

Health Insurance Research

Health Insurance Processes

SOURCE 1:

State Approval of Health Insurance Rate Increases

<https://www.ncsl.org/research/health/health-insurance-rate-approval-disapproval.aspx>

State	Individual Market	Small Group Market	Effective Rate Review Program
Alabama	State	State	Yes (as of June 2016)
Alaska *	State	State	Yes
Arizona	State	Federal	Partial (Associations: Partial)
Arkansas	State	State	Yes
California	State	State	Yes
Colorado	State	State	Yes
Connecticut	State	State	Yes
Delaware	State	State	Yes
Florida	State	State	Yes (Associations: Partial)
Georgia	State	State	Yes
Hawaii *	State	State	Yes (Associations: No)
Idaho *	State	State	Yes (Associations: Partial)
Illinois	State	State	Yes
Indiana [Rate Watch website]	State	State	Yes
Iowa *	State	State	Yes
Kansas	State	State	Yes
Kentucky	State	State	Yes (Associations: Partial)
Louisiana	Federal	Federal	No
Maine	State	State	Yes
Maryland	State	State	Yes
Massachusetts	State	State	Yes

State	Individual Market	Small Group Market	Effective Rate Review Program
Michigan	State	State	Yes
Minnesota	State	State	Yes
Mississippi	State	State	Yes (Associations: Partial)
Missouri	Federal (to State in 2018)	Federal	No (to State in 2018)
Montana	State	State	Yes
Nebraska	State	State	Yes (Associations: Partial)
Nevada	State	State	Yes
New Hampshire	State	State	Yes
New Jersey	State	State	Yes
New Mexico	State	State	Yes
New York	State	State	Yes
North Carolina	State	State	Yes (Associations: Partial)
North Dakota	State	State	Yes
Ohio	State	State	Yes
Oklahoma	Federal	Federal	No
Oregon *	State	State	Yes (Associations: Partial)
Pennsylvania **	State	State	Yes (Associations: Partial)
Rhode Island	State	State	Yes (Associations: Partial)
South Carolina	State	State	Yes
South Dakota	State	State	Yes
Tennessee	State	State	Yes
Texas	Federal	Federal	No
Utah	State	State	Yes
Vermont ***	State	State	Yes (Associations: Partial)
Virginia	State	State	Yes
Washington	State	State	Yes (Associations: No)
West Virginia	State	State	Yes
Wisconsin	State	State	Yes
Wyoming	Federal	Federal	No
District/Territories	Individual Market	Small Group Market	Effective Rate Review Program

State	Individual Market	Small Group Market	Effective Rate Review Program
District of Columbia	State (District)	State (District)	Yes
American Samoa	Federal	Federal	No
Guam*	State	State	Yes
Northern Mariana Islands	Federal	Federal	No
Puerto Rico*	State	State	Yes
Virgin Islands	State (Territory)	State (Territory)	Yes

Federal Health Reform

The Patient Protection and Affordable Care Act (ACA) establishes a process for reviewing certain increases in health plan premiums and requires plans to justify such increases.

The federal law requires states to report on trends in premium increases and recommend whether certain plans should be excluded from health benefit exchanges beginning in 2014, based on unjustified premium increases. Some of the key provisions took effect immediately, beginning with the 2010 plan year. (Title I, Subtitle A, Sec. 1003) Generally the federal provisions do not preempt state laws and regulations that provide more extensive scrutiny or powers to disapprove proposed rate increases. Details are provided within the three 50-state tables published below.

- **States to Receive \$22 million for 2016.** On June 15, 2016 the Centers for Medicare & Medicaid Services (CMS) announced the availability of \$22 million in funding to state insurance regulators to use for issuer compliance with Affordable Care Act key consumer protections. "These departments are responsible for making sure that premiums are reasonable and justified, ensuring company solvency, and protecting consumers," said Kevin Counihan, CEO of the Health Marketplace program within HHS.
- **Alabama Implements Rate Review Program.** Alabama regulators notified the federal government that, for the first time, they plan to review premium hikes on the state exchange, which currently only includes Blue Cross and Blue Shield of Alabama. (*AL.com, June 15, 2016*)

2017 Preliminary Filed Rates – Reported in The New York Times, 7/17/2016

- **Texas**, Blue Cross and Blue Shield is requesting rate increases of nearly 60 percent.
- **Oklahoma**, Blue Cross and Blue Shield has proposed increases that average 49 percent.
- **Missouri**, Humana has filed for a 34 percent increase.
- **Michigan**, Humana is seeking a 39 percent increase according to data posted by the [State Insurance Department](#).
- **Oregon** insurance commissioner recently approved a 24 percent increase for Providence Health Plan, which has the largest enrollment of any carrier in the state's individual insurance market.

