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Secretary Kathleen Sebelius
Department of Health and Human Services
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Comments of Consumers Union of U.S., Inc.,
to the U.S. Department of Health and Human Services
on "Premium Review Process; Request for Comments Regarding Section 2794 of the Public Health Service Act"
File Code DHHS–2010–PRR

Introduction

This letter responds to the Department of Health and Human Services request for comments regarding Section 2794 of the Public Health Service Act ("the Act").[1] This Section requires the Secretary to work with States to establish an annual review of unreasonable rate increases, to monitor premium increases and to award grants to States to carry out their rate review process. Our comments focus primarily on rate review as it applies to the non-group or individual market.

1. Rate Filings and Review of Rate Increases

Current Practice

A majority of states require prior approval of some or all individual market rates before they go into effect. About 12 states allow insurers to "file and use" rates but regulators have authority to review increases and seek changes if rates do not comply with state law. Many states with rate review authority also apply a "deemer" clause, allowing a rate increase request to be "deemed" approved regardless of whether it was actually reviewed after 30 or 60 days. A handful of states merely require insurers to file rates "for information only" or to submit rates with policy forms.

[1] Added by Section 1003 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111–148.

In most states with rate review, statutes provide that regulators must determine whether the requested rates would be "excessive, inadequate, or unfairly discriminatory" (or a similar standard). Depending on the state, statutes may also or instead require regulators to determine whether premiums would be "reasonable in relation to the benefits" to be provided to policyholders, a standard that refers to a plan's medical loss ratio. These two standards usually lead regulators to approve rates if they are actuarially justified (i.e., the insurer has used proper actuarial methods to predict medical claims and expenses and has shown that the rate hikes are necessary to cover those claims and expenses) and the new rates would meet the minimum medical loss ratio standards.

Current Practices May Be Insufficient

The above standards limit state regulators' ability to consider other relevant and important factors, including the size of dividends the company is sending to its parent or shareholders, excessive surplus or reserves, how the insurer is pooling – or not pooling – its members to spread risk, whether the insurer is taking sufficient steps to control medical and administrative costs, and the impact of rate increases on consumers.

Regulators often look only at the profits, claims experience, and expenses of the particular policy or block that is subject to a rate increase. If these narrow lines of business are projected to lose money, regulators generally don't consider whether a lower increase or no increase would pose a threat to the company's solvency and whether any potential losses would be minute relative to the company's overall surplus and profit-margins.[2]

Actuarial justification is largely dependent on the diligence of state actuaries to verify and decide whether the insurer is applying appropriate projection factors. Many states lack the resources to fully assess health insurers' rate justifications, including all underlying data to substantiate cost projections.[3]

In addition, actuarial justification alone does not give regulators authority to consider whether high increases are partly due to the result of insurers practices with respect to new and closed blocks of business. For example, when insurers stop selling a policy, it no longer enjoys an influx of healthy (newly underwritten) customers and rates tend to rise as previously healthy existing customers need medical care. People who now have health conditions can't shop around for a lower cost, open plan and face rapidly rising rates People who remain healthy can shop around and do to avoid rate increases, again,

[2] For example, recently Blue Cross Blue Shield of New Mexico, a division of Health Care Service Corporation (HCSC), claimed that it would lose money on its individual market plans covering 40,000 New Mexicans if it did not raise rates an average of 24.6%. But increases of this size were not necessary to protect the solvency of HCSC, which reported $6.7 billion in surplus at the end of 2009.

[3] The recent Anthem Blue Cross case in California demonstrates the need for increased scrutiny of rate increases. The company had originally sought to raise rates up to 39% for individual market customers, but an independent actuarial review conducted for the state concluded that Anthem overstated the medical trend and used faulty methods to project claims. See Review of Anthem Blue Cross 2010 Rate Increases, Axene Health Partners, LLC, April 28, 2010.

leaving sicker members to face rapidly increasing costs and premiums. Thus, the consumers in these closed blocks of business are forced to bear the risk of large claims, better suited to being spread more broadly across the company.

Another issue is that regulators rarely use rate review as a means to pressure insurers to control medical and administrative costs to achieve better affordability for consumers. Large increases may signify that an insurer needs to seek changes to its provider networks or reimbursement contracts. Insurers with large market shares are well-positioned to initiate cost-controlling, innovative changes to provider payments. But under current rate review standards, most regulators do not seek to examine provider contracts or other evidence to determine whether an insurer is taking adequate measures to control costs.

