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POLICY & ACTION FROM CONSUMER REPORTS

December 20, 2012

Center for Medicare and Medicaid Services
Department of Health and Human Services,
Attention: CMS-9972-P
P.O. Box 8012
Baltimore, Maryland 21244-1850

Submitted via www.regulations.gov

Re: File code **CMS-9972-P -** Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review

Dear Secretary Sebelius:

Consumers Union, the policy and advocacy division of Consumer Reports, submits these comments regarding the proposed rule implementing insurance market rules and rate review.

We commend HHS and its agency partners in crafting provisions that strive to fulfill the promise of the Affordable Care Act (ACA) and promote fair insurance premiums for the entire individual and small group markets, both inside and outside the Exchange. To that end, we see a number of laudable principles incorporated throughout the proposed regulations:

- **Standardization of rating factors** – Consumers Union supports the provisions that create a federal standard for fair health insurance premiums and require rate filings for all rate increases;
- **Same rules inside and outside the Exchange** – Consumers Union appreciates the provisions that strive to make comparable rules outside Exchanges that have already been applied to Exchanges; and
- **Single risk pool** – Consumers Union applauds the provisions that require insurers to consider all claims experience of all enrollees in all health plans, including those who do not enroll through the state's Exchange, as members of the single risk pool.

In addition to the items that we welcome above, there also are a number of provisions that we would like to comment on in detail below.

§147.102 – Fair Insurance Premiums

As stated above, Consumers Union commends HHS for establishing standard rules with respect to fair health insurance premiums, which will apply uniformly to both the individual and small group markets inside and outside Exchanges. Leveling the playing field within states will benefit consumers, not only curtailing many of the discriminatory practices carried out in the current insurance market, but also ensuring that consistent rules are more readily understood by consumers.

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There are, however, a few areas within this provision that Consumers Union believes can be strengthened to ensure greater consumer protections.

§147.102(a)(1)(iii) – Age rate variation

Consumers Union supports the flexibility provided to states to vary the age rate by less than 3:1. We also strongly support the proposal to adjust rates based on the enrollee's age at the date of the policy issuance or renewal. We would not support rate adjustment mid-policy, as other proposals (such as birthday) would allow. For insurance coverage to be understandable to consumers, premiums must be predictable and clear.

§147.102(a)(1)(iv) – Tobacco use

Consumers Union encourages HHS to add to this provision language that makes explicit that a state may decline using tobacco use as a rating factor altogether, in addition to permitting states to use a ratio narrower than 1.5:1.

Consumers Union Recommendation: Add language to this provision that makes it clear that states are permitted to decline to use tobacco use as a rating factor: "Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 1.5:1, including using a ratio of 1:1 (or no rating factor for tobacco use)**,** in connection with establishing rates for individuals who vary in tobacco usage."

§147.102(b) – Rating Area

Consumers Union supports setting a maximum geographic rating area of no more than seven within a state ((b)(3)), while allowing states to vary from that maximum with prior approval from HHS ((b)(4)). We ask that HHS establish criteria making it clear how HHS will evaluate states' requests for approval of geographic rating areas greater than seven (e.g., based on state population size, population distribution demographics within the state, etc.). We suggest that HHS should cap the number of rating areas that a state could seek approval of to be no more than fifteen.

Consumers Union Recommendation: Revise the regulation to cap the number of rating areas a state may propose as an alternative to (b)(3) at no more than fifteen rating areas. Establish criteria to evaluate state requests under (b)(4).

§147.102(c) – Persons included in the family

Consumers Union supports a federal definition of persons who should be included in the family for purposes of health insurance coverage. As suggested in the preamble, covered family members should include the employee or individual market policyholder, a spouse or partner (as defined by state law), biological children, adopted children, children placed for adoption, stepchildren, grandchildren, other children related by blood, foster children, and children under guardianship, and any other family member recognized under state law.

§147.102(c)(2) – Family tiers under community rating

For states that, pursuant to state law, do not permit any rating variation for ACA-permissible factors, we support states establishing uniform family tiers and corresponding multipliers.