- The largest insurer in **Tennessee**, Blue Cross and Blue Shield, has requested rate increases averaging 63 percent, according to the state insurance commissioner.
- Blue Cross and Blue Shield of **North Carolina**, which raised individual rates by an average of 32.5 percent this year, has requested a further increase of 18.8 percent for 2017.
- In **Wyoming**, the proposed rate increases are relatively modest, less than 10 percent. But Wyoming already has some of the highest rates in the country,
- All three carriers say they have lost money on many policies sold to individuals and families under the Affordable Care Act.
- **Missouri law authorizes Rate Review** with new law, [SB 865](#), signed July 2016; effective 2018 [[article 7/2016](#)]

Rate Review Annual Report for 2015 and 2014: [Published by CMS Dec. 2015; [Download PDF; 10 pages](#)]

- Rate review reduced total premiums for renewed single risk pool plans by an estimated \$1.1 billion in the individual market and by \$418 million in the small group market, for a total of \$1.5 billion.
- The weighted average rate increase implemented for single risk pool coverage was 6.9 percent in the individual market (8.7 percent initially requested) and 4.3 percent in the small group market (5.1 percent initially requested).
- In the individual market, altogether, an estimated 6.5 million consumers benefited from rate review. 30 percent of covered lives were projected to enroll in single risk pool plans with a rate increase that was reduced or denied. In the small group market, the projection percentage was 19.6.
- 577 health insurance issuers submitted 1,933 single risk pool product rate filings for the individual market in 2015. 683 of the 1,933 products were new (not offered in 2014). 443 of the 1,250 rate filings for renewed products requested a rate increase of 10 percent or more. Among all single risk pool filings with a rate change request of any size, the average rate increase requested was 8.7 percent and the average implemented was 6.9 percent. After the review process was complete, the percentage of filings with a rate increase of 10 percent or more dropped by approximately 24 percent. Premiums were reduced by an estimated \$1.1 billion in the individual market for single risk pool coverage in CY 2015 based on the difference between the requested and implemented rate changes.
- \$250 million in grant funding has been available to states over a five-year period to help with rate review activities. (Effective during the 2010 plan year.) "These funds will help states strengthen their oversight capabilities and will allow states that do not currently review rates to establish a program. In doing so, these grants will help states protect consumers and small employers by holding insurers accountable for unreasonable insurance rate increases that have made coverage unaffordable for many American families."

States with Effective Rate Review Programs

- Beginning September 2011, HHS announced the nationwide implementation of state-based programs to conduct rate review. HHS worked with states to strengthen or alter their programs. As detailed in the [rate review regulation](#) finalized on May 19, 2011, states with effective rate review systems must conduct reviews of proposed rates above the applicable threshold (10% from September 2011-August 2012), but if a state lacks the resources or authority to conduct the required rate reviews, HHS will conduct them.
- [Rate Review Grants to States - HHS announcement September 2013](#)
- [Review of Health Insurance Rate Increases](#) - HHS Fact Sheet, 9/1/2011
- An effective rate review system, as [described](#) by HHS:
- Must receive sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases.
- Must consider the factors below as they apply to the review:
 - Medical cost trend changes by major service categories
 - Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits) by major service categories
 - Cost-sharing changes by major service categories
 - Changes in benefits
 - Changes in enrollee risk profile
 - Impact of over- or under-estimate of medical trend in previous years on the current rate
 - Reserve needs
 - Administrative costs related to programs that improve health care quality
 - Other administrative costs
 - Applicable taxes and licensing or regulatory fees
 - Medical loss ratio; and
 - The issuer's capital and surplus.
- Must make a determination of the reasonableness of the rate increase under a standard set forth in state statute or regulation.
- Must post either rate filings under review or preliminary justifications on their websites or post a link to the preliminary justifications that appear on the CMS website.
- Must provide a mechanism for receiving public comments on proposed rate increases.
- Must report results of rate reviews to CMS for rate increases subject to review.
- To determine whether a state met these standards, HHS reviewed all available documentation, and met with state regulators and their staff to verify the information and obtain any updates. CMS will continue to accept information from states and monitor states in order to ensure correct classification. CMS can reevaluate the status of this list as changes are made in each state.

