



February 22, 2011

Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
Attn: OCIIO-9999-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Rate Increase Disclosure and Review; Proposed Rule (75 FR 81004-81029)

Dear Director Larsen:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments in response to the notice of proposed rulemaking (NPRM) on section 2794 of the Public Health Service Act, as added by section 1003 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Section 2794 directs the Secretary of HHS, in conjunction with the states, to establish a process for annual review of unreasonable increases in premiums for health insurance coverage.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for approximately 18 million Americans, predominantly in the individual and small and mid-sized group markets. ACHP members also have a significant presence in the Medicare Advantage market and some contract with their states to provide coverage to Medicaid beneficiaries. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP supports and commends the Department for the general approach taken in the proposed rule, which focuses on increases in underlying rates rather than increases in premiums; applies to increases at the level of a product consistent with the approach under state rate review laws; and defers to states that have, or will establish, effective rate review processes to determine which increases are considered to be unreasonable. State insurance departments already have the systems and expertise needed for evaluating the reasonableness of rate increases, and as noted in the proposed rule, new federal funding provides states with additional resources for this purpose.

In addition, ACHP supports the proposal to limit the application of the regulations to insurance sold in the individual and small group markets. As noted in the proposed rule, large employers have greater leverage in shopping for coverage and avoiding unreasonably high rate increases.

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Rate increases subject to review

Level of the threshold. ACHP appreciates HHS' intent to reduce the reporting burden associated with implementing section 2794 by limiting the federal review requirements to rate increases above an established threshold. Rate increases reflect underlying medical costs and benefit changes, and they may also be the result of the recession, as younger and healthier people have drop or lose coverage, leaving the insured pool with relative older and sicker policyholders. Also, as both the uninsured and Medicaid populations increase, and states reduce Medicaid reimbursement, providers are likely to shift more costs to commercial carriers, putting further pressure on rates. For these reasons, we believe that the proposed 10 percent threshold level will prove to be unnecessarily burdensome. The data provided in the preamble indicate that by using this threshold, most rate increases will be subject to review, not just those likely to be found as outliers. Specifically, the proposed rule indicates that, for the past three years, a majority of increases in the individual market exceeded 10 percent, along with more than 40 percent of increases in the small group market. As pointed out in the preamble, rate increases in the individual market and small group market typically exceeded 15 percent in the states examined by HHS.

In light of this information, in the final rule HHS should establish a higher threshold that would more appropriately capture unreasonable increases without creating an unnecessary reporting burden on health insurance issuers and an overwhelming number of proposed increases that must be reviewed by states and the Department.

We also suggest that new federal requirements under the Affordable Care Act for minimum Medical Loss Ratios will act as a "safety net" to restrain administrative cost and margin components that contribute to rate increases. If a health plan meets federal minimum MLR requirements, it indicates that the proposed rate increases reflect underlying trends in medical costs and do not include unreasonable administrative costs or margins. If the health plan does not meet federal minimum MLR requirements, because of lower than expected medical costs and/or higher than expected administrative costs and margin, then the plan's subscribers will receive rebates equal to the difference. Under this regulatory scheme, a higher rate review threshold would pose little risk to consumers.

If the final rule does not provide for a higher threshold, at a minimum HHS should analyze the results of initial filings and, as necessary, later adjust the threshold to a level that will appropriately capture unreasonable rate increases while minimizing the reporting burden. Upon review, if the majority of rate increases above the 10 percent threshold are found to be reasonable, the threshold for review should be raised to a level that will better target only the unreasonable increases. This potential for future adjustment to account for the outcome of the review process should be made with respect to both the national threshold and the future state-specific thresholds.

ACHP requests more explicit guidance on what rate increases are included in determining if the 10 percent threshold is met. Questions raised include:

- Benefit increases that apply to every member of a product. For example, if a plan improved all members' preventive health benefits to meet ACA standards, resulting in a rate increase, would such increases be considered in the 12-month look-back in determining the threshold?