§147.102(c)(3) – Application to small group

We appreciate providing flexibility to states to use either the per-member or composite rating for small group premiums, understanding that providing for employee choice makes it challenging to base small group premiums on average enrollee amounts. We note that using the composite rating may be challenging for employers who offer employee choice, something we strongly support. With employee choice, employers would not be able to establish the composite premiums until after employees make their choices.

§147.102(d) – Uniform age bands

Consumers Union supports the rule establishing age bands as proposed. We agree with HHS that a single age band for children 0 to 20 years of age is the right thing to do for families. Additionally, we support the gradual premium increments for people between 21 and 63 years. Not only will this make it easier for consumers to predict and get accustomed to yearly increases, but it will help make premiums more affordable for younger people who may be purchasing insurance for the first time.

§147.102(e) – Uniform age rating curves

Consumers Union supports HHS proposing that all states must establish uniform age rating curves, requiring HHS approval of each state's proposal. More importantly, we appreciate HHS proposing that it will establish a uniform age rating curve that states will be able to use that satisfies the ACA requirements of an age band variation of 3:1.

§147.104 – Guaranteed availability

§147.104(b) – Enrollment periods

The proposed standard suggests that a person would be required to wait for the triggering event for the special enrollment period to start. We believe individuals should be permitted to start the special enrollment process in advance of a known triggering event, such as adoption or birth of a child, or a loss of a job, so that gaps in coverage can be prevented when possible. We strongly recommend that HHS adopt a standard that allows consumers to apply for special enrollment thirty days prior to a known triggering event. Additionally, the rules should allow up to sixty days after a triggering event consistent with both the Exchange rules and COBRA rules (instead of the 30-day period proposed). Triggering events should include receipt of advance notice of plan termination. When an insurer is responsible for the triggering event, we urge HHS to require the insurer to give consumers a 14 day advance notice before the special enrollment period commences.

Consumers Union Recommendation: Add a provision that triggers a special enrollment period 30 days in advance of a known triggering event. Extend the time frame for special enrollment to 60 days from the triggering event. When an insurer is responsible for the triggering event, require the insurer to provide 14 day advance notice to consumers before a special enrollment period commences.

In relationship to the guaranteed renewability of coverage provision (§147.106), Consumers Union urges HHS to ensure that special enrollment triggers align with guaranteed renewability, such that any activity not the fault of the enrollee, which results in non-

renewability of a current plan, would trigger a special enrollment to allow the enrollee to obtain a new plan with seamless coverage. We urge HHS to add the "exceptions" to guaranteed renewability of coverage listed in §§147.106(b)(1) (if the plan sponsor fails to pay premiums), (b)(2) (if the plan sponsor commits fraud), (b)(3) (if the group plan sponsor fails to comply with a material plan provision regarding participation or contribution rules), (b)(4), (b)(5), (b)(6), §147.106(c), and §147.106(d) as explicit triggers permitting special enrollment so that consumers have seamless coverage.

Consumers Union Recommendation: Revise special enrollment provisions in §§147.104(b) and 155.420 to include in the list of special enrollment triggers activities listed as exceptions to guaranteed renewability (§147.106) that are no fault of the consumer (see suggested list above).

§147.104(e) – Marketing

Consumers Union appreciates that the provisions on marketing standards that apply to Exchanges are applied to all health insurance issuers, their officials, employees, agents and representatives. Reflecting our nation's experience with Medicare Advantage plans' ability to use marketing and benefit design to attract healthier-than-average risks, we would urge HHS to develop strict standards to measure whether marketing practices have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage. As well, we recommend that HHS establish a process for consumers to challenge marketing practices that would violate this provision, including a requirement that HHS and states provide clear notice to consumers on how to contact the appropriate authorities to make complaints about marketing practices.

We also urge HHS to require that Exchanges, state regulators, and agencies responsible for enforcing state unfair and deceptive practices acts (e.g. attorneys general, district attorneys) form inter-agency working groups and memoranda of understanding to monitor advertising and marketing practices, share intelligence about them, and allocate enforcement roles and responsibilities. As mentioned below, an outlier index rate, for example, should trigger an investigation into marketing practices.