As of June 2016:

- **46 states**, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have effective rate review in at least one insurance market;
- Alabama became the [45th state](#), as announced in April 2016.

- Missouri became the 46th state, with a July 2016 law.
- 43 states, the District of Columbia, have effective review for **all** insurance markets and issuers.
- The Federal government will conduct review in four-five states and two U.S. territories (American Samoa, Northern Mariana Islands) until those areas are able to strengthen their review processes and authorities.
- Resources and assistance are available to states and territories to help strengthen their review processes.
- Starting September 1, 2011, insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets are required to publicly disclose the proposed increases and the justification for them. Such increases will be reviewed by state or Federal independent experts to determine whether they are unreasonable. In future years, the threshold for review will be set on a state-by-state basis using data that reflect insurance and health cost trends in each state. And an easy-to-access, consumer-friendly disclosure form explaining the proposed increases will also be made publicly available through HHS, state and/or insurer websites.
The rate review regulations work in conjunction with other parts of the Affordable Care Act that also hold premiums down. The law requires insurers to spend at least 80 percent of premium dollars on direct medical care or to improve the quality of care instead of on overhead, advertising, and executive salaries and bonuses. If an insurer fails to meet that test, they must pay a rebate to their enrollees. This “medical loss ratio” regulation, released on November 22, 2010, makes the health insurance marketplace more transparent and increases the value consumers receive for their money.
- Since mid-September 2011, consumers in every state can go to HealthCare.gov to view easy-to-access, disclosure information explaining proposed increases that are 10 percent or higher than last year’s rates. Consumers see a summary of the key factors driving rate increases and an explanation provided by insurance companies for why the proposed increase is needed; Consumers also are given the ability to comment on large proposed rate increases.

State list rate review/public participation:

<https://advocacy.consumerreports.org/wp-content/uploads/2014/04/Exhibit-A-State-List-Public-Participation.pdf>

SOURCE 2:

Rate Review Processes in the Individual and Small Group Markets

<https://www.kff.org/health-reform/state-indicator/rate-review-program-effectiveness/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

- See KFF link for interactive table and map of rate review processes.

Title: Rate Review Processes in the Individual and Small Group Markets The Henry J. Kaiser Family Foundation				
Timeframe: as of March 17, 2017				
Location	State Has Effective Rate Review Program?	Individual Market Rate Review Process	Small Group Market Rate Review Process	Footnotes
United States	Yes: 47 states, including DC; No: 4 states	State: 48 states, including DC; Federal: 3 states	State: 48 states, including DC; Federal: 3 states	
Alabama	Yes	State	State	1
Alaska	Yes	State	State	
Arizona	Yes	State	State	
Arkansas	Yes	State	State	
California	Yes	State	State	
Colorado	Yes	State	State	
Connecticut	Yes	State	State	
Delaware	Yes	State	State	
District of Columbia	Yes	State	State	
Florida	Yes	State	State	
Georgia	Yes	State	State	
Hawaii	Yes	State	State	
Idaho	Yes	State	State	
Illinois	Yes	State	State	
Indiana	Yes	State	State	
Iowa	Yes	State	State	
Kansas	Yes	State	State	
Kentucky	Yes	State	State	
Louisiana	Yes	State	State	
Maine	Yes	State	State	
Maryland	Yes	State	State	
Massachusetts	Yes	State	State	
Michigan	Yes	State	State	
Minnesota	Yes	State	State	
Mississippi	Yes	State	State	
Missouri	Yes	State	State	
Montana	Yes	State	State	
Nebraska	Yes	State	State	
Nevada	Yes	State	State	

