 154.103(b). The ACA provides for the “grandfathering” of certain health insurance plans that existed as of March 23, 2010 (the date the ACA was enacted) and have not been changed in ways that substantially cut benefits or increase costs for consumers. *Id.* § 147.140(a)(1)(i). Grandfathered plans, which can be sold to individuals or groups, are exempt from many, but not all, of the new insurance market reforms. *Id.* § 154.103(b).

204. *Id.* § 154.215(a).

205. HHS set 10% as a threshold for identifying “potentially unreasonable rates” that would be subject to review. Rate Increase Disclosure and Review Proposal, *supra* note 155, at 81006. The 10% threshold, a uniform standard applicable to all rate increases nationwide, could change to a state-specific threshold. 45 C.F.R. § 154.200(a)–(b). A state-specific threshold is supposed to be based on state-specific factors, to the extent that such factors are available. *Id.* § 154.200(a)(2). A rate increase in the individual and small group markets that is 10% or more, applicable to a twelve-month period, would be subject to federal review. *Id.* § 154.200(a)(1). The 10% threshold is based on the average increase for all enrollees weighted by premium volume. *Id.* § 154.200(c). Although the 10% threshold may be replaced by a state-specific threshold determined by HHS, *id.* § 154.200(a)(2), no state-specific thresholds have yet been set. HHS denied requests for higher thresholds from Alaska and Wisconsin in 2012. *See* Ctr. for Consumer Info. & Oversight, *State-Specific Threshold Proposals*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html> (last visited Apr. 1, 2016).

must also, prior to implementation of the increase, submit a “preliminary justification” for the proposed rate increase to HHS and the insurance department in the state in which the rates will apply.²⁰⁶ HHS will then publicly disclose this information on its website,²⁰⁷ but will not necessarily review the proposed rate increase. Instead, HHS will review only the filed rate information if HHS has determined that the state in which the rates will apply does not have an “effective” rate review program.²⁰⁸

2. Effectiveness of State Review

HHS will determine that a state has an “effective” rate review program if (1) the insurer requesting the rate increase submits specific data and documentation to the state,²⁰⁹ (2) the state conducts a “effective and timely” review of the documentation submitted by the insurer,²¹⁰ and (3) the state’s determination of whether a rate increase is reasonable (or not) is made pursuant to a standard set forth in a statute or regulation.²¹¹ The state’s review must also include an examination of data and documentation related to the reasonableness of the assumptions used to develop the proposed rate increase, the validity of the historical data underlying the assumptions, and data related to past projections and actual experience, among other factors.²¹² In addition, the state must make

206. 45 C.F.R. §§ 154.200(a), 154.215(a)–(g). The preliminary justification must include, among other things, data related to rate development for the product, historical and projected claims experience, trend projections, claims assumptions related to any product benefit changes, and a history of rate increases for the product. Insurers must also submit a written description of the rate increase including, among other things, a description of the data and the assumptions used to develop the rate increase, and an explanation of the most significant factors causing the rate increase. *Id.* § 154.215(e)–(f).

207. *Id.* § 154.215(i). This is subject to the Freedom of Information Act regulations. *Id.* § 154.215(h)(2).

208. A state has an effective rate review program for the small group and individual markets if the state receives sufficient documentation to allow it to conduct a timely review. *Id.* § 154.210(a)–(b). Such a review must include an assessment of the reasonableness of the insurer’s assumptions, the validity of the historical data underlying the assumptions, data related to past projections and actual experience, the “impact of medical trend changes by major service categories,” the “impact of utilization changes by major service categories,” the “impact of cost-sharing changes by major service categories,” the “impact of benefit changes,” “changes in [the] enrollee risk profile,” the impact of over- or underestimates of medical trend in prior years, changes in reserve needs, “changes in administrative costs related to programs that improve . . . quality,” the impact of changes in taxes, licensing or regulatory fees, medical loss ratio, and capital and surplus. *Id.* § 154.301(a)(4). The regulations set forth the factors that HHS will consider, with respect to each insurance market in the state, in determining whether the state has an effective rate review program. *Id.* §§ 154.301(a), 154.210(a)–(b). The state must also conduct its review in accordance with standards set out in a state statute or regulation, *id.* § 154.301(a)(5), provide web access to the preliminary justification, and provide for public input, *id.* § 154.301(b). HHS can re-review the state’s rate review program to determine whether it has ceased to be effective. *Id.* § 154.301(d).

209. *See id.* § 154.301(a)(1).

210. *Id.* § 154.301(a)(2). The regulations do not define “effective.”

211. *Id.* § 154.301(a)(4).

212. *Id.* § 154.301(a)(2).

this information available to the public²¹³ and must report its final determination as to whether a rate increase is unreasonable within five business days of its determination.²¹⁴

If a state is deemed to have an effective program, only the state will review filed rates and will do so using its own methods and standards of review. And, the decision reached by the state regarding the reasonableness of the proposed rates will be accepted by HHS. Oddly enough though, despite the extensive list of data that states must review to have an “effective” review process, states are not required to have the authority to actually deny proposed rate increases. Thus, a state can have an “effective” rate review process even if it wholly lacks any authority—or does not exercise the authority it has—to prevent the implementation of a rate increase it finds unreasonable. In other words, the “review” part of the state’s rate review process must be sufficiently rigorous to detect an unreasonable proposed rate, but the enforcement part can be completely nonexistent. To have an “effective” process, states must look at, but they do not have to touch, filed rates. Perhaps this is why HHS has deemed so many states as possessing an “effective” rate review process. Currently, forty-five states, the District of Columbia, and three U.S. territories (Guam, Puerto Rico, and the U.S. Virgin Islands) are considered to have effective rate review in both the individual and small group markets.²¹⁵

On the other hand, if the state does not have an effective rate review program, HHS will conduct its own review to determine if the proposed rate increase is unreasonable.²¹⁶ If HHS, rather than a state, reviews the proposed rate increase, an additional set of rate-filing information must be provided to HHS to permit a determination as to whether the request is unreasonable. A proposed rate increase will be found “unreasonable” if it is “excessive,”²¹⁷

213. *Id.* § 154.301(b). The information must be made available on the state’s website or CMS’s website and must include a process for receiving public comments on the proposed rate increases. *Id.* § 154.301(b)(1)(i)–(ii).

214. *Id.* § 154.210(b)(2).

215. *State Approval of Health Insurance Rate Increases*, NAT’L CONF. ST. LEGISLATURES (Aug. 2015), <http://www.ncsl.org/research/health/health-insurance-rate-approval-disapproval.aspx>. Indeed, most states’ rate review processes would have been considered “effective” under these standards even before Congress enacted the ACA. In the preamble to the proposed rate review regulations, HHS stated that “most States have existing effective rate review programs that would meet the requirements of this regulation in substituting for HHS’ review of rate filings that meet or exceed the threshold” in one or both of the individual or small group markets. Rate Increase Disclosure and Review Proposal, *supra* note 155, at 81203.

216. Alabama, Missouri, Oklahoma, Texas, and Wyoming are the only states deemed to have ineffective rate review programs. *State Effective Rate Review Programs*, *supra* note 196. If a state lacks the resources or authority to conduct rate reviews, HHS will conduct the reviews or partner with the state to conduct the reviews. There are currently only five states where HHS will conduct rate reviews and two states where HHS will partner with the states to conduct rate reviews. *Id.*

217. A rate increase is excessive if it “causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage,” based on whether (1) it results in an MLR below the federal MLR standard in the relevant market, (2) any of its assumptions are not supported by substantial evidence, and (3) “the choice . . . or combination of assumptions on which the rate increase is based is unreasonable.” 45 C.F.R. § 154.205(b).

“unjustified,”²¹⁸ or “unfairly discriminatory”²¹⁹—a review standard similar to that widely applied by the states. If HHS determines that a proposed increase is unreasonable, HHS will post its determination on its website. HHS does not, however, have any authority to alter the rate or prohibit its implementation. If an insurer decides to proceed with an unreasonable increase, it must submit a final justification to HHS and post HHS’s determination and its final justification on its website.²²⁰ Thus, HHS’s main role in the rate review process is not to stop unreasonable rates, but instead to subject those rates to public scrutiny.²²¹ In essence, the ACA rate review process is an elaborate form of disclosure regulation²²² designed to inform consumers and shame insurers into lowering unreasonable rates.²²³

B. The Results: Light, But Not Much Heat

In the first five years the ACA’s rate review process was in effect, from 2011 to 2015, HHS estimated savings to consumers of about \$4.7 billion dollars.²²⁴

218. An increase is unjustified if the issuer provides data or documentation that is “incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.” *Id.* § 154.205(c).

219. An increase is unfairly discriminatory if it “results in premium differences between insureds within similar risk categories that: (1) [a]re not permissible under applicable State law; or (2) [i]n the absence of an applicable State law, do not reasonably correspond to differences in expected costs.” *Id.* § 154.205(d).

220. *Id.* § 154.230(c)(1)–(2).