Finally, current state practices often leave consumers without representation in the rate review process. When regulators do push insurers to lower proposed rate increases, these negotiations often occur between the insurer and state officials behind closed doors. Only a handful of states have more open procedures that require public notifications, disclosure of rate filings, and/or hearings for rate hikes. So it is usually difficult for consumers to determine why rate increases are approved, or in some cases, lowered at the behest of state regulators. Consumers generally lack representation by an independent expert who can examine insurers' projections in the interest of policyholders.

2. Defining Unreasonable Premium Rate Increases

As noted, current practice in states with rate review is to determine whether premium increases are excessive, inadequate, unfairly discriminatory, or fail to meet medical loss ratio standards. Section 2794 of the Public Health Service Act introduces a new standard for state and federal regulators to consider, that of an unreasonable rate increase.

Recommendations on Standards for Unreasonable Premium Rate Increases

Because the reasonableness of a rate increase cannot be determined without reviewing the experience and the underlying rationale for it, Consumers Union recommends review of **all** premium rate increases, per the guidelines above, with full public disclosure as listed below, notice to consumers and right to comment. However, if all rates can not be reviewed, the following factors should trigger a review:

When the rate increase exceeds the rate of medical inflation.

- When the rate increases apply to closed blocks.

- When the increases are unnecessary to protect the solvency of the entire company (as opposed to solvency of the specific block or line of business subject to increase).

When the insurer's past projections for medical claims and administrative expenses have been significantly different from actual incurred claims and expenses for any past rating period.

3. Public Disclosure

Current Practice

States have a wide spectrum of practices with respect to public disclosure of individual market rate filings. Oregon has recently enacted regulations requiring public disclosure of entire rate filings, to be posted online. Other states, such as Florida, North Carolina, and Arkansas make some rate filings available online but redact much information that insurers consider to be confidential trade secrets. Other states, such as Arizona and Texas, make all or part of filings available by inspection or mail through Public Records Act requests. Maryland keeps entire rate filings and requested rate increases confidential, and has released only the approved rate increase percentages pursuant to a public records request.

Public review of rate increases also requires access to insurers' financial statements. Insurers' financial statements may be obtained from state insurance departments, or from the NAIC's website but the organization charges a fee. However, most states do not post financial statements online but require a Public Records Act request, along with copying and mailing costs or a necessity to inspect at the state agency office. State regulators and insurers sometimes do not release specific information necessary to show profits, expenses, medical claims and historical financial data specific to each policy or block and for a particular state's individual market. This financial information is important to evaluate insurers' claims of individual market losses.

Information Relating to Justification that Should Be Publicly Available

For consumers and consumer advocates to understand rate increases and play an effective role in rate review, a new standard should be created detailing information that should be available and made easily accessible.

Regulators should make all individual market rate filings (in their entirety[4] and including associated correspondence), rate filing summaries and supporting financial information publicly available through agency websites within two weeks of receipt of a proposed increase. Documentation should include the following types of basic information necessary for a rigorous rate review process:

- Base rate increase for each block of business subject to an increase, and the overall average increase for all policies.

[4] As described above, provider contracts must be included in the rate review process. Insurers are likely to be unwilling to release provider contracts to the public. If a tradeoff is necessary, we recommend these contracts be subject to review by the regulators, even if they aren't subject to broader public disclosure.

- Table of rates for each product subject to an increase showing current and requested future monthly rates for each age category, or when applicable, for each health status tier or other rating factor category.
- Number of people in each block subject to an increase and the overall number of people impacted by the increase.
- Disclosure of whether each block subject to an increase is open or closed, description of each policy or policies included in each block.
- Insurer's financial information for the most recent full calendar year and subsequent quarters for the company as a whole, the total statewide individual market**,** and, when applicable, for each block subject to increase**.**

  Premium Revenues
  Expenses (amounts spent on each administrative category, including but not limited to executive salaries, broker commissions, cost control programs, premium taxes and assessments)
  Underwriting margin
  Investment income
  Net income
  Surplus
  Amounts held in other reserves, and whether insurer has reinsurance for potential claims.
  Percent of company's premium revenue derived from non-group market policyholders.

- Break down of rate increase components. What percentage of the increase is targeted for medical claims, administration, taxes, and profits/surplus?
- Break down of administrative expenses. What are projected administrative expenses going to cover, including the percentage of projected administrative costs targeted for broker commissions, compensation, cost/utilization control programs, wellness programs, etc.
- Experience period: What time frame of claims experience was used to project future medical claims and expenses?
- Description of how the insurer calculated medical cost increases. What rates of medical inflation were used? What other factors were used to project medical claims?
- Medical loss ratios to show compliance with new medical loss ratio standards under the Patient Protection and Affordable Care Act (PPACA), including annual medical loss ratio for each block subject to an increase, and anticipated future loss ratios for each block subject to an increase.
- Stockholder dividends paid in the past calendar year and subsequent quarters (to shareholders or parent companies).

