February 22, 2011

Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Attn: OCIIO-9999-P
200 Independence Avenue, S.W.
Washington, DC 20201
Via http://www.regulations.gov

Comments of Consumers Union of U.S., Inc.,
to the U.S. Department of Health and Human Services
on Rate Increase Disclosure and Review; Proposed Rule
OCIIO-9999-P

Introduction

Consumers Union[1], the nonprofit publisher of *Consumer Reports*, welcomes the opportunity to comment on "Rate Increase Disclosure and Review," the proposed rule to establish a process for the annual review of unreasonable premium increases under the Public Health Service Act, Section 2794 (Affordable Care Act § 1003). The rules would establish an important new tool for reining in rising health insurance premiums. We believe that many consumers will benefit from the increased transparency and oversight of rate increases envisioned in this rule.

We recognize that the proposed rule is designed to maintain the traditional role of the states in overseeing health insurance rates. Consumers Union has spent substantial time studying state rate review standards and rate increases, particularly in the individual market.[2] We believe that

[1] Consumers Union is a nonprofit organization chartered in 1936 to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of *Consumer Reports* and ConsumerReports.org, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports and ConsumerReports.org, with approximately 8.3 million combined paid circulation, regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] See. e.g., *An Advocate's Guide to Health Insurance Rate Hikes: What You Can Do To Protect Individual Market Consumers*, http://prescriptionforchange.org/document/consumers_union_health_insurance_rate_review_toolkit.

many aspects of the proposed rule will result in enhanced (and much-needed) scrutiny of certain rate increases. However, we also believe that the rule should provide greater incentives and a pathway for states to improve their rate review processes and for carriers to strive to curb underlying costs and make rates more affordable. We offer these comments to inform your rulemaking, express support for various proposed measures, and encourage HHS to strengthen the rule so that consumers in all states are better protected from unreasonable rate increases.

Our comments mainly address rate increases for consumers purchasing non-group coverage, although many comments could also apply to rate increases for groups. We provide comments on the following specific areas of the proposed rule:

- **The Level of Aggregation for Review**
- **The Threshold Triggering Review for Unreasonableness**
- **Criteria for Determining Whether a State Has an Effective Rate Review Program**
- **Standards Applied for HHS Review of Unreasonableness**
- **Disclosure of Justifications for Rate Increases Subject to Review**

I. The Level of Aggregation for Review

We support HHS's proposal to require consideration of rate increases at the product level. We also support the definition of "product" in Section 154.102 as "a package of health insurance benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State." Aggregation at a higher level, such as at a market segment or block of business level, would mask potentially unreasonable rate increases on some policies. For example, in a recent rate filing Blue Shield of California proposed an average 6.5% increase across 25 individual market plans effective March 1.[3] If the threshold for review were applied at the aggregate market segment level, the increases would not be reviewed. But a closer look at the filing reveals that nine plans are slated to get average increases higher than 10%, with the highest of those nine at an average of 17.2%. The rule as written would subject these plans to review for reasonableness.

By requiring review at the product level, carriers may be encouraged to bring separate products into one risk pool, thereby spreading costs more broadly across enrollees. However, we do believe that the evaluation of reasonableness for any rate increase subject to review should encompass a look at the carrier's risk pooling across the market segment. High rate increases on some products may appear to be reasonable and actuarially justified, but may be the result of carriers segregating risk, for example, through marketing practices or benefit design. Therefore, as discussed in Section III(5), we suggest that a state's review and HHS's own review include a carrier's risk pooling practices across the entire market segment as one factor for consideration when determining whether a rate increase for any specific product is reasonable.

We ask that you clarify throughout the rule that reviews are triggered at the product level. The word "product" – although defined in Section 154.102 – is not used to identify the rate increases

[3] See Blue Shield of California Life and Health Insurance Company Rates for Individual and Family Plans Effective March 1, 2001, Exhibit I.

subject to review under Section 154.200. For clarity, we suggest amending Section 154.200 to read "[r]ate increases *for each product* that meet or exceed…" Similarly, we recommend amending the wording of proposed Section 154.215 to more clearly reflect the intent that increases will be reviewed by product. Our suggested language of 154.215(a) is: "For each *product with* a rate increase subject to review, an issuer must submit a preliminary justification…" As proposed, the regulation requires that "for each rate increase subject to review" an issuer must submit a preliminary justification for "each product affected by the increase." This could create confusion because it suggests that "the increase" could potentially "affect" more than one product, which is not the case unless the carrier chooses to aggregate the claims experience of multiple products when calculating the increase under Section 154.215(d).