221. See Ctr. for Consumer Info. & Ins. Oversight, *Shining a Light on Health Insurance Rate Increases*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 21, 2010), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ratereview.html>. Furthermore, since HHS cannot reject proposed increases and cannot compel states to do so either, the decision as to whether an “unreasonable” rate increase will take effect rests on the authority (and desire) of the state to block the rate increase. Thus, the rate review process for states that already possessed strong rate review authority are largely unaffected by the ACA. Likewise, states with weak or no rate review authority will also see little difference. Only in those states that have improved their processes in response to the ACA will there be some effect. See generally SABRINA CORLETTE ET AL., URBAN INST., CROSS-CUTTING ISSUES: MONITORING STATE IMPLEMENTATION OF THE AFFORDABLE CARE ACT IN 10 STATES: RATE REVIEW (2012), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412649-Monitoring-State-Implementation-of-the-Affordable-Care-Act-in-States-Rate-Review.PDF> (discussing the effect of state responses to the ACA in ten states).

222. For an overview and criticisms of disclosure regulation, see Ben-Shahar & Schneider, *supra* note 23, at 647.

223. Professor Timothy Jost has noted,

This disclosure requirement is the key to the regulation. Although the statute does not authorize HHS to reject proposed rate increases, Congress determined that public disclosure of information supporting rate increases would invite public scrutiny of rate increase proposals and might have a “sentinel effect,” deterring unreasonable requests. In a number of instances in the past year, insurers have had rate increases rejected or have withdrawn proposed rate increases in the face of public criticism of the proposed increases.

Jost, Implementing Health Reform, supra note 200. For a brief history of regulation by shaming and its shortcomings, see Mary Graham, *Regulation by Shaming*, ATLANTIC, Apr. 2000, at 36, 36–40.

224. See 2015 RATE REVIEW REPORT, *supra* note 8, at 2 (estimating \$1.1 billion saved in the individual market and \$418 million in the small group market in 2015); 2014 RATE REVIEW REPORT,

From a strictly “green eyeshade” point of view, the federal investment in rate review appears to have paid off. For its \$250 million investment in grants to the states (plus its own administrative costs),²²⁵ the return on investment seems significant. From the perspective of an individual consumer, however, the results are not nearly as impressive.

While the aggregate savings reported by HHS appear shockingly large, actual savings to consumers were much less electrifying. For example, the HHS annual rate review report for calendar year 2013 states that rate review reduced total premiums nationwide in the individual market by an estimated \$290 million and the average requested rate increase was reduced by 8%.²²⁶ In the small group market, rate review reduced total premiums nationwide by an estimated \$703 million and the average requested rate increase was reduced by 11%.²²⁷ While total savings approaching a billion dollars may appear impressive, a closer look reveals that the rate review process put very little back in the pockets of consumers.

First, even after rate review, the average rate increase actually approved and implemented in individual markets in 2013 was still quite high—10.3%—only a small reduction from the 11.2% average rate increase originally requested by insurers.²²⁸ The average approved rate increase of 10.3% not only exceeded the 10% threshold figure that HHS established as a presumptively unreasonable rate of increase, but was also nearly seven times the U.S. rate of inflation in 2013, which was 1.5%.²²⁹ In the small group market, the numbers were not much better. Rate review reduced the average requested rate increase from 8% to 7.1%,²³⁰ which was still nearly five times the U.S. rate of inflation.

Second, actual savings to consumers were quite small. The total savings resulting from rate review in the individual market equaled less than 1% of total

supra note 8, at 2 (estimating \$290 million saved in the individual market and \$703 million in the small group market in 2013); 2013 RATE REVIEW REPORT, *supra* note 8, at 5 figs.1–2 (estimating \$311 million saved in individual market and \$866 million in the small group market in 2012); 2012 Rate Review Report, *supra* note 8 (estimating \$425 million saved in individual market and \$600 million in the small group market in 2011). HHS did not estimate savings for the individual or small group markets for 2014 due to the implementation of new market rules that year. 2015 RATE REVIEW REPORT, *supra* note 8, at 5.

225. See *supra* note 196 and accompanying text for reference to the ACA’s method of achieving this investment.

226. 2014 RATE REVIEW REPORT, *supra* note 8, at 2. The reduction in average requested rate increase in the individual market applied was based on the forty states for which HHS had data. *Id.* at 4.

227. *Id.* at 5. The reduction in average requested rate increase in the small group market applied was based on the thirty-seven states for which HHS had data. *Id.* at 2.

228. *Id.* at 3.

229. U.S. BUREAU OF LABOR STATISTICS, CPI DETAILED REPORT: DATA FOR DECEMBER 2013, at 1 tbl.A (Malik Crawford & Jonathan Church eds., 2014), <http://www.bls.gov/cpi/cpid1312.pdf> (listing the unadjusted change to the CPI-U (consumer price index-urban) for the twelve month period ending December 2013).

230. 2014 RATE REVIEW REPORT, *supra* note 8, at 5.

premium,²³¹ and resulted in average savings of just over \$9 per month per covered life for approximately one-quarter of those in the individual market.²³² Rates for the remaining three-quarters of the individual market were unaffected by rate review and those insureds saw no reduction in proposed rate increases.²³³ Savings in the small group market also equaled less than 1% of total premium.²³⁴ Average savings were just over \$16 per month per covered life for approximately one-fifth of those in the small group market.²³⁵ Similar to the individual market, rates for the remaining four-fifths of the small group market were unaffected by rate review.²³⁶ And while an average of \$16 per month is not an insignificant amount, the impact of these savings was moderated by the fact that these estimated savings would, in most cases, have been shared by both employers and the employees, since both typically contribute to health insurance premiums.²³⁷

Finally, and perhaps most importantly, it is not clear how much of these savings are actually attributable to rate review processes that were already in place prior to enactment of the ACA. At least some states reduced proposed rate increases in the small group and individual markets prior to enactment of the ACA, but there is no data on the estimated savings from those pre-ACA rate review reductions against which the post-ACA rate review estimated savings can be directly compared.²³⁸ While we can be sure that some amount of the nearly

231. Total premium in the individual market in 2013 was \$32.3 billion. Two hundred ninety million dollars, the estimated amount saved by rate review, translates to only 0.9% of total premium in the individual market. *Id.* at 4 tbl.1.

232. This figure results from dividing \$290 million (the estimated total savings) by 2.6 million (the total number of lives affected by the rate reductions), and then further dividing by twelve to get the monthly savings of \$9.26. *Id.*

233. Only 2.6 million of the 10.9 covered lives in the individual market realized any savings as a result of rate review. *Id.* If spread over the entire individual market, savings resulting from rate review equal only \$2.22 per month.

234. Total premium in the small group market in 2013 was \$78.2 billion. Seven hundred and three million dollars, the estimated amount saved by rate review, represents 0.9% of total premium. *Id.* at 6 tbl.2.

235. This figure results from dividing \$703 million (the estimated total savings) by 3.6 million (the total number of lives affected by the rate reductions), and then further dividing by twelve to get the monthly savings of \$9.26. *Id.*

236. Only 3.6 million of the 17.3 million covered lives in the small group market realized any savings as a result of rate review. *Id.* at 6. If spread over the entire small group market, savings resulting from rate review equal only \$3.39 per month.

237. The 2015 rate review report shows roughly similar results to those obtained in 2013. The average rate increase actually approved and implemented for renewing plans in individual markets in 2015 was 6.9%, a small reduction from the 8.7% average rate increase originally sought. *See* 2015 RATE REVIEW REPORT, *supra* note 8, at 7. The average rate increase approved for renewing plans in the small group market in 2015 was 4.3%, also a slight reduction from the 5.1% average rate increase sought. *Id.* While the rate increases sought in 2015 were lower than those sought in 2013, the overall rate of inflation in 2015 was also lower than in 2013. U.S. BUREAU OF LABOR STATISTICS, CPI DETAILED REPORT: DATA FOR DECEMBER 2015, at 1 tbl.A (Malik Crawford, Jonathan Church & Bradley Akin eds., 2015), <http://www.bls.gov/cpi/cpid1512.pdf> (listing the unadjusted change to the CPI-U for the twelve month period ending December 2015 as 0.7%). The rate of inflation in 2013 was 1.5%. *See supra* note 229 and accompanying text.

238. *See* KAISER FAMILY FOUND., QUANTIFYING THE EFFECTS OF HEALTH INSURANCE RATE

\$4.7 billion dollars of estimated rate review savings from 2011 to 2015 would have occurred even without the ACA's rate review process, we cannot know how much.

IV. THE LIMITS OF RATE REVIEW UNDER THE ACA

The ACA's rate review process was part of a larger package of reforms designed to address a host of defects in the private insurance market. Yet, the ACA's changes to rate review have neither substantially reduced premium increases nor markedly increased consumer savings. But it would be a mistake to assume the ACA's rate review shortcomings are limited to its lack of enforcement authority. Rate review's defects are more elemental. Even if the federal government and the states had the authority and the willpower to more aggressively clamp down on rates deemed to be unreasonable under the ACA's review standard, consumers would still see little change in what they pay for health coverage for three reasons. First, rate review does nothing to address the forces that drive up the medical cost component of health insurance rates—typically the largest contributor to rate increases. Moreover, while the rate review process that developed a hundred years ago may have been appropriate for fire insurance rates at that time, it is not effective for the current health insurance market, which has shifted from an indemnity model to a direct reimbursement model. Health insurers now directly participate in the setting of prices for healthcare services by paying providers directly. Despite health insurers' substantial involvement in medical price-setting, this aspect of insurer behavior is not reached by the rate review process. Thus, the single largest contributor to premium increases is unaffected by the rate review process. Second, another provision of the ACA—the MLR cap—pressures insurers to lower the loading charges included in their rates, dampening the potential benefits of rate review. Finally, rate review under the ACA applies to only 16% of the overall health insurance market, thereby severely circumscribing any beneficial effects of rate review for the overall health insurance market.