New Hampshire	Yes	State	State	
New Jersey	Yes	State	State	
New Mexico	Yes	State	State	
New York	Yes	State	State	
North Carolina	Yes	State	State	
North Dakota	Yes	State	State	
Ohio	Yes	State	State	
Oklahoma	No	Federal	Federal	
Oregon	Yes	State	State	2
Pennsylvania	Yes	State	State	
Rhode Island	Yes	State	State	
South Carolina	Yes	State	State	
South Dakota	Yes	State	State	
Tennessee	Yes	State	State	
Texas	No	Federal	Federal	
Utah	Yes	State	State	
Vermont	Yes	State	State	
Virginia	Yes	State	State	
Washington	Yes	State	State	
West Virginia	Yes	State	State	
Wisconsin	Yes	State	State	
Wyoming	No	Federal	Federal	
American Samoa	N/A	N/A	N/A	
Guam	N/A	N/A	N/A	
Northern Mariana Islands	N/A	N/A	N/A	
Puerto Rico	N/A	N/A	N/A	
U.S. Virgin Islands	N/A	N/A	N/A	
Notes				
The Affordable Care Act enures that any proposed rate increase by individual or small group market insurers at or above 10% will be scrutinized by independent experts to make sure it is justified. As detailed in the [rate review regulation](http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf) finalized on May 19, 2011, and amended in 2011, 2012, and 2013, states with effective rate review systems must conduct reviews of proposed rates above the applicable threshold, but if a state lacks the resources or authority to conduct the required rate reviews, HHS will conduct them. To determine whether a state met these standards, HHS reviewed all available documentation and met with state regulators and their staff to verify the information and obtain any updates.				

The data table indicates if the state has an effective rate review process in place, and whether a Federal or State rate review process will be used to review proposed insurance rate increases. As of September 22, 2014, 46 states and the District of Columbia have effective rate review in both insurance markets. In five states (AL, MO, OK, TX, and WY), the Federal government will conduct reviews in both markets until those areas are able to strengthen their review processes and authorities. Please see the [data source](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html) for a list of effective rate review system criteria and for state status updates.				
Effective July 16, 2014, CMS issued letters to the territories clarifying that the new provisions of the PHS Act enacted in title I of the Affordable Care Act are appropriately governed by the definition of "State" set forth in that title, and therefore the rate review requirements do not apply to group and individual health insurance issuers in the territories. The definition of "State" is defined at 45 C.F.R. § 154.102.				
Sources				
[List of Effective Rate Review Processes](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html), The Center for Consumer Information & Insurance Oversight (CCIIO), CMS; updated March 17, 2017.				
Footnotes				
1. Effective April 2016, correspondence from the Alabama Department of Insurance confirming its intent to comply with the rate review regulation (45 CFR Part 145), Alabama now has effective rate review in both the individual and small group market.				
2. Oregon State law exempts from rate review association plans that retain 95% or greater of their employer groups (ORS 743.734).				

SOURCE 3:

Rate Review Processes in the Individual and Small Group Markets

<https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment>

SUMMARY: This brief reviews the evidence on how key ACA provisions have affected the growth of health care costs. Coverage expansions produced a predictable jump in health care spending, amidst a slowdown that began a decade ago. Although we have not returned to the double-digit increases of the past, the authors find little evidence that ACA cost containment

provisions produced changes necessary to “bend the cost curve.” Cost control will likely play a prominent role in the next round of health reform and will be critical to sustaining coverage gains in the long term.

- While the Affordable Care Act (ACA) has been largely defined by its coverage expansions, its authors recognized the need to include mechanisms to slow the growth of health care costs. The law’s provisions took aim at Medicare spending and to a lesser extent, factors that affect costs in the individual and group private market. To understand the law’s impact and potential to “bend the cost curve,” it is important to isolate the effects of the ACA from those attributable to the economic recession and recovery. Although the ACA’s future is in doubt, cost containment will remain a key ingredient of any health reform effort. In this brief, we discuss key ACA provisions and their effects on containing overall cost growth and the cost of ACA-related gains in coverage.