- Changes in rating factors other than base rates. For example, if some benefit adjustment factors, geographic area factors, or age-gender adjustments are increased, are the increases in those factors included?
- Allowable small group increases above trend within a state’s rate review laws. For example, if a state allows a small group insurer to increase rates for any particular group by 15 percent above the trend for the block, is the aggregate of those increases included?

Establishing state thresholds. In developing state-specific thresholds for increases subject to rate review, HHS should take into account local market conditions, such as provider consolidation, that affect medical cost trends. In many areas, rate increases reflect the market leverage wielded by large hospital systems and dominant specialty practices; the Massachusetts Attorney General has documented these pressures on health plans. State thresholds should be set with these market factors taken into consideration. We also suggest that HHS should provide further information in the final regulation on the process and considerations that will be used for updating thresholds in the future. Finally, the Department should consider allowing states that have an effective review process to also set the review threshold for the state, perhaps after the first year or two years of experience in working with the new review requirements.

Timing. The proposed rule would notify issuers of the rate review thresholds for the upcoming calendar year by September 15th. If the thresholds are to have a sentinel effect on proposed rate increases, health plans must consider a variety of decisions with relatively long lead times, including product development and marketing decisions. They must meet requirements for notification of employees about their plan choices. Also, health plans will require sufficient time to prepare for the submission of preliminary justification documents for rates that may be over the threshold. For these reasons, we urge you to consider an earlier date for the updated thresholds, perhaps July 1.

Preliminary justification

For the submission of information that is part of the preliminary justification of rate increases above 10 percent, ACHP recommends that the Department utilize documentation requirements that are required by states whose rate review programs are determined by HHS to be effective. In many states, health plans currently submit detailed information in rate filings for individual and small group products. Requiring health plans to resubmit this information in a different manner and format would impose unnecessary administrative cost. This would be avoided if the Department accepted documentation for preliminary justifications identical to the information required by states that have effective review programs in place.

In states in which rate review is limited to certain product lines, issuers may find that rates for some products will be reviewed for reasonableness by the state, but for other products HHS will make the determination. To reduce reporting burden in these cases, an issuer should be permitted to file with HHS under the part three rate filing documentation requirements the same information they would otherwise file with the state for rate review purposes. That is, the issuer should not have to manage multiple rate filing documentation requirements and formats. If HHS finds that the information provided was insufficient for HHS review, it could then request additional information from the issuer.

The proposed rule requires certification by a member of the American Academy of Actuaries that rates are reasonable in relation to benefits provided. This is generally a requirement of state rate review, and ACHP believes that it would be appropriate to require such certification as part of the rate filing documentation requirements in part three of the preliminary justification.

Finally, we question whether the proposed requirement that the preliminary justification include information on employee and executive compensation and a three-year history of rate increases for the product is consistent with actuarial practice. The preliminary justification summarizes the rationale for a rate increase for a product and should focus on information considered as part of an objective actuarial analysis. This particular information proposed for inclusion would appear to be not relevant to actuarial analysis to determine the reasonableness of a rate increase and should not be required in the preliminary justification.

Posting of information on HHS website

ACHP agrees that the public should have access to information about the results of the rate review process. However, the requirements of the proposed rule raise significant potential for consumers to be confused between (1) rate increases that are in the process of undergoing review and (2) increases that have been reviewed and found to be unreasonable. If the focus of the rate review process is to bring attention to unreasonable increases, then we recommend that posting should be limited to those cases where rates have been reviewed and have been found to be unreasonable – i.e., posting would occur at the end of the review process. The Department should not post proposed rate increases and the associated preliminary justifications just because they are above the threshold that triggers review.

However, if HHS elects to proceed as proposed and post all information provided under the preliminary justification, we offer three recommendations:

- First, posting of information for rate increases under review should be separate from information about products for which a final determination of an unreasonable rate increase has been made.
- Second, once a proposed rate increase has been reviewed and found to be reasonable, that proposed increase and the information provided under the preliminary justification should be removed from the public posting.
- Third, disclaimers should be carefully written to make clear to the public either that a review is underway and no determination has yet been made, or the review is complete and the rate increase has been found to be reasonable.