A. *Rate Review, Indemnity Insurance, and Direct Payment to Providers*

Rate review can have only a small effect on health insurance premiums for one simple reason: the current rate review process does not give regulators the right tools to do the job. The ACA's rate review process, which is based on property-casualty rate review, is limited to reviewing only certain factors affecting the rate, mainly the reliability of claims data, the appropriateness of actuarial assumptions based on those data, the level of profits and administrative costs included in the rate, and mathematical calculations. This type of limited rate review was appropriate for fire insurance rates a century ago when insurance regulators were concerned with both inadequate rates due to reckless

REVIEW 6 (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8376.pdf> (“Because many states had some form of review process in effect prior to the September 1, 2011 implementation of the ACA's rate review standards, the reduction in requested rate increases as a result of rate review cannot be attributed fully to the ACA.”).

competition and price gouging due to cartel pricing. Nineteenth-century rate review was unconcerned with the underlying prices of goods and services that affected claims costs because those prices were not affected by insurer conduct. Fire insurance rates were not volatile because of the underlying costs of building materials and labor, but because of insurer behavior—specifically, charging inadequate premiums and engaging in collusive price-setting. Since the ACA follows the property-casualty approach to rate review, health insurance rate review is also unconcerned with the underlying prices of goods and services that affect healthcare claims costs. As a result, ACA rate review simply accepts healthcare provider price increases and ensures that those price increases are fully incorporated into insurance rates.

If modern health insurance still operated on an indemnity basis, like property-casualty insurance, and if health insurers were engaging in haphazard or discriminatory ratemaking, the ACA rate review process would be a reasonable regulatory strategy for ensuring appropriate rates. However, modern health insurance no longer adheres to the indemnity model of insurance. Instead, insurers have a direct role in setting the prices paid for healthcare goods and services—a role that regulators are powerless to scrutinize during the rate review process. To understand the role insurers play in setting prices, it is important to understand (1) the differences between indemnity and direct provider payment models, (2) the health insurance industry's shift from the indemnity to the direct provider payment model, and (3) how the shift to the direct provider payment model has contributed to rising medical costs.

1. Two Models of Insurance: Indemnity vs. Direct Provider Payment

The key to understanding the shortcomings of the ACA's expanded rate review process can be found in the difference between two fundamentally different models of insurance: the indemnity model (the form of insurance upon which rate review is based), and the direct provider payment model (the form of insurance currently embraced by the health insurance industry). These two models involve fundamentally different roles for the insurer in the direct development of underlying claims costs, and therefore insurance rates.

Indemnity insurance, the model for property-casualty insurance, involves a two-party relationship.²³⁹ Under the indemnity model, the insurer and the insured enter into a contract to cover specified risks. If there is a covered loss, the insurer makes a payment to the insured (for first-party insurance) or someone other than the insured who has suffered a loss (for third-party insurance).²⁴⁰ Indemnity insurers generally have no preexisting, direct financial relationship with a third party making a claim under an insurance policy.²⁴¹

239. This is true regardless of whether the insurance coverage is first party or third party. First-party insurance covers claims of the insured. ABRAHAM & SCHWARCZ, *supra* note 14, at 183. Third-party insurance covers claims by a third party against the insured. *Id.*

240. In the case of third-party insurance, losses are paid as the result of a settlement or court judgment of a claim arising between the injured third party and the insurer.

241. For a description of indemnity insurance, see EMMETT J. VAUGHAN & THERESE M.

Claims are paid to a third party according to the terms of the policy between the insurer and the insured. Data from claims payments, as well as various other data collected by an insurer, such as the physical location of the insured property and its market value, can be used to calculate insurance rates.²⁴² Prior to the 1980s, health insurers largely used the indemnity insurance model.²⁴³ The health insurance contract was a two-party arrangement between the insured (or an employer in the case of employer-based coverage) and the insurer. Insurers reimbursed insureds directly for incurred medical costs and did not contract with healthcare providers or set the prices paid to providers.²⁴⁴ In this respect, health insurers and property-casualty insurers used the same indemnity insurance model. Health insurers did not participate in the setting of physician or hospital prices, just as automobile insurers did not participate in the setting of prices for automobile parts or labor rates for repair shops. For indemnity insurance, the rate review process assumes no insurer control over underlying claims costs and properly treats the insurer as a “pass-through” entity for the purposes of those costs.

2. Modern Health Insurance and the Direct Provider Payment Model

From the early 1960s through the mid-1970s medical care costs—and thus health insurance rates—had been increasing rapidly,²⁴⁵ and insurers were looking for ways to control those costs. BCBS plans paid for hospital care on the basis of allowable costs, and commercial health insurers paid a percentage of billed charges, typically 75% to 80%.²⁴⁶ This form of payment discouraged price competition among hospitals, since every service that generated a cost could be billed and therefore generate revenue.²⁴⁷ The lack of price competition not only led to higher hospital prices generally, it also had the unusual effect of driving up prices in geographic areas that had more hospitals. In other words, high prices went hand in hand with high numbers of hospitals.²⁴⁸ In the absence of price

VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 166–67 (11th ed. 2014).

242. *See id.* at 132–37 (describing various informational components used to develop a premium).

243. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 258–60, 291–92 (1982). BCBS plans were the exception to this approach. Blue Cross plans typically reimbursed hospitals directly. *See* ROBERT D. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 87 (1963). A minority of Blue Shield organizations were pure indemnity insurers. *Id.* (noting that in the late 1950s only 21% of Blue Shield organizations were indemnity-type plans while the rest were direct payment service plans or a combination of direct payment and indemnity plans).

244. STARR, *supra* note 243, at 291.

245. Although increases in the cost of medical care are often attributed to the Medicare and Medicaid programs, which were enacted in 1965, the main driver of costs was the fee-for-service, reasonable cost payment system. *Id.* at 385.

246. Marjorie Smith Carroll & Ross H. Arnett III, *Private Health Insurance Plans in 1978 and 1979: A Review of Coverage, Enrollment, and Financial Experience*, 3 HEALTH CARE FIN. REV. 55, 65 (1981) (noting that commercial insurance plans offering major medical coverage usually paid 75% to 80% of the costs of medical care).

247. MICHAEL A. MORRISEY, HEALTH INSURANCE 175–76 (2d ed. 2014).

248. *Id.*

competition, hospitals incurred greater costs by competing on nonprice factors such as new equipment, expanded services, and fancier amenities.²⁴⁹

The response of the health insurance industry was to try to control costs through managed care techniques,²⁵⁰ including through the use of selective contracting with providers. Selective contracting allowed insurers to negotiate lower prices from providers.²⁵¹ This was the genesis of limited provider networks and the direct provider payment model. As a result, most health insurers shifted away from the pure indemnity model.²⁵² Insurers instead negotiated, contracted with, and paid medical care providers directly, becoming direct financiers of medical care providers.²⁵³ While the limited network cost-control strategy worked initially, it began to backfire after only a few years.

Although limited networks helped hold down the growth of medical care costs through the mid-1990s, healthcare costs—and health insurance premiums—began to grow rapidly in the mid-1990s, with health insurance premiums reaching annual increases of 8% to 14%.²⁵⁴ One major reason for the increase was provider consolidation. Provider consolidation thwarts selective contracting by limiting insurers' ability to exclude some providers from their networks, particularly those providers that have a large enough share of an insurer's book of business.²⁵⁵ Empirical evidence suggests that providers may have responded to selective contracting by consolidating. Beginning in the mid-1990s, provider consolidation increased, especially among hospitals,²⁵⁶ affording providers greater market power and the ability to command higher prices from the insurers with whom they contracted. As discussed earlier in Section I, the high prices charged by providers are the main drivers of skyrocketing health insurance

249. *Id.*; see also James C. Robinson & Harold S. Luft, *Competition and Cost of Hospital Care, 1972 to 1982*, 257 JAMA 3241, 3243–44 (1987).

250. For a brief overview of the growth of managed care, see Peter D. Fox & Peter R. Kongstvedt, *A History of Managed Health Care and Health Insurance in the United States*, in *ESSENTIALS OF MANAGED HEALTH CARE* 3, 3–20 (Peter R. Kongstvedt ed., 6th ed. 2013).

251. David M. Cutler et al., *How Does Managed Care Do It?*, 31 RAND J. ECON. 526, 528 (2000) (noting that in the 1990s health insurers offered managed care plans that employed supply-side managed care techniques, including the development of networks of favored physicians and hospitals with whom plans bargained hard for low rates).

252. See Fox & Kongstvedt, *supra* note 250, at 10 (noting that in the mid-1980s traditional indemnity health insurance accounted for 75% of the commercial market, but declined to the single digits by the year 2000 because it had been replaced by managed care).

253. See Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J. L. & MED. 436, 441 (2010) (“The health insurance industry in the United States is already far down the path toward becoming primarily a health care payer, and only secondarily an insurer of health risks.”).

254. See MORRISEY, *supra* note 247, at 197.

255. Limited-provider networks can hold down provider prices only under certain conditions: there must be a large number of providers, those providers must have excess capacity, and none of the providers can have a significant share of the insurer's business. *Id.* at 201.