- Historical 5-year profitability of the block of business, the company's total individual market, as well as the company as a whole
- Historical 5-year rate increases, overall averages and by block, as well as historical rates requested.
- Historical 5-year enrollment figures by policy or block.
- General description of the types of data or actuarial assumptions that have been kept confidential (if any).

4. Exclusion from Exchange

No comments.

5. Grant Allocation

To remedy deficiencies in current individual market rate review, states must implement stronger review standards and a more transparent review process for non-group consumers. Consumers Union recommends that grants be awarded to states that have in place or commit to move to, a rate review process that includes:

- **Prior Approval**

  All carriers must file new or increased individual rates and required documentation with a state's reviewing agency for pre-approval at least 90 days prior to the proposed effective date of the rates. The carrier must provide data substantiating its actuarial projections, including all information needed for regulators to apply the standard of review (discussed below).

- **Notice and Comment Period**

  Carriers must send all plan members impacted by the proposed rate increases notice of the proposed change at least 90 days before the proposed effective date. Carriers must inform members that they have an opportunity to comment on the rate increases, and provide information on how and where consumers may comment. In addition, state reviewing agencies must prominently post links to notices of rate increases on their websites.

  The state shall receive and review public comment about the proposed rates during the 90 day period, through a public hearing, regular mail, emails, and/or a providing a website for posting comments. Opportunities for public education and comment regarding rate increases should include after-business hours or weekend forums in various geographic locations where large numbers of policyholders and certificate-holders live.

- **Public Disclosure**

  States should have strong public disclosure standards that provide the information related to justification recommended in Section 3 above. In addition, states should provide a summary of their actions in reviewing rate increases and the reasons for approving or denying a requested increase. Summaries should be posted on a state agency's website within 7 days of a rate increase approval, modification, or denial.

- **Standard of Review**

  Current review standards must be strengthened to permit regulators to consider the following factors when reviewing rates:

  - Reasonableness of actuarial assumptions and projections, including historical and projected claims and administrative expenses.
  - Medical loss ratio standards based on auditable data.
  - The company's risk pooling across its entire individual market. Special consideration must be given to closed blocks and new policies in this interim period before 2014 reforms. Regulators need broad authority to require insurers to price rate increases on the basis of the aggregated claims experience of open and closed blocks.
  - The company's overall financial profile for the 5-year preceding period, including surplus, reserves, other mechanisms for solvency protection, dividends paid to parent companies or shareholders, investment income, administrative costs, broker compensation, and executive compensation. For example, the solvency of a small block should be a minor consideration when overall financial solvency is very strong.
  - Whether the company is taking adequate measures to contain medical and administrative costs, including a review of provider contracts or reimbursement data if necessary.[5]

[5] The Massachusetts Legislature authorized its Attorney General to study healthcare cost drivers in the private commercial market. The Attorney General reviewed scores of insurer-provider contracts and financial data, and publicly released some previously undisclosed information about how much insurers pay providers. The Attorney General found that prices paid by insurers to providers vary significantly and these price variations are not correlated to quality of care, sickness of the population served or complexity of services, or other factors reflecting the value of services provided, but are instead correlated to market leverage of hospital and physician groups. See *Examination of Health Care Cost Trends and Cost Drivers*, Report for Annual Public Hearing, Office of Attorney General Martha Coakley, March 16, 2010. Oregon recently passed a statute providing that its insurance regulators, when determining whether to approve requested increases, should consider among other factors, "changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same plans." Oregon Revised Statutes section 743.018(5)(f).

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- Enrollment history over past five years and potential hardship on members.

State standards must allow reglators to reject increases that are unnecessary or excessive, based on an analysis of the above factors.

- **Consumer Representation**

  Each unreasonable increase, as defined in Section 2 above, should be reviewed by a consumer representative employed by the state agency or contracted to review rate increases on behalf of consumers. The consumer representative should have knowledge of rate setting and must have clear authority to participate fully in the state's review process, representing the best interest of consumers.

  The consumer representative should publish a report analyzing the merit of the proposed increase and recommending approval or disapproval of the increase, as well as steps needed to moderate future increases (such as cost control, provider reimbursement changes).

- **Hearings**

  If an increase appears unreasonable, it should trigger a public hearing by the regulators. The carrier and the state agency should be required to provide public notice of the hearing.

With the new grant resources, the regulatory agency must provide sufficient resources to competently and aggressively review and evaluate the assumptions and justifications for rate increases.

Thank you for the opportunity to comment on Section 2794 of the Public Health Service Act.

Respectfully submitted,

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Consumers Union