Consumers Union Recommendation: HHS should develop strict standards to measure, evaluate, and penalize a health insurance issuer, employee, agent or other party acting on behalf of the issuer that is undertaking marketing practices that discourage enrollment of individuals with significant health needs in health insurance coverage**.** HHS should require Exchanges to work with other state agencies and regulators to monitor marketing, share information, and allocate enforcement roles.

§154.200 – Rate increases subject to review

Consumers Union believes that relying solely on "state-specific" thresholds "based on factors impacting rate increases in a State" will be unlikely to prod issuers or providers to control costs. Under this standard, many states will be perpetuating wasteful spending if they apply a threshold that is based on their own particular costs of health care and/or health insurance coverage.

We recommend using the lower of a state-specific trend or a nationwide threshold based on average, or even slightly less-than-average, rates of private-sector health care cost

increases, to put appropriate pressure on issuers and providers to bend the cost curve. The threshold should be developed by HHS, based on the following discrete information:

- Nationwide, per person in private coverage, year-over-year spending on the medical services covered by a standard, comprehensive private health insurance policy, including shares paid by consumers out-of-pocket and the share reimbursed by health plans. Both overall spending and by major EHB service category should be tracked;
- National, average, per enrollee, year-over-year spending on insurance administration (including profit) by commercial health insurers, by line of business;
- Both measures (spending on medical services and spending on administration, including profit) should be combined in a weighted fashion to create the threshold measure.

Every effort should be made to ensure the currency of the measure; in other words, to minimize time lag between the threshold measure and the source data used to create it. The measure should endeavor to be as consistent as possible with other components of the health care law that employ definitions for medical services and administration (such as MLR filings and rate review filings).

Consumers Union Recommendation: Establish an HHS threshold based on the lower of a state-specific trend or nationwide average (or slightly less than average) rates of private sector health care cost increases. Develop threshold criteria as stated above.

§154.200(a)(2) – State-specific threshold

Consumers Union supports HHS issuing decisions on state requests for a state-specific threshold for rate review in advance of the open enrollment period, subject to our comments above regarding development of threshold criteria. We also strongly believe HHS should allow time for public comment on state requests. The public should be given a minimum of 30 days to provide comments. Given the short time frame for approval, HHS should allow the public to sign up for alerts when states submit a request for a state threshold, so consumers can be notified immediately when a request in submitted.

Consumers Union Recommendation: Add requirement for HHS to provide a minimum of 30 day notice to the public, provide opportunity to comment, and consider public comment in its decision to approve or reject requests for state-specific threshold levels.

§154.215 – Submission of rate filing justification and §154.220 – Timing of providing the rate filing justification

Consumers Union commends HHS on the proposal to require issuers to submit standardized rate filings for all rate increases, not just those above 10%, prior to the implementation of the rate increase. We think this will be essential for HHS to fulfill its responsibilities.

§154.301 – HHS's determination of effective rate review programs

Consumers Union generally supports the additional criteria HHS has proposed and believes that they should be part of an effective rate review program. The proposed factors under

§154.301(a)(4) provide a good start for a determination of effectiveness, but to achieve the goal of curbing excessive rate increases, states' rate review should consider additional factors, as described below.

§154.301(a)(4)(xii) – Surplus and capital

Consumers Union urges HHS to maintain the factor, "The health insurance issuer's capital and surplus." It was not clear in the proposed regulations whether new language for §154.301(a)(4)(xii) was meant to replace the current regulatory provision dealing with surplus and capital. We believe the current provision (xii) dealing with surplus and capital should be retained and the proposed (xii) also should be retained, and renumbered. Proposed rates usually have a contribution to surplus included in the rate and when surplus levels grow beyond what is necessary or required to protect against insolvency, regulators should be required to consider the use of surplus to keep rates affordable for consumers.