256. ROBERT MURRAY & SUZANNE F. DELBANCO, *CATALYST FOR PAYMENT REFORM, PROVIDER MARKET POWER IN THE U.S. HEALTH CARE INDUSTRY: ASSESSING ITS IMPACT AND LOOKING AHEAD* 16–18 (2012), http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf.

premiums. And, as also discussed in Section I, a host of market failures ensure that the consumers who purchase healthcare goods and services through health insurance cannot effectively control healthcare prices. The result is escalating health insurance rates: as provider prices escalate, the medical cost component of health insurance rates increase.

Unsurprisingly, because the rate review process does nothing to address the underlying cost drivers of medical care, rate review cannot control the medical cost component of health insurance beyond identifying mathematical errors and faulty actuarial assumptions. Rate review can, however, address the loading charge portion of a rate since items such as administrative costs and profits are within the control of the insurer. But one provision of the ACA—the MLR requirement—limits the effectiveness of rate review with respect to the loading charge.

B. Control of the Loading Charge

Although rate review is capable of holding insurer profits and administrative costs in check, the ACA's MLR requirement imposes a hard cap on the total amount of administrative costs that can be included in an insurer's rates. Health insurers in the individual and small group markets are prohibited from allocating more than 20% of premium to profits and administrative costs (an MLR of 80%).²⁵⁷ Insurers in the large group market are prohibited from allocating more than 15% of premium to profits and administrative costs (an MLR of 85%).²⁵⁸ The requirement is enforced through a retrospective accounting and rebate system. An insurer that fails to meet this requirement for a given market must rebate to each of its insureds (or the employer in the case of group coverage) the amount of the difference on a pro rata basis.²⁵⁹ In this respect, the MLR requirement works as a retrospective rate-setting mechanism.

While the MLR requirement can result in a rebate, the principal function of the MLR requirement is to encourage insurers to calculate rates consistent with the MLR limits in the first place. In other words, the MLR requirement creates pressure on insurers to keep loading charges within the established limits. There is evidence that insurers are indeed lowering administrative costs during the ratemaking process, that is, before rates are submitted for rate review. After the implementation of the MLR requirement, the amount of rebates and the number of insureds covered by the rebates have both declined. Rebates have declined dramatically from \$1.1 billion paid to 12.8 million insureds for premiums paid in 2011²⁶⁰ to \$332 million paid to 6.8 million consumers for 2013.²⁶¹ This means that

257. 42 U.S.C. § 300gg-18(b)(1)(A)(ii) (2012).

258. *Id.* § 300gg-18(b)(1)(A)(i).

259. *Id.* § 300gg-18(b)(1)(A).

260. Ctr. for Consumer Info. & Ins. Oversight, *The 80/20 Rule: Providing Value and Rebates to Millions of Consumers*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 21, 2012), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/mlr-rebates06212012a.html>.

261. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CONSUMERS BENEFITED FROM 80/20

the loading charges included in rates have fallen dramatically, giving insurance regulators fewer opportunities to reduce loading charges during the rate review process.²⁶²

C. *The Limited Scope of Rate Review*

The third factor confounding the effectiveness of the ACA's rate review process is the limited scope of the review process itself. As noted earlier, the ACA's rate review provisions are applicable to only the small and individual group markets,²⁶³ the smallest segments of the private health insurance market. Large group, self-funded, and grandfathered plans are not covered. This means that less than one-sixth of those covered by the U.S. private health insurance market have coverage affected by the ACA's rate review provisions.²⁶⁴ Thus, whatever benefits are to be derived from the ACA's rate review process, those benefits accrue to only a very small portion of the private health insurance market and leave most of the health insurance market unaffected.

V. A NEW ROLE FOR RATE REVIEW?

As the preceding sections have demonstrated, there are a host of reasons why the current health insurance rate review process is not a terribly effective method for controlling health insurance rate increases: rate review applies to only a small portion of the health insurance market, the ACA does not require the federal government or the states to reject unreasonable rates when found, the ACA's MLR cap dampens the effect of rate review on a rate's loading charge, and, most importantly, health insurance rate review is modeled on an

RULE IN 2013, at 2 fig.2 (2014), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf.

262. This does not mean that states cannot enforce the MLR requirement at the rate review stage. Indeed, a handful of states do so. Karaca-Mandic et al., *supra* note 24, at 1363 (noting that in 2013 eight states employed a rate review system for individual market products that required a minimum loss ratio of 80% or more as a condition for approval of filed rates). These eight states had moderately lower rates than states that did not require a high (80% or more) MLR as a condition of approval. *Id.* at 1365. This important study suggests that a rate review process in the individual market that aggressively enforces the MLR requirement prospectively (before rates are approved), rather than retrospectively (at the end of the year), can yield lower rates. While the benefits to consumers of a strict, prospective MLR rate review requirement should not be minimized, it is important to emphasize two points. First, even this aggressive rate review does nothing to address the underlying medical costs that are the major drivers of health insurance rate increases. Thus, 80% of the rate remains untouched by this aggressive rate review process. Second, the study does not consider the substantial retrospective MLR refunds—over \$1 billion—that were made to policyholders in the individual market during the study period, 2010 to 2013. See *supra* notes 260–61 and accompanying text for a summary of the amounts paid.

263. See *supra* notes 199–203 and accompanying text for a discussion regarding the ACA's rate review provisions and their exemptions.

264. About 201 million Americans were covered by private health insurance in 2013. JESSICA C. SMITH & CARLA MEDALIA, U.S. CENSUS BUREAU, HEALTH INSURANCE IN THE UNITED STATES: 2013, 2 fig.1 (2014), <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>. Only 28 million of those received health insurance in the small group and individual markets. See *supra* Part II.B.1.b–c.

inapplicable property-casualty model that cannot address the underlying medical costs that drive up the cost of health insurance. Undeniably, casting a bright light on these shortcomings may cause some to condemn the rate review process as little more than a toothless, unimaginative, and ineffective expansion of a congenitally weak state-based rate review process. But such criticism would be too harsh. Rate review is not inherently incapable of holding down the underlying costs of medical care, rather it simply is not employed as effectively as it could be. This is rate review's greatest sin, the sin of omission.²⁶⁵ Rate review's soupçon of rate oversight could indeed be enhanced and transformed into a powerful tool to combat skyrocketing health insurance rates, but only if it is modernized in a way that enables it to address current failures in the health insurance market.

A. *Rate Review as a Cost Control Mechanism*

Before specifically addressing the use of rate review as a cost control mechanism, there is the preliminary question of whether we really need another cost control device. There is no shortage of cost control policy prescriptions; indeed, we are awash in “remedies” for the high cost of medical care, including, but not limited to, health maintenance organizations, managed care, capitated payments, integrated delivery systems, health savings accounts, consumer-directed health plans, pay for performance, health information technology, comparative effectiveness research, bundled payments, patient-centered medical homes, and value-based purchasing.²⁶⁶ All of these approaches, however, possess the same flaw: they do nothing to remedy the system-wide problem of excessive provider prices. Instead, these approaches view the cost problem largely as a function of excessive or inefficient individual medical encounters, informational deficits, or care coordination difficulties. As a result, health insurance rates have continued their steady climb skyward. What is needed is a mechanism to address the market failures that lead to excessive provider prices.

But why use rate review to address these market failures? If excess prices are really the problem, why not simply create a price-setting commission, like the one currently used by Maryland to set hospital prices?²⁶⁷ There are practical, theoretical, and political reasons for favoring a rate review approach to addressing the problem of spiraling healthcare prices.

265. See James 4:17 (New American Standard Bible) (“[T]o the one who knows *the* right thing to do and does not do it, to him it is sin.”).

266. Theodore Marmor & Jonathan Oberlander, *From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy*, 27 J. GEN. INTERNAL MED. 1215, 1215–17 (2012) (decrying these and other approaches to cost control as “fads” that do little to address the cost problem on a system-wide basis).

267. The most commonly proposed price control mechanism is the establishment of an all-payer price-setting commission (similar to Maryland's system), or a private payer price-setting commission like the one used in West Virginia. For a brief overview of the Maryland and West Virginia price-setting systems, see Sommers et al., *supra* note 95, at 2–5.

1. Practical Reasons for Using Rate Review

There are compelling practical reasons for employing a new rate review process to address market failures that lead to excessive provider prices. First, the new rate review process would be flexible and dynamic. Not only could it be employed to address the problems afflicting a specific market, it could also be adapted to address changes in market conditions. Second, rate review could make use of existing infrastructure and expertise.

a. Rate Review Is Flexible

Flexibility is the most compelling practical reason to adopt a new rate review process as a means to address excessive provider prices. Unlike strict price-setting, which appears to be gaining favor among many health policy scholars and economists,²⁶⁸ the rate review process is capable of employing myriad innovative and flexible tools for addressing health insurance market failures. As discussed more fully below, the rate review process can be used in a range of ways, from promoting greater price competition among providers to directly regulating provider payment rates, depending on the needs and conditions of the local market. This flexibility is important because not all states suffer from the same level of provider consolidation and market power. For example, in the Minneapolis-Saint Paul area, there is greater competition among hospital systems, leading to low health insurance premiums. In contrast, just over the border in Wisconsin, with different provider networks and insurers, a health plan with similar benefits could cost three times as much as one available in Minneapolis-Saint Paul.²⁶⁹ Given these differences, the same one-size-fits-all price-setting approach may not be optimal for both markets.