II. The Threshold Triggering Review for Unreasonableness

We find the 10% threshold for reviewing rate increases filed or effective on or after July 1, 2011, as set forth in section 154.200(a)(1) to be appropriate for the transition year. We also very much support the requirement in section 154.200(c) that makes increases less than the threshold reviewable if they would meet the threshold when combined with any other rate increase in the 12-month period preceding the effective date. We are aware that in some states carriers raise rates on a bi-annually, quarterly, or even more frequent basis. Policyholders often receive these cumulative increases all at once on the policy renewal date, resulting in sticker shock.

Section 154.200(a)(2) requires that beginning in calendar year 2012 and thereafter, rate increases will be reviewed if they exceed "state-specific thresholds as determined by the Secretary … based on the cost of health care and health insurance coverage in the state" or if they exceed 10 percent when the Secretary has not established a state-specific threshold. Section 154.200(b) provides that review is triggered if the "weighted average" increase for all enrollees subject to the increase exceeds the applicable threshold.

We have concerns that relying solely on "state-specific" thresholds "based on the cost of health care and health insurance coverage in a State" will be unlikely to prod carriers or providers to control costs. Many states suffer from market concentration of providers and/or insurers. These states, and others with above average cost trends, will be "chasing their own tail" if they apply a threshold that is based on their own particular cost of health care and 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 healthcare cost increases to put appropriate pressure on carriers and providers to bend the cost curve. This threshold should be developed by HHS so it includes the following qualities:

- Tracks nationwide, per person, 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 heath plans. Aggregating consumer and insurer shares together will eliminate any biases introduced by changes in benefit levels, although minor utilization effects should be expected.

- National, average, per person, year-over-year spending on insurance administration (including profit) should also be tracked.
- 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).

We also urge HHS to adopt an additional threshold for review based on a maximum increase for any one policyholder or group. Behind an average weighted increase for a policy there may be a much larger increase for individuals or groups in different rating cells. By establishing a second trigger, such as review of any rate increase resulting in more than 17% for any person or group, the rule would add a layer of protection for consumers and result in states or HHS examining cross-subsidizing (or lack thereof) within a product.

III. Criteria for Determining Whether a State Has an Effective Rate Review Program

Section 154.210 provides that HHS will review a rate increase meeting the threshold or it will adopt a state's determination of whether the increase is unreasonable if the state:

> (1) Has "an effective rate review program"; and
> (2) Provides to HHS its final determination as to the reasonableness of a rate increase, including an explanation of how its analysis of the issuer's actuarial assumptions and validity of underlying data, as well as the issuer's data related to past projections and actual experience, factored into its determination. See § 154.210(a), (b); §154.301(a)(3).

Section 154.301 sets forth five criteria that HHS will use to determine whether a particular state has an effective rate review program for small group and individual market rates and for different types of products within those markets.

We generally support the five criteria and believe that they should be part of an effective rate review program. The criteria for an effective state program are: (1) collection of sufficient data and <u>documentation</u> from insurers to conduct the review described in (3); (2) the state conducts an effective and <u>timely review</u> of the data and documentation; (3) the state's rate review process includes an examination of the <u>reasonableness of assumptions and validity of historical data</u> underlying the assumptions; (4) the examination includes <u>analysis of the impacts</u> of various changes and other factors; and (5) the state makes its determination under a <u>standard that is set forth in a state statute or regulation</u>. These factors understandably focus primarily on the reasonableness of assumptions used to calculate rate increases and the impact of changes that can affect the medical trend and administrative expenses.