THE TRAJECTORY OF NATIONAL HEALTH SPENDING

- First, let’s look at the big picture. As shown, national health expenditure (NHE) grows regardless of macroeconomic conditions, although this growth often slows in periods of recession. The historical patterns reflect slower growth due to cost containment efforts of managed care in the 1990s; upturns from the managed care backlash and spending on blockbuster drugs in the early 2000s; a deceleration through 2007 with a rapid rise of cheaper generic drugs and slower rate of introduction of new technology; and a dramatic slowdown in growth through 2013, with a deep recession and modest recovery. The patterns also reflect the impact of the ACA, as large-scale coverage expansions began in 2014.
- Why the dramatic slowdown from 2007-2013?
 - Studies estimate that the 2007-2009 recession and the slow recovery from it explained somewhere between 37 percent and 70 percent of the slowdown. Others point to the spread of high-deductible health plans (HDHPs), which incentivize price-conscious consumers to shop for care and avoid low value care. Just four percent of employers offered HDHPs in 2005; by 2011, nearly a third of employers offered such plans. A 2013 study suggested that less generous benefit design might have accounted for 20 percent of the slowdown. Slower adoption of expensive new medical technology and fewer new blockbuster drugs may have also been contributing factors.
- The ACA’s coverage expansion in 2014 spurred a spike in spending, as would be expected. These provisions allowed millions of people to get health insurance through the exchanges and through Medicaid expansion. Health care costs increased by 5.3 percent in 2014, from a low of 2.9 percent in 2013. The Office of the CMS Actuary estimated that increased use of health care services accounted for nearly 40 percent of the increase in per-capita health spending. Health costs grew by 5.8 percent in 2015, and preliminary estimates by the Altarum Institute indicate a steady growth rate of 5.4 percent over 2015.
- Analysis of the ACA’s effects on cost containment rests on three concepts: first, that any provisions affecting only the individual market can have little effect on overall health

spending, because only 6% of people under age 65 are in that market; second, that the slowing of the trajectory of health care spending predates the ACA and complicates analysis of its effects; and third, that while increased utilization of health care due to the ACA's coverage expansion drove cost growth in the early years, health care prices will likely exert a powerful influence on the trajectory of health care costs over the long run.

KEY COST-CONTAINMENT PROVISIONS

- Medicare Reforms
 - One of the most immediate and direct ways that the ACA produced savings was through reductions in provider payment updates and Medicare Advantage (MA) payments. Prior to the ACA, payments to MA plans were 14 percent higher than the cost of covering similar beneficiaries under the traditional Medicare program, according to the Medicare Payment Advisory Commission. The ACA reduced payments to MA plans over six years, and by 2016, payments to MA plans were just two percent higher than costs in the traditional Medicare program. Although critics were concerned that these cuts would mean that plans withdrew from the program, according to Kaiser Family Foundation, enrollment actually increased from 24 percent in 2009 to 31 percent in 2016. The payment reductions produced short-term federal savings of \$68 billion between 2011 and 2016.
 - The ACA provided a regulatory framework for containing costs in Medicare by setting a per capita target for spending growth and creating a 15-member Independent Payment Advisory Board (IPAB) to develop a plan to reduce spending if that target is exceeded. What the board can recommend is constrained: by law, it cannot raise premiums, reduce benefits, or increase cost sharing, meaning that their recommendations are mostly confined to cuts in provider payments. The board's proposals become law unless Congress explicitly overrides them. Spending did not exceed per capita targets in the ACA's first three years, and therefore IPAB was not triggered. The IPAB currently has no members, which reflects a congressional majority strongly opposed to its existence. IPAB has been targeted for repeal on a bipartisan basis and is not likely to survive as a cost containment mechanism.
 - Beyond IPAB, the ACA authorized multiple initiatives designed to wring savings out of Medicare through administrative simplification, improved quality, better care coordination, and reduced payment rates. Some of the most prominent examples include the Hospital Readmissions Reduction Program (HRRP); Accountable Care Organizations (ACOs) through the Medicare Shared Savings Program and Pioneer Program; primary care medical homes; and bundled payment models. This emphasis on moving to value-based reimbursement dovetails with changes in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which mandated that Medicare move from fee-for-service to alternative payment models, such as those with risk-sharing arrangements or reimbursement tied to quality measures.