The flexibility of addressing market failure through rate review also means that local policies can be adapted to changing conditions. Rather than focusing on setting a price, a rate review approach would focus on a broader goal: lowering the cost of health insurance. Over time it can, therefore, adopt new, more flexible approaches to cost control. In contrast, once a static and fixed administrative structure for price-setting is established (i.e., a rate-setting agency), its process could become institutionalized and self-perpetuating,²⁷⁰ leading to policy stagnation that could blunt the development of competition-enhancing products or new, innovative payment systems.²⁷¹

268. See *supra* note 94 and accompanying text for a survey of scholars who opine that price-setting is a viable solution.

269. Jordan Rau, *The 10 Least Expensive Health Insurance Markets in the U.S.*, KAISER HEALTH NEWS (Feb. 13, 2014), <http://kaiserhealthnews.org/news/10-least-expensive-health-insurance-markets-in-us/>.

270. See, e.g., James Q. Wilson, *The Rise of the Bureaucratic State*, 41 PUB. INTEREST 77, 93 (1975) (noting the potential for “self-perpetuating” agencies, that is, the creation of agencies that produce “a set of political relationships that make exceptionally difficult further alteration of that program”).

271. See William M. Sage, *Getting the Product Right: How Competition Policy Can Improve Health Care Markets*, 33 HEALTH AFF. 1076, 1081–82 (2014) (arguing that focusing on market concentration and prices alone does not alter the fact that the modern provision of healthcare has

b. Existing Infrastructure and Expertise

A rate review approach would also make use of existing infrastructure and expertise. Every state already has its own insurance department, with its own expert staff, that closely oversees and regulates its own domestic health insurers. Establishing yet another state agency—a stand-alone rate-setting bureaucracy—would not only be costly, time consuming, and potentially subject to protracted political debate, it would also layer yet another bureaucratic agency onto an already overburdened healthcare sector.²⁷²

Insurance departments already have staffs with knowledge of the prevailing market climate, the financial condition of health insurers, the major drivers of health insurance rate increases, and the market power of providers. Furthermore, insurance departments have the tools necessary to fully evaluate market conditions. Insurance departments have broad authority to undertake, at the expense of the insurance industry, in-depth examinations of each insurer's operations to ensure that insurers offer reasonably priced products and operate in a manner that is fair to consumers.²⁷³ These examinations, called “market conduct examinations”²⁷⁴ could be used to evaluate the payment contracts between insurers and healthcare providers,²⁷⁵ with the costs of such examinations borne by insurers.²⁷⁶ Thus, insurance departments already have significant authority, expertise, and the capacity to make determinations about how best to address market defects that affect health insurance prices.

become a series of process steps that can be billed for rather than assembled).

272. States are already awash in administrative agencies that regulate and/or oversee their healthcare sectors. For instance, in Connecticut, there are numerous state agencies, including the Office of Health Care Access, Office of the Healthcare Advocate, Commission on Health Equity, Department of Insurance, Department of Public Health, Department of Social Services, Connecticut Health and Educational Facilities Authority, Connecticut Health Insurance Exchange, and the Health Information Technology Exchange of Connecticut, which regulate or oversee various aspects of the state's healthcare and health insurance industries. See *Departments and Agencies*, CT.GOV, <http://portal.ct.gov/Department-and-Agencies/> (last visited Apr. 1, 2016).

273. See HEALTH MGMT. ASSOCS., STRENGTHENING THE VALUE AND PERFORMANCE OF HEALTH INSURANCE MARKET CONDUCT EXAMINATION PROGRAMS: CONSUMER RECOMMENDATIONS FOR REGULATORS AND LAWMAKERS 7 (2013), http://www.naic.org/documents/committees_conliaison_related_health_mce.pdf.

274. *Id.* For an example of a state insurance department's market conduct examination authority, see 27 R.I. GEN. LAWS ANN. §§ 27-13.1-1 to -8 (West 2016).

275. See, e.g., *Care New England Health Sys. v. R.I. Office of the Health Ins. Comm'r*, C.A. No. PC 10-6984, slip op. at 14–15 (R.I. Super. Ct. Sept. 28, 2011), <https://www.courts.ri.gov/Courts/DecisionsOrders/decisions/10-6984.pdf> (finding that health insurance commissioner appropriately used market conduct authority to investigate payment contract between insurer and hospital).

276. See, e.g., 27 R.I. GEN. LAWS § 27-13.1-7(a) (“The total cost of the examinations shall be borne by the examined companies . . .”).

2. Theoretical Reasons for Using Rate Review

Two aspects of federalism, state innovation and interstate competition, provide theoretical reasons for adopting a new rate review process.

a. *States as Laboratories of Innovation*

First, using rate review to address market failure could lead to the kind of state-based policy innovation that is one of the hallmarks of federalism. Perhaps the most widely cited value of federalism is the notion that states, functioning as “laboratories of democracy,” promote the development and testing of policy innovations that might not otherwise be pursued at the federal level.²⁷⁷ The idea was most famously and compellingly expressed by Justices Holmes²⁷⁸ and Brandeis²⁷⁹ nearly a hundred years ago. Indeed, “Brandeis’s exegesis of the argument for experimentation”²⁸⁰ that “a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country,”²⁸¹ is now “part of the federalistic catechism.”²⁸² And, the expected benefits of experimentation can transcend the borders of the experimenting state. As states employ their own policy experiments, a wide range of potential policy solutions could potentially

277. See *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991) (recognizing that federalism “allows for more innovation and experimentation in government”); *Fed. Energy Regulatory Comm’n, v. Mississippi*, 456 U.S. 742, 787–88 (1982) (O’Connor, J., concurring in part and dissenting in part) (“[T]he Court’s decision undermines the most valuable aspects of our federalism. Courts and commentators frequently have recognized that the 50 States serve as laboratories for the development of new social, economic, and political ideas.”); *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 US 1, 49–50 (1973) (identifying experimentation as a benefit of local control); Erwin Chemerinsky, *The Values of Federalism*, 47 FLA. L. REV. 499, 528–30 (1995) (noting that the “states as laboratories” argument is frequently cited in support of federalism); Michael W. McConnell, *Federalism: Evaluating the Founders’ Design*, 54 U. CHI. L. REV. 1484, 1498 (1987) (arguing that federalism creates competition that fosters innovation in governmental functions); David Freeman Engstrom, *Drawing Lines Between Chevron and Pennhurst: A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 TEX. L. REV. 1197, 1225 (2004) (“The ‘experimentation’ rationale holds that multiple jurisdictions function as ‘laboratories of democracy’ and thereby allow for limited, exploratory testing of policy innovations that cannot be safely pursued at the federal level.”); Harry N. Scheiber, *Foreword: The Direct Ballot and State Constitutionalism*, 28 RUTGERS L.J. 787, 805 (1997) (noting that “the idea of the states as ‘laboratories’ has endured and attracted the attention, approvingly or otherwise, from commentators and political actors on all points in the political spectrum”).

278. See *Truax v. Corrigan*, 257 U.S. 312, 344 (1921) (Holmes, J., dissenting); see also Scheiber, *supra* note 277, at 804–05 (noting that more than a decade before Brandeis’s famous statement in *New State Ice Co. v. Liebmann*, “Holmes had pointed the way for this kind of argument in commending federalism for allowing states to be ‘insulated chambers’ in which legislative experimentation could be implemented with relatively little danger to other states of the Union or the welfare of the national citizenry generally”).

279. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

280. Scheiber, *supra* note 277, at 804.

281. *Liebmann*, 285 U.S. at 311.

282. Scheiber, *supra* note 277, at 804–05.

emerge to address problems common to all states.²⁸³ States, or even the federal government, could learn from or adopt another state's innovative approach.²⁸⁴ Probably the best-known example of successful state experimentation in healthcare is the 2006 Massachusetts health insurance mandate, which served as a model for the ACA's individual mandate.²⁸⁵

b. Interstate Competition

Interstate competition is another federalism-based reason for states to adopt a more robust rate review process. The competition between states to attract mobile citizens and businesses that can “vote with their feet,” or exit one state for another, provides a strong motivation for policy action.²⁸⁶ In addition, interstate competition makes states more responsive to their own citizens in order to keep those citizens from leaving.²⁸⁷ A new rate review process that addresses market failures that drive up the cost of health insurance could not only help lure employers from other states (by lowering their health insurance costs), but could also help a state retain businesses for the same reason.

3. Political Reasons for Using Rate Review

Finally, there are significant political reasons favoring a new state-based rate review process. First, the federal government is unlikely to enact any significant new legislation enhancing federal oversight over health insurance anytime soon. The legal and political aftershocks of the ACA continue to reverberate, and opponents of the ACA continue their fight to repeal the ACA.²⁸⁸ Second, federal deference to state regulation of insurance, including

283. See, e.g., *United States v. Lopez*, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring) (“[T]he States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear.”). As more states experiment, more policy solutions are likely to be tried. See McConnell, *supra* note 277, at 1498 (“Lower levels of government are more likely to depart from established consensus Elementary statistical theory holds that a greater number of independent observations will produce more instances of deviation from the mean.”).

284. See PAUL E. PETERSON, *THE PRICE OF FEDERALISM* 17–19, 25–26, 46–47 (1995) (discussing the differing approaches used by state and federal governments); Paul E. Peterson & Daniel Nadler, *Freedom to Fail: The Keystone of American Federalism*, 79 U. CHI. L. REV. 251, 255 (2012).