HHS expects that a "vast majority of States will be able to conduct effective reviews in the future, should they choose to." (45 C.F.R. Part 154, p. 81001). However, our research and other evidence suggest that many states lack the authority and/or sufficient resources to protect consumers from excessive rate increases. A Kaiser Family Foundation survey, cited by HHS in the proposed regulation preamble, notes that "having approval authority over rates does not necessarily protect consumers from large rate increases, and that the rigor and thoroughness that states bring to rate review can vary widely, depending on motivation, resources, and staff capacity."[4]

We have concerns that the proposed criteria, by establishing a minimal definition of an effective rate review program, do not go far enough to encourage best practices in the states. Working in tandem with the ACA rate review grants, this regulation should strive to improve the standards and processes under which rates are evaluated so that consumers in *every state* are afforded a minimum level of rate review that will effectively help constrain the growth in premium rates. The five proposed criteria for effective rate review in Section 154.301 provide a good start for a determination of effectiveness, but to achieve the goal of curbing excessive rate increases, states rate review should consider a host of other factors, provide far greater transparency than is currently available, and should include an avenue for public input.

We recommend that the proposed regulations set forth additional criteria (points 1-9 below) that states should consider including in their rate review programs to achieve effective review. After HHS makes an initial determination of whether a state has an effective rate review program in 2011, HHS should re-evaluate each state's program in three years to determine whether a state has implemented these criteria or some combination of them in a way that is effectively restraining rate increases. If in three years time, HHS finds that a state's rate review process is not achieving measurable results to benefit consumers, HHS can require states to take additional steps or, if appropriate, can revoke the state's status of having an effective rate review program.

We suggest amending the proposal to provide that the additional criteria for an effective rate review program shall include the factors below, in addition to the factors already in Section 154.301.

1. Authority to deny the proposed increases before they go into effect, or at a minimum, the ability to negotiate for lower rates

Prior approval authority to reject a rate increase before it goes into effect is an important tool in restraining premium increases. Yet, several states, including California, Texas, and Illinois currently lack prior approval authority. HHS must carefully consider whether states lacking prior approval authority have sufficient means to review increases and negotiate for lower rates. States with "file and use" procedures often require only an actuarial certification from the carrier that rates meet state standards. File and use states may not review data underlying rates at all unless policyholders complain. Retroactive review of increases already in effect, even when rates are found to be unjustified, provides little relief to consumers or businesses who have

[4] "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," Kaiser Family Foundation and Georgetown University Health Policy Institute, Dec. 2010, available at www.kff.org.

dropped coverage, reduced benefits, or switched carriers to avoid the increase. Still, even states with prior approval may fall short of effective rate review, as noted, due to insufficient review standards, data collection, or resources. Therefore, prior approval should be one – but not the deciding – factor in a determination of effectiveness.

2. Sufficient filing requirements and data collection enabling in-depth review

Collecting data underlying rate increases is crucial for effective review. States vary widely in the type and amount of information collected. States that conduct in-depth review with hearings in the individual market, such as Maine and Rhode Island, receive and analyze extensive data. Other states rely on data that is much less complete. Rate filings that we have examined suggest that some carriers provide explanations and basic information to support increases, such as premium and cost projections. But they may not contain the historical claims data used to develop projections and other information relevant to the rate calculation. If medical trends are broken down by categories, such as unit cost or utilization, or by benefit category, rate filings must show how overall trends were developed from these components.

Further, while the SERFF electronic system has resulted in some standardization of filings, attached actuarial memorandums tend to differ among carriers in the same state. HHS should consider whether the state has statutes, regulations or bulletins identifying the types of information that must be provided in a rate filing and whether the state requires standardized filings, so that all carriers are providing the same breadth of information in a similar format.

HHS's proposed criterion #1 for an effective rate review program provides that a state should receive "data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3)," which are (i) the reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and (ii) the health insurance issuer's data related to past projections and actual experience. We support requirements for data collection. The requirement that the state collect and review data showing how past projections related to actual experience is important to discourage issuers from "padding" cost projections or minimizing revenue projections.

In addition to the language in (a)(1), this standard should specify that at a minimum, such data would include historical claims experience data for at least five years preceding the proposed rate increase and specific data to support any adjustments or assumptions that cause the projected loss trend to deviate significantly from historical patterns. It should also include underlying data supporting all rating factors applied to individual policyholders or groups and information showing how the rate increase was distributed across risk categories. Further, the data collection standard should not be limited to the information related to actuarial assumptions in HHS's criterion #3. States must collect data related to the factors in criterion #4, such as changes in administrative costs, and those additional factors that we recommend for effective rate review programs.