Confidentiality. In those cases where HHS (and not the state) will conduct the rate review, and an issuer must provide rate filing documentation under part three of the preliminary justification, the final rule should clarify the treatment of confidential information as defined under the Freedom of Information Act. ACHP strongly believes that information that can harm an issuer's competitive position and that typically is held in strictest confidence should never be posted on the HHS website. While the FOIA rules provide for protections, the proposed rule does not make clear precisely how these rules will apply in the case of the rate filing documentation. For example, will guidelines be provided regarding the process by which an issuer may designate information provided under part three as confidential? If HHS determines to make public information that an issuer has designated as

confidential, will the issuer be notified in advance and given an opportunity to object as provided under HHS's FOIA process?

Effective state rate review

The proposed rule seeks comments on whether public comment should be made a requirement for an effective state rate review program. ACHP believes that the elements of an effective state rate review program should be tied to the objective application of standards regarding actuarial soundness. While members of the public should be offered an opportunity to express to state officials their views regarding rising health insurance rates, public comment should not be made a formal requirement of the rate review process.

The proposed rule implies that an effective rate review program be based on actuarial standards, but the requirements could be strengthened. In particular, as discussed in the next section, states should be required to ensure that rates are actuarially sound and adequate. Additionally, states should require issuers to provide certification by a member of the American Academy of Actuaries that rates are reasonable in relation to the benefits provided.

Determination of unreasonable rate increase

ACHP supports the proposal that, in states with effective rate review programs, applicable state law be used in determining whether a rate increase is unreasonable. When HHS is to make the determination, the proposed rule sets out three categories under which increases may be determined to be unreasonable: increases that are "excessive," "unjustified," or "unfairly discriminatory." This approach appears to be largely consistent with the definitions used in state rate review laws. The Department should provide to issuers the actuarial analyses for its determination of proposed increases deemed unreasonable under these categories.

However, unlike state laws, the proposed rule does not require that the resulting rates be both actuarially sound and adequate, a deficiency which ACHP recommends be corrected in the final rule. The requirement that rates be adequate helps ensure that health plans remain solvent, and that medical claims get paid. ACHP is concerned that the regulations, by focusing on the magnitude of the increase in rates, rather than the adequacy and reasonableness of the rate itself, could lead to unintended consequences regarding solvency. Market competition disciplines issuers to keep rate increases as low as possible, yet there are times when a large rate increase might be necessary to produce rates that are adequate to cover anticipated medical claims, administrative expenses, and a reasonable contribution to reserves. If issuers respond to the proposed rule by holding back on rate increases at the cost of not being able to cover the cost of anticipated medical claims, administrative expenses, and some contribution to reserves, it could put these insurers, and ultimately policyholders, at risk. The interests of the public will not be well served with a rate review process that does not address rate adequacy. ACHP recommends that HHS and states be required to consider as part of the review process whether the actual rates being proposed have been determined to be actuarially sound and adequate.

We are concerned about the implications for state determinations of unreasonable rates of a statement that appears in the [Rate Review Filing Form](#) developed by NAIC. In Section 3 of that form, item #10 reads: "Since the rate filing cannot be understood without a wider understanding of the company, the

health insurance issuer's most recent Annual Financial Statement and related supplemental filings may be accessed at the following website: <https://eapps.naic.org/insData>.” We believe that rate filings should be evaluated independently from a company's financial position. The product for which rates are filed should be actuarially sound, and either the rates are justified actuarially or not.

ACHP agrees that in determining whether a rate increase for a product is unreasonable, HHS should consider whether the issuer's proposed rates are likely to meet the federal minimum Medical Loss Ratio standard, as long as this standard is applied at the market level, not the product level. Under the new federal interim final regulations, this standard is applied at the market level in accordance with the recommendation of the National Association of Insurance Commissioners. Determining that a rate increase is unreasonable if the minimum Medical Loss Ratio was not met for a product would effectively raise the minimum loss ratio for a state market at a higher level.

Finally, ACHP recommends that the HHS review process should enable an issuer to appeal for a timely reconsideration of a determination that a rate increase is unreasonable.

Thank you for the opportunity to comment on the proposed rule. We would be happy to answer any questions or provide additional information.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Smith".

Patricia Smith
President and CEO