- Early evidence from the HRRP has shown decreases in hospital readmissions, but no firm data on overall cost savings. According to an analysis by the Kaiser Family Foundation, for fiscal year 2017, 79 percent of hospitals in the United States will receive a penalty and that penalty payments will total over half a billion dollars.
 - Most of the ACA's provisions promoting value-based payment were small-scale, voluntary programs that, at best, can be considered proof-of-concept demonstrations rather than cost containment initiatives. The programs have had variable effects on costs, and their ability to "bend the cost curve" remains conjecture.
 - For example, the ACA promoted ACOs as both a quality improvement and cost containment mechanism. In 2015, more than 400 ACOs in the Pioneer ACO Model and the Medicare Shared Savings Program generated \$429 million in savings, but bonuses paid to high-performing ACOs produced a net loss of \$216 million. ACOs with more experience tend to perform better over time.
 - A recent study of the Comprehensive Primary Care Initiative (CPCI), a 2012 CMS initiative in 500 practices to improve quality and reduce costs, found minimal effects on costs or outcomes after two years. The program did not generate enough savings in Medicare Parts A and B to cover care-management fees associated with the program.
 - In the most recent CMS evaluation, bundled payments also show modest effects on costs, depending on the model and clinical condition. In the most prevalent model, episode payments decreased spending for orthopedic surgery (mostly hip and knee replacements), but increased spending for spinal surgery, relative to comparison hospitals. These results were from voluntary programs; although CMS issued rules for a mandatory bundled payment system for heart attack treatment, bypass surgery, and surgical hip and femur fracture treatment in December 2016, the mandatory system may not survive a Republican administration and Congress that is opposed to it.
- Private Market Insurance Reforms
 - The ACA includes a slew of new regulations affecting the private insurance market, both on and off the exchanges. These include a prohibition on lifetime and annual caps on coverage, a mandate to cover "essential health benefits," premium rate review, and the Medical Loss Ratio (MLR) provision, which required insurers to provide a customer rebate if they spend too high a percentage of premium dollars on non-medical expenditures. It is difficult to tease out the countervailing effects of these regulations on health care costs, especially because the provisions affect the individual, small group, and large group markets differently.
 - The most significant provision targeting long-term cost growth is the tax on high-cost health plans, known as the "Cadillac Tax". The provision imposes a 40 percent excise tax on high-cost, employer-sponsored insurance that was to begin in 2018. However, Congress voted to delay its implementation until 2020—an

indication of the political difficulties of reining in health spending. Proponents predicted that this tax would spur employers to shift away from high-cost health insurance—long incentivized by preferential tax treatment—and in so doing drive down overall health care spending. Many unions, employer groups, and insurers continue to oppose the tax, however, and it remains unclear whether Congress will allow it to take effect.

- In the individual market, the ACA focused on the creation and stability of exchanges as a way to promote competition and contain health care costs. Economic theory predicts, and evidence suggests, that a higher number of insurers in a marketplace correlates with lower premiums. But as we stated in a previous brief in this series, the exchanges have undergone significant turmoil in the past three years, and recent insurer departures have left some marketplaces with little or no competition.
 - In the individual market, premium rate reviews were an explicit mechanism to restrain premium increases and keep costs down. An early analysis by Kaiser Family Foundation of the rate review provision found that 20 percent of filings resulted in lower premium increases due to the rate review process. On average, premium rate increases were 1.4 percentage points lower than originally requested. Another analysis by the Department of Health and Human Services found that in 2013, rate review reduced premiums in the individual and small-group markets by almost \$1 billion. The actual effects on health care costs, however, is unknown, given that insurers could have inflated premium increase requests above what would have been present in the absence of the provision.
 - Commonwealth Fund data on the effects of the medical loss ratio provision show that the law has had a modest effect on reducing premium overhead and providing consumer rebates. Insurers reduced overhead spending by \$350 million in 2011 and \$1 billion in both 2012 and 2013. According to the Congressional Budget Office (CBO), rebates to customers, effectively lowering their premiums, totaled over \$2.4 billion over the 2011 – 2014 period. The overall impact of the MLR provision on costs is uncertain, as insurers can reduce administrative costs or increase claims costs to avoid paying penalties.
- WHERE WE ARE AND WHAT WE DON'T KNOW
 - Much is unknown about the effects of various cost-containment provisions within the ACA. Depending on whether the ACA is repealed in total or pieces of it remain, we may not be able to determine what effects the law has had. To date, evidence has shown health spending has slowed since the ACA's passage in 2010. However, as ACA coverage expansion provisions are implemented, we are seeing an increase in overall spending, although to an extent, that is to be expected. Medicare demonstrations around payment and delivery reforms are potentially useful in slowing cost growth, but they remain unproven and even the successful programs produce only modest savings. In private insurance, provisions like rate review and MLR have had, at most, a minimal impact on overall health care costs.