3. Ability to conduct in-depth review of increases subject to review

Some states review the data underlying rates and closely analyze the assumptions used to project revenues and costs. Other states, even some that require support for actuarial assumptions, do not have the staff resources to conduct a careful review. In the past few years, we have seen several examples of carriers submitting actuarial memoranda using cost projections based on medical trends that were found to be inflated, for example in California, Maine, and Connecticut. In addition, in several states in the individual market, we have seen carriers add factors such as duration, anti-selection, or leveraging to the medical trend. These "add-ons" result in significant increases to the cost projection (and are therefore likely to result in higher indicated rate increases), but the carriers do not provide supporting data for such factors or demonstrate whether the impact of such factors was removed from the calculation of the base medical trend.[5]

Other factors, such as "provisions for adverse deviation" (PFAD) that may be added to account for "uncertainty" are merely hidden profit margins.[6] While medical loss ratio rebates may provide future corrections for mistaken or inflated projections, the hardship will already have been inflicted on consumers and businesses. For these reasons, it is critical for state insurance departments to closely examine assumptions to ensure they are reasonable and justified.

The only standard related to the depth of a state's review in the proposed regulation is criterion # 2 of Section 154.301(a)(2). Criterion # 2 holds that a state would meet effective rate review in part if it "conducts an effective and timely review" of the data and documentation submitted. This presents a circular definition: effective review means, in part, that the state conducts "effective and timely" review of data. More specificity is needed to define what constitutes effective review. States that merely accept an insurer's actuarial certification that rates meet state laws as proof that rates are reasonable should not be deemed effective due to the highly subjective, broad leeway the professional guidelines for actuaries allow.[7] States should have an actuary independent of the insurer review increases meeting the regulation's threshold for unreasonableness review, using underlying data that allows testing of the carrier's assumptions.

In addition, the state should review the reasonableness of past and anticipated administrative expenses, reserves, and profits or contributions to surplus.

Further, most states with prior approval or "file and use" have a deemer period, which allows rates to be deemed approved if not disapproved within a specified time frame, usually 30 to 60 days (the time may vary by product or carrier type within a state). HHS must receive assurances

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[5] The independent actuary hired by the California Department of Insurance in Spring 2010 to review Anthem Wellpoint's rate increase request found, for example, that the insurer had double-counted the impact of the age of the population (as well as incorrectly projecting trend lines). Duke Helfand, "A Mathematical David Stuns a Healthcare Goliath," *Los Angeles Times*, July 15, 2010.

[6] A "PFAD" factor for "uncertainty" was included, for example, in the cost trend for Blue Shield of California that resulted in rate increases of up to 59% for some customers, due to three cumulative increases over six months. The third round of increases is still under review by the California Department of Insurance.

[7] See NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act, May 12, 2010: "Most states with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with state law…This allows the states to rely on the Code of Professional Conduct and the Standards of Practice that actuaries must follow."

from each state that they will not allow rate increases meeting the trigger to go into effect before the state determines reasonableness.

4. Review for medical loss ratios complying with federal law.

The criteria for effective review should specify that the state must apply medical loss ratio (MLR) standards that comport with those under the ACA, unless the state has received a temporary waiver. Numerous states, for example, have on their books the National Association of Insurance Commissioners old model for the individual market (or some variation), which used an MLR standard of 50% to 60%.[8]

5. Strong standard of review applied in a manner that is most protective of consumers.

Proposed criterion #5 is that the state's determination is made under a standard that is set forth in State statute or regulation. There is no suggestion of what the standard should be or how an existing state standard should be applied to achieve effective review. The two most common standards of review in states that have rate review are: premiums should be "reasonable in relation to the benefits provided" and rates "shall not be excessive, inadequate, or unfairly discriminatory." Some states use either or both of those standards; and some use different standards for different products; for example, they may apply the excessive standard only to HMOs or non-profit carriers.

Most states interpret the "reasonable in relation to benefits" standard as a minimum medical loss ratio standard.[9] If carriers show that the anticipated or lifetime loss ratio will meet a certain minimum, states will conclude that the rates are "reasonable in relation to benefits." The "excessive" standard is generally broader and provides greater review authority than the reasonableness standard; however, again, the effectiveness of the standard depends on how states apply it. In many states, these terms are not defined and can lead to a very subjective analysis by regulators.