285. Jennifer B. Wiggins, *Mandates, Markets, and Risk: Auto Insurance and the Affordable Care Act*, 19 CONN. INS. L.J. 275, 284 (2013) (noting that the ACA's individual mandate was modeled on Massachusetts's individual mandate law). Another example is Medicare's adoption of the diagnoses-related group payment system that was first pioneered by New Jersey. See Law & Ensminger, *supra* note 132, at 3, 3–4 n.15.

286. See generally Charles Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416 (1956) (discussing the policy implications that attend this competition).

287. John O. McGinnis & Ilya Somin, *Federalism vs. States' Rights: A Defense of Judicial Review in a Federal System*, 99 NW. U. L. REV. 89, 107–08 (2004) (“Citizens dissatisfied with state policy not only have the option of lobbying for change, but also of moving to another state that deliberately seeks to attract them with more favorable policies. To the benefits of political voice provided by interstate diversity, the possibility of interstate competition adds those of exit.”).

288. See, e.g., Noam N. Levey, *House Republicans Vote to Repeal Obamacare, Again*, L.A. TIMES (Oct. 23, 2015, 9:52 AM), <http://www.latimes.com/nation/la-na-obamacare-repeal-house-20151023-story.html> (noting the 240-to-189 House of Representatives vote to repeal major portions of

health insurance regulation, has been,²⁸⁹ and continues to be, the dominant organizing principle of federal insurance legislation. Even the ACA, which in some ways appears to be a federal takeover of health insurance regulation, still goes to great lengths to preserve traditional state-based regulation of health insurance, as evidenced by state-based exchanges,²⁹⁰ deference to state determinations of required health benefits in plans offered on exchanges,²⁹¹ overwhelming deference to state-based rate review processes,²⁹² and many other aspects of the ACA.²⁹³

B. A New Rate Review Process

Before turning to the mechanics of the new rate review process, there are two steps a state must take before it can use rate review to address the market failures that drive up provider prices. First, rate review must be expanded to cover all fully insured markets. This means rate review should be applied to large group market rates in the same way it is now applied to individual and small group market rates.²⁹⁴ This expansion would not only ensure the influence of the new rate review process over the entire fully insured market, it would also ensure a spillover effect on the ERISA self-funded market. Insurers that administer ERISA self-funded plans do not negotiate separate payment contracts with each provider, one for the insurer's fully insured plans and another for the insurer's self-funded plans. Insurers use the same contract for both types of plans.²⁹⁵ Thus, to the extent that the new rate review process obligates insurers to take actions to correct for market failures and those actions are incorporated into provider contracts, those corrective actions would apply with equal force to fully insured and self-funded plans.²⁹⁶

Second, the new rate review process would have to be based on a new

the ACA, including the requirement that Americans obtain health insurance).

289. See Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 397 (2005) (tracing federal deference to state insurance regulation from the Supreme Court's decision in *Paul v. Virginia*, 75 U.S. 168 (1868), to the inclusion of ERISA's "savings clause," which exempts from preemption state laws that regulate insurance).

290. See Alice Noble & Mary Ann Chirba, *Individual and Group Coverage Under the ACA: More Patches to the Federal-State Crazy Quilt*, HEALTH AFF. BLOG (Jan. 17, 2013), <http://healthaffairs.org/blog/2013/01/17/individual-and-group-coverage-under-the-aca-more-patches-to-the-federal-state-crazy-quilt/> (noting that the ACA "seeks to preserve and even enhances" the traditional role of the states in regulating health insurance).

291. See *id.* (noting that states can determine their own required benefits for health plans sold on exchanges).

292. See *supra* Part III.A for a discussion of the wide deference the ADA affords state-based rate review processes.

293. See Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL'Y REV. 275, 291-306 (2013) (detailing the regulatory freedom that states enjoy under the ACA).

294. Rate Increase Disclosure and Review Proposal, *supra* note 155, at 81006 (noting that only eighteen states have authority to review rates for some or all of the large group market).

295. See *supra* Part II.C.3.

296. See *infra* Part V.C.2.

statutory standard—one that gives insurance commissioners direct authority to address the problem of excessive provider prices.²⁹⁷ But that authority must be flexible; it cannot take a one-size-fits all approach. There are many ways to address price-related market failures in healthcare, and the new rate review authority should afford an insurance commissioner the flexibility to develop and apply a variety of methods to address price-related market failures. The following proposed mechanisms, which illustrate a range of increasing regulatory control, are but a few examples of such methods.

1. Point-of-Service Incentives

An insurance department could require insurers to include point-of-service incentives in their health plans and provide demonstrable, significant projected cost savings from these incentives as a condition of rate approval. Point-of-service incentives are price control mechanisms that involve no direct regulatory control of provider prices, but instead are designed to nudge consumers toward lower cost providers through the use of financial incentives. Two examples of point-of-service mechanisms are tiered cost sharing²⁹⁸ and reference pricing.²⁹⁹ A tiered cost-sharing mechanism would place hospitals, physicians, and other providers into cost-sharing tiers according to their costliness. For example, health insurers could be required to include variable hospital deductibles of \$0, \$500, or \$1,000, depending on a hospital's tier. Likewise, physician copays could range from \$0, \$20, or \$35 based on their tier. Insurers could be required to identify to the insurance commissioner the most expensive hospitals and physicians and place them in the costliest tier as a condition of rate approval.³⁰⁰

Reference pricing works on a similar principle by placing indirect price pressure on providers through nudging consumers to lower-priced services. Under reference pricing, insurers pay a specific benefit amount for a particular

297. In most but not all states this would require additional legislative authority. Some state insurance commissioners already possess some authority to control the relationship between insurers and providers in order to control costs. *See, e.g.*, 32 R.I. CODE R. § 17:7(e) (LexisNexis 2016) (requiring health insurers to adopt affordability standards developed by the commissioner and including hospital contracting conditions as a condition for approval of health insurance rates). Rhode Island has established hospital contracting provisions that limit annual hospital rate increases, including quality incentive payments, to the U.S. All Urban Consumer Less Food and Energy CPI (CPI-Urban) for the Northeast Region plus 1%, decreasing over time to CPI-U plus 0% by 2018. *Id.* § 2:10(d)(3)(E). Thus, the annual rate of increase for 2015 shall be no more than 2.7%. R.I. OFFICE OF THE HEALTH INS. COMM'R, HEALTH INS. BULL. NO. 2015-1, 2015 CPI-URBAN (AFFORDABILITY STANDARDS) (2015), http://www.ohic.ri.gov/documents/1_2015%20-1%20CPI%20Urban%20Affordability%20Standards.pdf.

298. Matthew B. Frank et al., *The Impact of a Tiered Network on Hospital Choice*, 50 HEALTH SERVS. RES. 1628, 1628 (2015) (finding that “[d]ifferential cost sharing can steer patients toward preferred hospitals” that offer lower costs and higher quality).

299. Paul B. Ginsburg & L. Gregory Pawlson, *Seeking Lower Prices Where Providers Are Consolidated: An Examination of Market and Policy Strategies*, 33 HEALTH AFF. 1, 3–5 (2014) (describing point-of-service cost control strategies).

300. This requirement counters the pressure providers would bring to bear on insurers to place them in a lower tier.

procedure, such as knee replacement, a colonoscopy, or magnetic resonance imaging. Consumers are free to use any provider they wish, but if they choose a provider that charges more than the reference price, the consumer must pay the difference out of pocket.

Mandating such point-of-service incentives for all insurers as a condition of rate approval could effectively negate provider threats, such as boycotts, and help level the insurer-provider playing field with respect to price in two ways. First, all insurers would be subject to the same point-of-service requirements. Thus, no provider could take advantage of its strong market position to play insurers off one another to secure higher prices. Second, an insurer that yielded to the pressures of a particular provider to place that provider in a preferred pricing tier or to set its reference price too high would risk denial of its rates.³⁰¹

2. Increasing Insurer Leverage Through Joint Negotiations

Another approach would be to coordinate payment negotiations between all insurers and each must-have and market-dominant provider. Joint negotiations would have one goal: to counter the ability of powerful providers to demand higher prices by threatening to leave an insurer's network. Every insurer fears a loss of customers if a must-have or market-dominant provider leaves its network. This fear allows providers to play insurers off one another, giving those providers greater leverage to extract higher prices. An insurance commissioner could address this problem by requiring that insurers jointly contract for prices with must-have and market-dominant providers, restoring some semblance of a level playing field and negating the ability of the provider to threaten to abandon the network of any one insurer. A provider's options would be limited to either opting out or remaining in all insurer networks—an all-or-nothing proposition that would undercut a provider's ability to walk away from any one insurer's network. The insurance commissioner would not participate in the negotiations, but would instead require insurers to participate in such joint negotiations as a condition of rate approval.

3. Limiting the Growth of Contracted Prices

The next step up in regulatory control by insurance commissioners would be to limit the annual growth of contracted provider prices. One strategy would be to peg the growth of provider prices to some inflation-linked standard, such as the rate of annual increases allowed by Medicare to its providers or the Consumer Price Index (CPI).³⁰² As a prerequisite to rate approval, insurers

301. Point-of-service strategies are not without drawbacks. These include difficulties ensuring effective communication with consumers about out-of-pocket costs associated with various providers and the empirical complications associated with designating cost-sharing tiers and provider payment tiers. See Ginsburg & Pawlson, *supra* note 299, at 2–4. See generally John L. Adams et al., *Physician Cost Profiling—Reliability and Risk of Misclassification*, 362 NEW ENG. J. MED. 1014 (2010) (finding that tiering of physicians with respect to costs of services may produce misleading results).