- Outside of the ACA explicitly, high-deductible health plans and insurance mergers will likely have important effects on health spending, although the magnitude is hard to predict. Also in the mix are the long-term effects of changes in Medicare (particularly the role of IPAB), the Cadillac Tax, and the role of new technologies.
- Medicare. In 2015, the CMS Chief Actuary found that that Medicare per-capita spending growth was just 0.12 percentage points below the trigger rate for IPAB to take effect. It is likely that the IPAB threshold of GDP + one percentage point will be hit in 2017. Although it is highly unlikely that IPAB will survive, any mechanism that caps spending at this rate would force billions of dollars in savings.
- Cadillac Tax.
 - The provision most likely to have a dramatic effect on premiums and curbing spending growth—the Cadillac Tax—remains years from implementation in the best-case scenario. Estimates of its explicit effects are varied. CBO and the Joint Committee on Taxation (JCT) recently estimated that in 2020, even if employers did not make any changes in response to the tax, five to ten percent of enrollees in ESI plans would be subject to the tax and that share would grow to between 15 and 20 percent in 2025. If implemented as currently outlined under the law, CBO and JCT estimate that the tax will reduce deficits by nearly \$80 billion by 2026.
 - Some changes have occurred even though the tax has not been implemented. The 2016 Kaiser Employer Health Benefits Survey found that some employers have changed their plans' coverage or increased cost sharing to avoid the tax. Another survey done by Mercer found that a significant number of respondents were taking steps that will limit their exposure to the tax. Forty-eight percent have implemented a consumer-directed health plan (CDHP), 38 percent have encouraged employees into CDHPs, 28 percent raised deductibles, and 17 percent dropped high-cost plans. A recent study found that consumer-directed health plans—combining high deductible plans with personal medical accounts—reduced health care spending significantly for firms offering CDHPs over three years.
- Technology.
 - The role of technology in accelerating health spending has been well established. While we do not know what new technologies are on the horizon, the current growth and proliferation of specialty drugs and new drug price increases suggest upward pressure will be exerted. New technologies can extend treatments to broader populations and improve life expectancy. They also can change the cost of treating patients, potentially increasing cost by providing more services, having a negligible effect through replacement, or decreasing utilization and potentially cost. The key challenge for policymakers is designing systems that

promote cost-effective technologies while reducing the use of expensive technologies that do little to improve outcomes.

- POLICY CONSIDERATIONS MOVING FORWARD

- It is too early to draw firm conclusions about the ACA's effect on cost containment, especially given that the provisions with the greatest potential impact— notably the Cadillac Tax and the IPAB —have not been implemented. Still, the intense opposition to both provisions provides good reason to temper our expectations about the degree of cost containment we can achieve through the ACA alone. As the Trump Administration and Republican controlled Congress debate repealing or replacing the ACA, policymakers face a number of choices to reduce the growth of health care costs going forward.
- IPAB, as designed, has few proponents. In a comprehensive report, the Kaiser Family Foundation list a number of options for amending IPAB. These include modification to spending target and limits on savings targets, revising IPAB and Congressional consideration of proposals, and revising the scope of recommendations. But the idea of a per capita Medicare cap as a failsafe or backstop measure to contain costs remains on the table.
- The Cadillac Tax incorporated a generally accepted economic principle—that preferential tax treatment encourages overconsumption of health care—in what appears to be a politically unacceptable way. Options to achieve the shared goals of the Cadillac Tax or make the tax more equitable could include a cap on the tax exclusion of health benefits, changing thresholds and indexing, and phasing in the tax over different income tiers.
- The climate for Congressional action on drug prices could dampen the impact of these technologies on overall health spending, although policy has proven difficult to enact in this area. Interventions aimed at reducing drug spending range from allowing the government to negotiate drug pricing, prohibit “pay for delay” arrangements, to allowing imported drugs from outside the United States. The recently passed 21st Century Cures Act will increase research funding and eventually lead to the development of more expensive new drugs, exerting upward pressure on overall health spending.
- The long-term impact of the ACA on health care costs depends on several factors, chief among them whether the law is repealed or stripped down to its bare bones. If Congress continues to punt on the Cadillac Tax and repeals IPAB, the prospect of future cost containment may be bleak. Long-term trends in medical technology and new pharmaceuticals remain important unknowns, but the ACA does little to directly affect these drivers of health care cost growth. The ACA-driven payment and delivery innovations have thus far yielded modest cost savings. Ongoing trends in the employer market, such as the move toward consumer-directed health plans, might hold the most promise in the absence of more directed government policies.
- The challenge to “bend the cost curve” remains an urgent one. The ACA provided needed coverage for millions of previously uninsured people, without a return to

the double-digit spending increases of the past. But the sustainability of these coverage gains, and extensions to the remaining uninsured, likely depend on implementation of cost containment measures that more directly, and forcefully, produce long-term changes in the growth of health care costs.