In states applying either of these standards (particularly in the individual market), regulators often narrowly focus their review on whether a specific policy or group of policies is profitable – that is, whether the projected revenues are going to cover projected costs and expenses and result in a reasonable medical loss ratio.[10] Therefore, both of these approaches often exclude a range of relevant factors from consideration. Indeed, perhaps most detrimentally, this type of narrow review does not examine specific underlying medical cost irregularities, provider contracts, or

[8] See National Association of Insurance Commissioners, Guidelines for Filing of Rates for Individual Health Insurance Forms, Model Regulation 134.
[9] See e.g. the National Association of Insurance Commissioners, Guidelines for Filing of Rates for Individual Health Insurance Forms, Model Regulation 134 ("…benefits shall be deemed reasonable in relation to premiums" if the anticipated loss ratio is between 50% and 60%, depending on the renewability aspects of the policy).
[10] Insurers often argue that each policy or block of business must be independently profitable and they will attempt to impose large rate hikes on any policies reportedly producing losses despite large profits elsewhere in the company. In a widely-reported example, Wellpoint Inc., parent company of Anthem Blue Cross, claimed that the company lost $10 million in 2009 on individually-insured Californians, yet the company reported $2.7 billion of profit in the fourth quarter 2009, just as it tried to raise rates by up to 39% on some individuals. See Insurer Blames Health Costs for California Rate Hikes, LA Times, Feb. 24, 2010.

whether insurers use incentives for providers to improve quality and control costs. There is no analysis of market conditions, such as concentration of carriers or providers that can be exacerbating rate increases.

HHS has asked commentators to identify specific factors that state should consider in their reasonableness review in addition to those enumerated in the proposed regulation. Based on our analysis of problems in the individual market and on rate review practices in the states, we believe that the following additional factors should be considered in a state's reasonableness evaluation:

(a) broader solvency and financial strength of the entire company;
(b) insurer's risk pooling practices (which may be segregating high and low risk, resulting in unnecessarily high increases for certain policies or policyholders);
(c) effect and hardship on consumers;
(d) history of rate increases;
(e) balance of solvency against affordability for consumers; (f) the company's mission in the case of nonprofit insurers;
(g) insurer's quality and cost control efforts; and
(f) lack of competition in the provider and carrier markets.

Effective rate review standards should allow regulators to consider these additional factors and to find a rate increase unreasonable based on any combination of some or all factors. The actuarial soundness of specific policies or groups of policies is important, but must be viewed in light of the broader solvency of the company and balanced against consumers' needs for affordable coverage.

6. Robust public information to consumers and a transparent process allowing consumer input.

Many states have indicated that they will use rate review grant funds to improve transparency. Consumers need more plain language information about rate increases, how premiums are set, and the factors driving healthcare costs. States should also gather and disclose historical rate increase data by insurer and by policy. State rate filings, as well as *all parts* of justification forms should be disclosed in their entirety online to maximize insurer accountability.

HHS has asked for comments on whether the public's ability to comment on unreasonable rate increases during the review process should be considered as one criterion for an effective rate review program. We answer "yes" and urge you to adopt this criterion for effectiveness. In the individual market, we have seen repeated good outcomes for consumers in states that hold public hearings, such as Maine and Rhode Island. Iowa recently began holding public comment sessions regarding rate increases. After listening to the concerns of Wellmark policyholders about a proposed 10.8% increase, the state's Insurance Commissioner lowered the increase to 8.5% and decided to further investigate the company's capital adequacy in relation to risks and the potentially adverse impact of the company's market share on consumers.[11]

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[11] See *Iowa Commissioner: Wellmark May Increase Rates by 8.5%, Not By 10.8%*, Insurance Journal, Feb. 3, 2011, available at http://www.insurancejournal.com/news/midwest/2011/02/03/183210.htm.

Consumer participation maximizes accountability and allows regulators to better assess the impact of a rate increase on individuals, families and employers. It also sheds light on the effectiveness of state review as regulators are forced to respond to specific consumer concerns. States that provide for an explicit consumer role in health insurance proceedings benefit from a more complete and balanced perspective in their decision making.[12] In their participation, consumers and their representatives can surface new issues, or amplify them, and make a substantial contribution by presenting evidence that enables regulators to make a more informed decision.[13] This regulation should include that providing mechanisms for consumer intervention in rate proceedings will weigh in favor of a state's effectiveness determination by HHS.