302. One state, Rhode Island, has already implemented such a standard. See *supra* note 297 and accompanying text.

would have to demonstrate that all new or renewed provider contracts (entered into since its last rate filing) limit annual price increases to no more than the inflation-linked standard. This mechanism would effectively eliminate provider leverage as a factor in setting annual price increases, since providers could never expect to get annual increases greater than those established by the inflation-linked standard.

This approach certainly has some disadvantages. First, it would effectively cement in place existing payment disparities between providers. For example, the higher rates that the larger, more powerful hospital systems could command in the past would continue to be higher than the lower rates paid to smaller community hospitals.

Another problem would stem from the fact that provider payment rates are often set years in advance. Health insurers often enter into multiyear contracts with providers, locking in payment rates for years into the future.³⁰³ It is not unusual for such contracts to last four of five years.³⁰⁴ As a result, the effect of a cap on price increases would not be felt uniformly across all providers for several years until all contracts had been renegotiated. However, over the long term, the effects of this approach could be significant. The CPI has typically been lower than average health insurance increases,³⁰⁵ and Medicare payment rates have generally increased at a much slower rate than those of private health insurance.³⁰⁶

4. Setting Payment Rates

Rate setting is the most interventionist approach of the four mechanisms discussed in this Article. Under a rate-setting approach, insurers would be required to make payments to providers according to standards established by an insurance commissioner. For instance, providers could be required to use Medicare payment methods and use Medicare rates (or some multiple

303. See, e.g., *A Review of Hospital Billing and Collection Practices: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Commerce*, 108th Cong. 114 (2004) (statement of Jack O. Bovender, Jr., Chairman and CEO of Hospital Corporation of America) (noting that Hospital Corporation of America has over 5,000 contracts with managed care providers across the country and that many are multiyear contracts); Matthew Sturdevant, *Anthem, Hartford HealthCare Hammer Out Deal*, HARTFORD COURANT (Oct. 3, 2014, 12:52 AM), <http://www.courant.com/business/Connecticut-insurance/hc-anthem-hartford-healthcare-1003-20141002-story.html> (noting that Anthem BCBS, Connecticut's largest health insurer, agreed to new multiyear contracts with five Connecticut hospitals).

304. E.g., *Care New England Health Sys. v. R.I. Office of the Health Ins. Comm'r*, C.A. No. PC 10-6984, slip op. at 6–7 (R.I. Super. Ct. Sept. 28, 2011), <https://www.courts.ri.gov/Courts/Decisions/Orders/decisions/10-6984.pdf> (noting that BCBS of Rhode Island entered into five-year contracts in 2004 and four-year contracts in 2009 with Care New England Health System, a multihospital health system).

305. See *supra* notes 229–30 and accompanying text.

306. See generally Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades*, 22 HEALTH AFF. 230 (2003) (finding that Medicare's ability to price aggressively the services it covers has resulted in a lower growth rate for its healthcare spending than the private sector).

thereof)³⁰⁷ as a prerequisite to rate approval. This approach would make payments to providers more equitable (i.e., providers in the same geographic area would be paid similar rates) and would reduce insurers' administrative costs by eliminating the need to negotiate separate contracts with different providers. It would also simplify the insurers' processing of claims for payment since providers would all be paid at the same rate.³⁰⁸ However, this approach also would not be felt uniformly across all providers for several years until all existing provider contracts expired.

Of course, price-setting in the medical context will evoke hysterical criticisms and be decried as "Soviet-style" economics. Yet, medical price-setting has taken place in the United States for over thirty years. In response to runaway costs and excessive provider power, Medicare began setting prices for hospitals in 1983³⁰⁹ and for physician services since 1992.³¹⁰ And, as Uwe Reinhardt has observed, "It's hardly likely that the Reagan administration or Congress thought themselves inspired by Soviet theory These policy makers just thought the new system made more economic sense."³¹¹ And, the system has worked. Medicare has realized a lower growth rate for healthcare spending over the last few decades than private health insurance.³¹²

Of course, one of the complaints about Medicare rate setting is that allegedly low Medicare rates cause hospitals to increase their fees to other payers, notably those who are privately insured. Indeed, hospitals claim that they need to make up for low Medicare and Medicaid payment rates by shifting costs to private payers. In other words, hospitals charge private payers more because they must do so to stay in business.³¹³ However, the available evidence suggests otherwise. Hospitals command higher fees from private health insurers because of their market power, not merely to make up alleged deficits created by stingy

307. See Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. HEALTH POL., POL'Y & L. 679, 689-90 (2012) (suggesting a price cap as a multiple of Medicare rates, such as 150% to 175% of Medicare rates).

308. See Jonathan Skinner et al., *The 125 Percent Solution: Fixing Variations in Health Care Prices*, HEALTH AFF. BLOG (Aug. 26, 2014), <http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices/> ("We suggest a short-term solution: The federal Medicare program has in place a complete system of prices for every procedure and treatment. It's not perfect, but it is uniform across regions, with a cost-of-living adjustment that pays more in expensive cities and less in rural areas. If every patient and every insurance company always had the option of paying 125 percent of the Medicare price for any service, we would effectively cap the worst of the price spikes.").

309. See Rick Mayes, *The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System*, 62 J. HIST. MED. & ALLIED SCI. 21, 51 (2007).

310. See Uwe E. Reinhardt, *Medicare's Soviet Label*, N.Y. TIMES: ECONOMIX BLOG (Nov. 12, 2010, 6:00 AM), <http://economix.blogs.nytimes.com/2010/11/12/medicares-soviet-label/>.

311. *Id.*

312. See Boccuti & Moon, *supra* note 306.

313. See Austin Frakt, *Hospitals Are Wrong About Shifting Costs to Private Insurers*, N.Y. TIMES: UPSHOT (Mar. 23, 2015), http://www.nytimes.com/2015/03/24/upshot/why-hospitals-are-wrong-about-shifting-costs-to-private-insurers.html?_r=0 ("To hear some hospital executives tell it, they have to make up payment shortfalls from Medicaid and Medicare by charging higher prices to privately insured patients. How else could a hospital stay afloat if it didn't?").

government payers.³¹⁴ Indeed, there is evidence that when Medicare reimbursements are cut, some hospitals have reduced their costs or output rather than shift more costs to private payers.³¹⁵

Opponents to price controls will also argue that price-setting inevitably leads to increased utilization by providers trying to make up for lost income. Their argument rests primarily on the Maryland experience with hospital price-setting. Since 1977, Maryland's independent rate-setting agency, the Maryland Health Services Cost Review Commission, has set hospital rates for all payers, including Medicare and Medicaid.³¹⁶ After imposing hospital price constraints, patient volume increased in Maryland hospitals.³¹⁷ The main problem with the Maryland case is that there may be causal factors other than price controls driving the increased utilization. Nevertheless, the Maryland experience provides the most salient argument against any price-setting strategy that is not coupled with utilization control.

As noted above, however, empirical evidence suggests that hospitals react to price controls by lowering costs and volume, rather than increasing the volume of services provided. A recent long-term, well-controlled study that tracked changes to Medicare payments data from ten states from 1995 to 2009 found that a 10% reduction in Medicare price was ultimately associated with a 4.6% reduction in discharges among the Medicare patients.³¹⁸ In other words, hospitals did not respond to lower Medicare prices by increasing utilization. Instead they lowered utilization of Medicare services. Furthermore, hospitals did not cost-shift by increasing utilization of services paid for by private insurance. Instead, hospitals responded to price cuts by reducing their scale of operations.³¹⁹

314. See Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 123 (2011); Chapin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 HEALTH AFF. 935, 939–41 (2013).

315. See Chapin White & Tracy Yee, *When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care*, 32 HEALTH AFF. 1789, 1794 (2013) (concluding that Medicare payment reductions cause hospitals to reduce capacity and provide fewer services rather than shift costs to other payers); David Dranove et al., *How Do Hospitals Respond to Negative Financial Shocks? The Impact of the 2008 Stock Market Crash* 30 (Nat'l Bureau of Econ. Research Working Paper Series, Working Paper 18853, 2013), <http://www.nber.org/papers/w18853.pdf> (concluding that hospitals do not shift costs, but instead cut costs when faced with reductions in Medicare or Medicaid payments).

316. See Robert Murray, *Setting Hospital Rates to Control Costs*, 28 HEALTH AFF. 1395, 1395–96 (2009); see also *HSCRC Overview*, MD. HEALTH SERVS. COST REV. COMM'N, <http://www.hsrcr.state.md.us/aboutHSCRC.cfm> (last visited Apr. 1, 2016).

317. See Murray, *supra* note 316, at 1403 (“Although Maryland has performed well in controlling hospital length-of-stay, cost per admission, and the rate of growth of hospitals’ year-to-year payment levels, the growth in overall hospital volume (largely admissions and outpatient visits) in recent years has undermined the regulatory system’s overall cost performance.”); Mark Pauly & Robert Town, *Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency*, 37 J. HEALTH POL., POL’Y & L. 697, 700–01 (2012).

318. White & Yee, *supra* note 315, at 1789.

319. See *Id.* at 1794 (“In general, hospitals seem to behave like a prototypical profit-maximizing firm: They increase output when they are paid higher prices for that output, and they decrease output

C. Likely Objections to a New Rate Review Process

A new rate review process that addresses market failures would certainly generate objections, as do all efforts to control healthcare costs or increase regulation. While not an exhaustive list, the following represent the most likely general objections to an expanded rate review process.

