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May 14, 2010

Mr. Donald B. Moulds
Acting Assistant Secretary for Planning and Evaluation
Office of the Secretary
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington D.C. 20201

Re: DHHS-2010-PRR, Premium Review Process; Request for Comments Regarding Section 2794 of the Public Health Service Act

Submitted via Federal e-Rulemaking Portal: www.regulations.gov

Dear Mr. Moulds:

On behalf of America's Health Insurance Plans (AHIP), the national association representing nearly 1,300 member companies providing health, long-term care, dental, disability, and supplemental coverage to more than 200 million Americans and participating in Medicare, Medicaid, and other public programs, we welcome the opportunity to respond to the Request for Information ("RFI"), published in the *Federal Register* on April 14, 2010, regarding the Premium Review Process. Section 2794 of the Public Health Service Act (PHS Act) 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 ("Section 2794 Rate Review Process").[1]

Our community is strongly committed to the successful implementation of the "Patient Protection and Affordable Care Act" ("PPACA").

In addition to responding in detail to the questions posed in the RFI, we would like to make the following five broad points:

[1] The statutory basis for the Rate Review Process is found in Section 2794 of the PHS Act as added by § 1003 of the Patient Protection and Affordable Care Act.

- The new Section 2794 Rate Review Process should be considered in the context of all of the other PPACA regulations affecting health plans, including the new medical loss ratio (MLR) provisions;

- Rate review should continue to occur at the state level;

- The annual review of "unreasonable increases" in premiums should be tied to principles of actuarial standards and solvency and should be applied consistently across states;

- Actuarial justification and disclosure should be accomplished in a way that provides consumers with useful and understandable information; and

- The new grant funding should promote state flexibility and not mandate a single approach.

In addition, we encourage the Secretary to use the proposed rulemaking process instead of issuing regulations in interim final form. We believe PPACA provides the Secretary with sufficient flexibility to allow for a proposed rulemaking process on this subject, since the law requires only that the Secretary establish "a process for the annual review of . . . unreasonable increases in premiums" beginning with the 2010 plan year. Recognizing that this is a very technical and complex area that has a significant impact on consumers, employers, and health plans, we believe it is critical that the public receive as much advance notice as possible of the proposed rule. By establishing a deliberative rulemaking process and allowing maximum opportunity for input from stakeholders, the Secretary can ensure that the Department of Health and Human Services has sufficient time to fully digest and consider the meaningful comments submitted by interested parties and, in so doing, help ensure that these legislative provisions are implemented without causing disruptions for consumers.

The New Section 2794 Rate Review Process Should be Considered in the Context of All of the Other PPACA Regulations Affecting Health Plans, Including the New MLR Provisions

The Section 2794 Rate Review Process is one of many new provisions enacted in PPACA that impacts the regulation of health insurance coverage. The extent of these changes is illustrated in the chart on the following page which identifies the wide range of statutory and regulatory requirements the new health reform law imposes on health plans.

This chart demonstrates that the new law regulates every aspect of health plan operations, including MLR requirements that cap administrative costs and profits. The rate review process should be considered in the context of this newly expanded regulatory structure, recognizing that it is a significant component – but not the only aspect – of a multi-faceted strategy for regulating health plans. Ultimately, the implementation of the rate review provisions should give policymakers and the public the assurance that there will be more consistency across the states in

ensuring that premiums will be actuarially justified and that resources will be provided to support the execution of these functions.

NEW STATUTORY AND REGULATORY DIRECTIVES FOR HEALTH PLAN OPERATIONS

New Regulations on Operations

- Caps on Medical Loss Ratios — PHSA Sec. 2718
- Prohibition on Lifetime Limits — PHSA Sec. 2711
- Regulated Annual Limits — PHSA Sec. 2711
- Guaranteed Issue — PHSA Sec. 2702
- Guaranteed Renewability — PHSA Sec. 2703
- Premium Rate Review — PHSA Sec. 2794
- No Preexisting Condition Exclusion or Discrimination — PHSA Secs. 2704 and 2705
- Regulation of Waiting Periods — PHSA Sec. 2708
- New Federal Appeals Process — PHSA Sec. 2719
- Regulation of Grandfathered Plans — PPACA Sec. 1251
- No Health Status Rating — PHSA Sec. 2701
- Restrictions of Rescissions — PHSA Sec. 2712
- Quality Reporting Requirements for Coverage and Provider Reimbursement — PHSA Sec. 2717
- Standards for Health Data and Information Systems — PPACA Sec. 1104

New Regulations on Product Design

- Required Essential Health Benefit Package — PPACA Sec. 1302
- Required Preventive Services — PHSA Sec. 2713
- Required Uniform Summary of Benefit and Coverage Documents and Standard Definitions — PHSA Sec. 2715
- Required Emergency Room Services Coverage — PPACA Sec. 1301
- Required Dependent Coverage — PHSA Sec. 2714
- Required Coverage for Approved Clinical Trials — PHSA Sec. 2709
- New Federal Standards for 'Qualified' Health Plan — PPACA Sec. 1301

New Required Fees and Taxes

- 40% Excise Tax on High Cost Plans — IRC Sec. 4980I
- Annual Fee on Health Insurance Providers — PPACA Sec. 9010
- Pass-Through of Manufacturers' Fees — PPACA Secs. 9008 and 9009
- Limitation on Deduction for Compensation for Health Insurance Executives — PPACA Sec. 9014
- Risk Corridor Payment Adjustment System — PPACA Sec. 1342
- Payment for Reinsurance Program for Individual Market — PPACA Sec. 1341
- Fees to Fund Comparative Effectiveness Research — IRC Secs. 4375, 4376, and 4377
- Tax Treatment for Certain BCBS Plans — PPACA Sec. 9016
- Federal Risk Adjustment Mechanism — PHSA Sec. 1343

Rate Review Should Continue to Occur at the State Level

AHIP recommends that the Section 2794 Rate Review Process build on the states' traditional role of regulating health insurance premiums. The vast majority of states have authority to review and approve rates through their existing statutes, and the implementation of the new PPACA provisions should build on the states' experiences.