Whether a state provides an explicit, formal role for consumer intervention or not, states should use any consumer input received, including the public comments, as evidence in its overall analysis of the rate increase, and states should weigh the impact on consumers against the company's need for the increase.

7. Adequate notice to consumers of a proposed rate increase.

HHS should consider whether the state requires carriers to give notice of a proposed rate increase in a reasonable amount of time before the new rate goes into effect. Sixty days, for example, would allow consumers to learn more about the increase, using available information, to shop around for a new policy if necessary and feasible, or make budget adjustments.

8. Strong rate review track record or demonstrated steps toward implementing effective review.

An indicator of effective state review is a state's history of reviewing rate increases and negotiating with carriers for lower rates. In addition, or in the alternative, HHS should consider how states are implementing rate review programs using the federal premium review grants. At a minimum, the state should demonstrate that it is on track to fulfill all grant requirements and that the resulting program will meet the criteria described above.

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[12] See CA Health & Safety Code section 1348.9 (establishing a "Consumer Participation Program" affording the opportunity for consumer intervention on HMO regulations or decisions affecting a significant number of consumers by the Department of Managed Health Care and compensation by DMHC for substantial contributions on such matters); Massachusetts law M.G. L. 176Gs. 27(d)(2) (regarding HMO mergers and acquisitions). For several decades, California has provided for consumer intervention in the automobile and property/casualty lines of insurance. CA.Insurance Code 1861.10,

[13] See "Toolkit for Creating Consumer Participation in Policy Decisions," Consumers Union (2007) at http://yourhealthdollar.org/pdf/yourhealthdollar.org_toolkit-for-creating-consumer-participation.pdf. A recent example of such a significant consumer group contribution is found in a February 16, 2011 decision by the Oregon regulator. A consumer group in Oregon, OSPIRG, had filed a challenge to a requested rate increase by United Healthcare. Based in part upon issues raised by OSPIRG, the state regulator reduced a requested 16.8% increase to 10%. The state regulator found the requested increase for administrative expenses to be unreasonable, resulting in an estimated saving of $3.28 per member per month and making the administrative costs for 2011 less than for 2010. See http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzNwE

By incorporating stronger criteria for effective state review, the regulation would move states toward more vigorous oversight of potentially unreasonable rate increases than is likely under the proposed regulation.

9. HHS must ensure that all products meeting the threshold are subject to review.

Within market segments, some states apply different standards of review or different requirements based on the type of product or type of carrier. Michigan, for example, requires non-profit insurers and HMOs to obtain state approval of rate increases before they go into effect. For commercial insurance products, rates are file and use.[14]

Therefore, we support the language in Section 154.301, in which HHS has stated that it will apply the criteria for effective review of rates for the small group market and the individual market, "and also, as applicable depending on State law, the review of rates for different types of products within those markets." Because of the patchwork in many state statutes governing rate increases, HHS must ensure that all rate increases meeting the threshold are subjected to an effective review process by the state or by HHS. HHS also should consider whether the state has loopholes allowing carriers to avoid or expedite review for certain products, such as those issued with a guaranteed medical loss ratio. If states do not expand their rate review capacity to include product types or carrier types that are not now subject to review, then HHS should review those particular increases.

IV. HHS Should Apply These Enhanced Standards To Its Own Review For Unreasonableness

Consumers in every state can have the benefit of effective review if HHS improves its own standards for reviewing rates in states that do not meet the criteria for effective state review. We recognize that HHS lacks the authority to reject a rate increase that is found to be unreasonable. For this reason, we urge HHS to adopt the same stronger criteria for its own reasonableness determinations that are recommended above, including providing an avenue for consumer input regarding increases subject to HHS review.

HHS has asked specifically for comments on what additional factors should be considered in its own rate review in addition to those proposed, which are whether the increase is "excessive, unjustified, or unfairly discriminatory." We appreciate that HHS proposes to use a slightly different standard than the standard commonly used in the states (excessive, inadequate, or unfairly discriminatory). (As we saw in Maine in 2009-2010, a carrier litigated the

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[14] Also in Michigan, nonprofit insurers must file detailed justifications for rate increases and policyholders may request a rate hearing regarding the proposed increase. For HMO products, carriers must file rating methodologies used to set rates and rate increase requests with justification at least 60 days before the proposed effective date. MICH. COMP. LAWS § 500.3525. Regulators determine whether HMO rates are "fair, sound, and reasonable in relation to services provided." MICH. COMP. LAWS § 500.3519 For commercial insurance products, insurers need only certify that benefits are reasonable in relation to premiums.