1. There Would Be Significant Political Obstacles

There would indeed be significant political hurdles to implementing this new rate review process. Health insurance payments are a major source of income for the physicians, hospitals, pharmaceutical companies, and others in the medical services industry. Regulatory controls leading to lower health insurance payments would generate significant political opposition from the medical services industry. This may be why the ACA's cost control measures for private health insurance are so weak.³²⁰ Indeed, the political risks of insurance-based cost control are evident in the failed Clinton health reform plan of 1993–94. The Clinton plan included de facto budgetary caps on health spending, including caps on private health insurance premiums. This threat to the income of the medical services industry helped kill the Clinton plan.³²¹

While rate review-based efforts to control prices would undoubtedly generate political opposition from powerful hospitals and physicians, opposition to enhanced rate review would not likely be as fierce as it was in 1993 and 1994 with the Clinton plan because, unlike then, health insurers are less likely to oppose rate review-based price controls now. Health insurers would benefit from such controls through lower claims costs and perhaps lower administrative costs associated with more closely controlled prices. Nevertheless, increasing an insurance commissioner's authority would not be an easy sell to state legislatures, especially in light of the predictable rhetoric claiming price controls would lead to rationing or "death panels."³²²

when the costs of production rise."). The evidence on physicians is mixed. There is evidence that physicians respond to a decrease in payments with higher utilization. *See, e.g.,* Mireille Jacobson et al., *How Medicare's Payment Cuts for Cancer Chemotherapy Drugs Changed Patterns of Treatment*, 29 HEALTH AFF. 1391 (2010) (finding physicians responded to a decrease in price for a chemotherapy drug by increasing the rate of chemotherapy treatment for patients with lung cancer, increasing the rate of chemotherapy for patients with newly diagnosed cancer, and switching to more costly chemotherapy agents). There is also evidence that physicians respond to price cuts by better managing care and through lower use of marginally effective services. *See, e.g.,* Carrie H. Colla et al., *Impact of Payment Reform on Chemotherapy at the End of Life*, 8 J. ONCOLOGY PRAC. e6s, e12s (2012) (finding that "for a range of services with marginal value, a reduction in fee-for-service reimbursement can better align payment with quality-of-care goals").

320. Marmor et al., *supra* note 94, at 486; Jonathan Oberlander, *Throwing Darts: Americans' Elusive Search for Health Care Cost Control*, 36 J. HEALTH POL., POL'Y & L. 477 (2011).

321. Oberlander, *supra* note 320, at 478–479.

322. *See* Elizabeth Weeks Leonard, *Death Panels and the Rhetoric of Rationing*, 13 NEV. L.J. 872 (2013) for a discussion of continued resistance to universal healthcare in the U.S. based on two taboos: taxation and rationing.

2. ERISA

ERISA is often an impediment to state-based health insurance reform.³²³ Congress enacted ERISA to establish minimum standards for private employee retirement and benefit plans, including plans covering health insurance benefits.³²⁴ ERISA does not, however, mandate any specific benefits or regulate the substantive content of benefit plans. Rather, ERISA contains provisions that preempt state laws that “relate to” employee benefit plans.³²⁵ This means that states cannot dictate the content or conditions of self-funded employee benefit plans. States can, however, regulate the private insurance that is sold to employers.³²⁶ Thus, while ERISA does not preempt any efforts to mandate price controls on health insurers, self-insured employers would not be subject to such regulation. This begs the question: How could price controls through rate review apply to self-insured employer groups? As briefly discussed earlier, the answer is quite simple. In addition to administering their own fully insured plans, health insurers also administer most self-insured plans. But, regardless of whether a patient is covered by a fully insured or self-funded plan, the insurer pays the provider treating that patient according to the payment terms of the contract between the insurer and the provider. Those payment terms cover all claims processed by the insurer for that provider, regardless of whether those claims originated under a fully insured or self-insured group plan.³²⁷ This means that the new rate review mechanisms suggested in this Article, like joint negotiations, capping increases, and rate setting, would have a spillover effect on ERISA self-insured plans. Any other outcome would entail administrative costs and difficulties that insurers that administer self-insured plans simply would not undertake. For example, it is highly unlikely that an insurer would negotiate separate provider contracts for every provider in its network, one for self-insured plans and another for fully insured plans, and set up separate internal payment systems for each contract. Moreover, no self-funded employer group plan would object to benefitting from the cost savings that would flow from the new rate review process. Thus, ERISA is unlikely to present a substantial obstacle to a state’s efforts to address healthcare market failures through rate review.

3. What About Federal Antitrust Laws?

Would the rate review mechanisms suggested in this Article violate federal antitrust laws? No. First, the MFA exempts the business of insurance from federal antitrust law to the extent it is regulated by state law, with the exception of agreements or acts of boycott, coercion, or intimidation.³²⁸ However, a state

323. Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 86, 88, 89 (2009) (“Any comprehensive state-level health reform legislation . . . must take into account the states’ vulnerability to ERISA preemption.”).

324. *Id.* at 89.

325. 29 U.S.C. § 1144(a) (2012).

326. *See id.* § 1144(b)(2)(A); Korobkin, *supra* note 185, at 89.

327. *See supra* Part II.C.3 for a discussion of the specifics of such payment terms.

328. 15 U.S.C. §§ 1011–1013 (2012).

action exemption would also apply. The state action exemption would apply if the state compels the anticompetitive activity, the activity is essential to a state regulatory scheme inconsistent with the federal antitrust laws or required as part of a scheme that the state clearly articulates and actively supervises, and the activity is one in which the state has a legitimate regulatory interest.³²⁹ Indeed, there is historical precedent for state insurance commissioners regulating rates. When Blue Cross insurers operated under their original mode of operation, as financing operations for hospitals through direct payment to hospitals, state insurance departments had authority to regulate the contracts between Blue Cross insurers and hospitals and physicians, including payments terms. Antitrust laws were not a concern.³³⁰

4. Why Not Fix the Underlying Market?

Advocates of market-based solutions argue that price controls are not a good substitute for efforts directed at the root causes of high provider prices. As Mark Pauly and Robert Town have suggested when discussing the Maryland rate-setting system:

We may thus be better off by advocating leaving hospital regulation aside and concentrating necessarily limited political attention and clout on what drives spending growth, rather than on what causes the messengers to deliver the bad news. The tax exclusion, subsidies, and patents that increase the amount and prices of cost-increasing technical change, vigorous antitrust enforcement, and the ever elusive leadership and climate change that could reduce variations in medical practice might all be better points of attention than trying to control a price or profit margin, which is in many ways an effect rather than a cause of spending growth. At most, regulation could be limited to markets unable to be workably competitive; even here the case would have to be made that the skill and political climate is as favorable to good regulation as it has been in Maryland.³³¹

Their reasoning is hard to argue with, except with respect to whether the implementation of all the changes they suggest is realistic. Provider prices are high now. Health insurance costs are continuing to increase at a rate that outstrips general inflation. Efforts to eliminate subsidies, undo provider

329. The state action immunity doctrine, set out in *Parker v. Brown*, 317 U.S. 341 (1943), provides a form of “inverse preemption,” allowing a state to stave off federal antitrust enforcement of anticompetitive behavior by imposing state regulation over that behavior. See Frank H. Easterbrook, *Antitrust and the Economics of Federalism*, 26 J.L. & ECON. 23, 25 (1983) (describing *Parker*’s state action immunity doctrine as a form of “inverse preemption”). In order for the exemption to apply, the state must clearly articulate its policy to substitute regulation for market competition and must actively supervise implementation of that policy. *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

330. See, e.g., Larry D. Carlson, *The Insurance Exemption from the Antitrust Laws*, 57 TEX. L. REV. 1127, 1187–88 (1979) (describing laws in Pennsylvania and Massachusetts that provided the state insurance commissioner authority to approve contracts between BCBS corporations and providers, including approval of reimbursement terms).

331. Pauly & Town, *supra* note 317, at 706.

networks, and change tax laws will require sustained political attention, continuous legislative efforts, and a good deal of time. When faced with the choice between a long-term campaign to make multiple fundamental system changes and concentrating limited political attention on controlling market failure through insurance rate regulation, the latter is the more realistic option.

CONCLUSION: THE FUTURE OF HEALTH INSURANCE RATE REVIEW

The ACA has reaffirmed the private insurance model as the main healthcare financing system for the U.S. population not covered by government programs such as Medicare and Medicaid. Yet, this system of healthcare financing through private insurance can no longer simply import regulatory practices that are better suited to other forms of insurance. Rate review is a perfect example. The ACA has implemented an extensive federal rate review process that uses as its model the traditional property-casualty approach to rate regulation. The results are predictable. The ACA's rate review process has not and will not limit health insurance price increases because, as Wendy Mariner and others have argued, health insurance is fundamentally different from other types of insurance.³³² Sadly, the drafters of the ACA and HHS did not recognize that a different mode of rate regulation should apply to health insurance. This not only led to provisions in the ACA that limited the effectiveness of rate review, but also to overblown claims of what rate review can and is doing to save consumers money. None of this, however, prevents any state from recognizing that a different mode of rate review ought to apply to health insurance. This Article has offered a critical analysis of the ACA's rate review provision in the hope that state legislators, policymakers, and insurance regulators will recognize the full potential of a rate review process specifically tailored to health insurance.

332. Mariner, *supra* note 253, at 450.