Consumers Union Recommendation: Retain §154.301(a)(4)(xii) in current regulations, rather than replace with proposed new section (xii) and the proposed section (xii) should be retained and renumbered.

§154.301(a)(4) – Additional factors

Consumers Union proposes to add a number of additional factors that must be taken into consideration to the extent applicable to a filing under review:

- The broad solvency and financial strength of the entire company;
- The effect and hardship of the rate increases on consumers;
- The company's history of rate increases;
- The balance of solvency against affordability for consumers;
- The company's mission in the case of nonprofit insurers;
- The company's quality and cost control efforts; and
- The lack of competition in the provider and carrier markets.

Consumers Union Recommendation: Amend the proposed regulations to provide that the criteria for an effective rate review program shall include additional factors to the ones already included in §154.301(a)(4) as stated above.

§154.301(b) - Public disclosure and input

HHS has included having "a mechanism for receiving public comments on those proposed rate increases" as one criterion for an effective rate review program. We urge you to strengthen this criterion by requiring states to make the mechanism for public comment available before a rate is implemented and require states to consider public comment in their review of the proposed rates.

Additionally, if a state opts to link to HHS, rather than post the rate filings on their own website, states should be required to link directly to the specific rate filing a consumer is trying to access.

Consumers Union Recommendation: Require states to make the mechanism for public comment available before the rates are implemented and require states to consider public

comment in their review of the proposed rate increases. Require that state links to the HHS website directly link to the specific rate filing that the consumer is trying to access.

§154.301 – New provision on language access

Consumers should be able to access rate filing information in multiple languages. HHS should adopt the same language standards utilized by Department of Justice (DOJ)[1] and in the Health and Human Services (HHS) LEP Guidance for determining the translation of written documents that is "500 LEP individuals or 5 percent of those eligible to be served by an Exchange, whichever is less." This 5 percent threshold is outlined in the Department of Justice and HHS' LEP Guidances, as well as recently revised regulations from the Centers for Medicare and Medicaid Services on marketing by Medicare Part C & D plans.

Consumers Union Recommendation: Require each state to provide information about rate filings in multiple languages, at a minimum, to reflect those languages available on the state's Exchange consumer portal or the Federal Exchange portal for the state.

§156.80 – Single risk pool

Consumers Union applauds HHS for including claims experience of all enrollees, excepting only those covered by grandfathered plans, as members of each insurer's single risk pool within a state and market. We recommend amending the proposed rule, however, to preclude issuers from thwarting the single pool requirement by excluding the enrollees of issuer subsidiaries or affiliates from its single risk pools. The rule would thus require that any subsidiary's or affiliate's enrollees shall be included in the single risk pool of the parent corporation, rather than allow each subsidiary or affiliate to separately pool individual or small group market risk.

§156.80(d) – Index rate

Consumers Union is very supportive of the concept of an index rate. The index rate is essential in creating a standard starting point for insurers in the applicable markets to price their plans.

We suggest amending the language in §156.80(d) to clarify that claims costs include the shares paid by the insurer and share paid by the enrollee and includes in-network and out of-network claims. Further, the regulatory language does not make it clear if this accounting is based on prior year claims or an estimate of future year claims. The preamble seems to suggest the latter. In that case, we recommend an audit and reconciliation process to assess the accuracy of the issuers' predictions subsequently.

HHS should monitor the methodologies that plans use in estimating their index rate. In 2014, there will not be any past experience upon which to base the index rate calculation. It is not clear how HHS is directing insurers to calculate the index rate in 2014 or in subsequent years for new plans. The preamble indicates that HHS is considering allowing additional flexibility in product pricing in 2016 after issuers have accumulated sufficient claims data. Any additional flexibility to insurers must include an audit of their index rate methodologies, and HHS should impose penalties for insurers that repeatedly estimate an

[1] 75 Fed. Reg. at 43337.

index rate substantially higher or lower than the index rate based on actual claims data, such as barring such issuers from being certified as Qualified Health Plans.