Superintendent's rate decision on the ground that the term "inadequate" required her to allow at least a 3% profit margin in the rate increase.)

However, the definitions of the standards used for HHS review give us pause. The definition of excessive, for example, largely adopts the "reasonable in relation to benefits" standard and relies heavily on an examination of medical loss ratios and actuarial assumptions. As noted, this narrow focus allows, or may be read to require, regulators to ignore important considerations, such as those listed in item 5 above. The definition should be amended to indicate that those factors will be included when HHS considers whether a rate increase is excessive.

V. Disclosure of Justifications for Rate Increases Subject to Review

With respect to the disclosures required under the proposed regulation, we urge you to include a broader list of information that will be included in the preliminary justification. The rule should adopt the standardized proposed NAIC rate increase disclosure form. Consumers and businesses should have enough information so that they or their representatives or experts can identify red flags in the rate increase calculation, examine the claims history and compare trends, examine reserves, surplus, profits, and revenue. They should be specifically informed of savings realized from quality and cost control programs or new payment models. Information related to a carrier's statewide and nationwide finances is also relevant and important for consumers to understand the insurer's financial condition and the extent to which it acts in the interest of customers. This is vital information for making choices in the market.

Finally, we have strong concerns about a major exception to the otherwise strong level of transparency contemplated by the rule. Section 154.215(i) proposes that preliminary justifications for rate increases subject to review will consist of three parts: a rate increase summary, a written description justifying the increase, and – for when HHS does the review– rate filing documentation. Under section 154.215(i)(1), HHS "will promptly make available" to the public parts one and two on the HHS website; HHS will post part three "after its receipt thereof" with a critical exception: HHS will not post any information designated as "confidential." Section 154.215(i)(2)(i).

A fundamental feature of the Affordable Care Act is the requirement that rate increase information be publicly disclosed. Section 2794 of the Act provides that the Secretary "… shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers." For the most part, the proposed regulation recognizes the preeminence of such public disclosure. We thus strongly support the proposed regulation's provision that parts one and two, the summary and written description, will be promptly disclosed to the public. They provide important information. As well, we agree with HHS's statement that part 3 contains information "consumers would benefit from." We strongly urge that part three—the rate filing documentation-- should be disclosed promptly as well, with no portion being designated as "confidential" or otherwise excised from public release.

Our experience with insurers has been that they often make broad claims of "trade secret" or "competitive harm," keeping essential information from public view. Yet, there is a growing recognition—reflected in the ACA itself, in applications from the states for federal rate review

grants, and in some state laws—that public disclosure of rate information is critically important, especially as affordability remains a key consumer concern. All of the factors listed in section 154.215(g) describing the content of the rate filing documentation for HHS review are necessary for any consumer group or business to investigate the reasonableness of proposed rates. And much of the information that falls under part 3 will be required to be disclosed in other settings, such as in California under a new statute regarding rate disclosures. [15] We see no good reason to create a less transparent standard for filings under federal review.

We also believe that HHS should require carriers to submit data about provider reimbursements and contracts. Provider market power is a large and growing driver of health care cost increases. Regulators, consumers and their advocates cannot properly gauge the role of this important cost driver if provider reimbursement rates and contracts are considered "trade secrets."

Health insurance is so critical that consumers can no longer be kept in the dark about why rates are going up. HHS should not support carriers' arguments that release of data will result in competitive harm. Such assertions, with no demonstrated basis in evidence, should not be permitted to keep information from public view. This would reinforce the worst practices in some states that keep all or large portions of rate filings confidential.

Consumers Union looks forward to working with HHS and the states in the coming years to ensure strong rate review and affordable coverage for American consumers.

Sincerely,

DeAnn Friedholm
Director, Health Care Reform Campaign
Consumers Union

[15] All individual and small group market rate filings are to be publicly disclosed under California law, with the exception of contracted rates between the plan and providers. CA Health & Safety Code 1385.07; CA Insurance Code; 10181.7.