To further strengthen the single risk pool requirement, **we recommend** that HHS also clarify that the index rate established by each issuer would be set on a consistent, annual basis. It is clear that an issuer must establish this rate based on the total combined claims costs in a given market, adjusted for the issuer's expected market-wide payments and charges under the risk adjustment and reinsurance programs. A standard time period for this process is needed to ensure the index rates are established on a consistent basis across all applicable insurers. One standard annual index rate calculation makes sense for several reasons, including that consumers will need accurate and lasting premium quotes when they shop for coverage (in most cases during the annual open enrollment period), that the risk adjustment and reinsurance programs (which affect the index rate) operate on an annual basis, and that a consistent annual index rate would help increase stability and efficiency in administration of the federally-financed premium tax credits.

Suggested language is underlined:

> *Index rate*—(1) *In general.* in August each year, as applicable, a health insurance issuer shall establish an <u>annual</u> prospective index rate for a state market based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. <u>These claims costs will include all amounts for essential health benefits paid by the issuer and assigned to the enrollee. Claims costs include in-network and out-of-network services. These total claims costs are to be divided by the average number of enrollees for the year to establish the index rate.</u>

We also recommend that either state insurance departments or HHS investigate whether there has been a pattern or practice that resulted in adverse selection when an insurer has an index rate that is an outlier to the other insurers' index rates in a particular market in a particular state. Given the requirements for guaranteed issue, and restrictions on marketing, we assume that the index rates for insurers in any particular market in any particular state should be clustered together. As the preamble states, "We expect that percentage renewal increases generally would be similar across all plans in the same risk pool, but may differ somewhat due to the permitted product differences described above."

<u>§156.80(d)(2)(i) – Permitted plan-level adjustments to the index rate</u>

Consumers Union recommends omitting the words "and cost-sharing design." The actuarial value of the plan will encompass the cost-sharing design of the plan.

<u>§156.80(d)(2)(iv)</u>

We suggest deleting §156.80(d)(2)(iv). We are concerned that this provision would allow for a backdoor to medical underwriting (which is not permitted) or to adjust for age twice – once in the index rate and again in the rating factors.

We support that the single risk pool requirement applies to catastrophic plans. But we are concerned that this provision would give issuers the ability to adjust the premium rates for catastrophic plans for the "expected impact of the specific eligibility categories for those plans" given that they will enroll mainly people who are younger than 30. This would result

in risk pooling that falls short of the statutory requirement for a single risk pool, by allowing issuers to consider a different risk pool when pricing catastrophic plans.

In addition, the catastrophic plans are already expected to have an actuarial value of less than 60 percent (the actuarial value for bronze plans, the lowest metal tier of coverage allowed in the individual and small group markets) and a very high deductible. But the single risk pool provision would permit additional downward adjustments in the index rate for a catastrophic plan based on enrollee characteristics (i.e. for purposes of setting the premium rate for a catastrophic plan, the risk pool would include only all of an issuer's other enrollees under 30). Allowing an additional adjustment for the predominantly younger population that is expected to enroll in these plans would allow plans to double count for age (here and again in rating factors) and, to some extent, segment an issuer's catastrophic plans from its other product offerings (though as we understand it, enrollees in the catastrophic plans would be considered as part of the risk pool for enrollees in all other plans that an insurer might offer).

While this policy proposal would make catastrophic plans cheaper for younger people (and modestly reduce costs for other enrollees in other plans above age 30), it will also increase the price disparity between bronze and silver plans, which are eligible for purchase with federal subsidies, and catastrophic plans, which are not. Some younger people might be attracted to the lower premiums of the catastrophic plans, without realizing that they will \ pay significant out-of-pocket costs should they need medical care and that they will have to forego the federal subsidies for which many in this age group are eligible. In addition, the whole reason the catastrophic plans were included in the ACA was to bring younger, healthier people into the overall risk pool. We urge to you delete §156.80(d)(2)(iv).

On behalf of Consumers Union, we welcome the opportunity to comment on these important regulations and realizing the full promise of the Affordable Care Act.

Sincerely,

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