Many states explicitly apply a reasonableness standard in reviewing rates with a basic actuarial requirement that the benefits provided be reasonable in relation to premiums.[2] This requirement

[2] *See* NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms. Specifically, the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms provide that "A basic actuarial requirement in the establishment of a premium rate scale is that the benefits provided be reasonable in relation to premiums. This requirement has been incorporated in the statutes of many jurisdictions and in the regulations and operating rules, formal and informal, of the insurance departments of probably all jurisdictions."

has been incorporated in the statutes of many jurisdictions and in the regulations and operating rules, formal and informal, of insurance departments.[3]

State insurance commissioners also are tasked with supervising insurance company solvency.[4] As a result, states already have significant expertise in assuring that consumers are charged appropriate premiums and that these premiums are sufficient to cover the cost of medical care, maintain adequate reserves to fund contingencies, and meet any state rules relating to consumer protections.

The Annual Review of "Unreasonable Increases" in Premiums Should Be Tied to Principles of Actuarial Standards and Solvency and Should Be Applied Consistently Across States

We urge the Secretary, in developing the Section 2794 Rate Review Process, to establish a strong linkage between the process of reviewing rate filings and supervising solvency. An approach that delinks the regulation of premiums from health plan solvency would seriously undermine the financial stability of health plans and threaten their ability to pay benefits. By contrast, a strong commitment to health plan solvency – ensuring that health plans have sufficient resources to pay benefits – is a critically important regulatory protection for consumers. Health plan solvency also is important to health care providers who rely on health plans having the financial wherewithal to pay claims.

In a January 6, 2010 letter to congressional leaders, the National Association of Insurance Commissioners (NAIC) urged the continued linkage between premium regulation and solvency:

> If federal regulators are given the authority to deny premium increases that are needed to maintain the solvency of a company or to exclude carriers from the marketplace in response to these needed premium increases, the ability of state regulators to ensure the financial stability of companies could be severely compromised. We urge the conferees to avoid any provision that could separate the regulation of premiums from the regulation of solvency.[5]

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[3] Many state statutes explicitly apply the reasonableness standard in reviewing rate changes relative to benefits. *See, e.g.,* Ariz. Admin. Code § 20-6-607, 3 Colo. Code Regs. § 4-2-11, Del. Code tit. 18 § 2501 *et seq.*, Fla. Admin Code r. 69O-149.005, Iowa Admin. Code r. 191-36.9, Kan. Admin. Regs. § 40-4-1, 806 Ky. Admin. Regs. 17:070, Mass. Gen. Laws. ch. 176g, §16, S.C. Code § 38-71-310, Tenn. Comp. R. & Regs. 0780-1-20, Utah Admin. Code r. 590-85, 14 Va. Admin. Code § 5-130-10.

[4] *See, e.g.,* Wash. Rev. Code § 48.46.040.

[5] *See* letter available at http://www.naic.org/Releases/2010_docs/health_reform_insight.htm

Implementation will require that the term "reasonable" and/or "unreasonable" increases be further explained. In setting a standard for determining whether rates are reasonable or unreasonable, the Secretary should take into account the necessary range of factors affecting the rates and avoid any metric that is arbitrary. Building premiums involves taking into account a variety of factors, including:

- Price per service
- Utilization of services
- Adverse selection
- New medical technology
- Cost-shifting from the underfunding of public programs
- State insurance taxes and fees
- Assessments for high-risk pools
- Regulatory compliance
- Aging of the population
- Unhealthy lifestyles

We recommend that the Secretary require a state-based review by insurance commissioners. Recommendations should be solicited from the American Academy of Actuaries for how best to review actuarial soundness and solvency, while also considering whether a proposed rate increase has a projected MLR that meets the standards of section 2718 of the PHS Act.

Moreover, rate review should not force small businesses to subsidize losses resulting from coverage sold in the individual insurance market (*e.g.*, as currently seen in Maine). This approach to rate regulation increases the financial burden on small businesses that are already struggling with rising health care costs and a weak economy. The nation's economic recovery will be hindered in states where regulators take this approach and burden groups and small businesses with higher costs.

Actuarial Justification and Disclosure Should Be Accomplished In a Way that Provides Regulators and Consumers with Useful and Understandable Information

Section 2794 also requires health plans to submit to the Secretary and the relevant state a justification for an unreasonable increase prior to the implementation of the increase. Disclosure of this information is required by both the Secretary and by health plans on their Internet websites.

AHIP and its membership are committed to transparency and believe consumers should have access to better information about the factors contributing to premium increases. Following a meeting between Secretary Sebelius, the President, NAIC leadership, and the CEOs of five health plans, the Secretary on March 8, 2010 addressed a letter to the company representatives asking them to make information on rates and rate increases transparent. She requested that these companies publicly display information regarding, among other items:

- The drivers of rate increases
- The number of individuals impacted by rate increases
- The estimates on medical costs and utilization increases and the assumptions behind them
- Explanations of what the companies are doing to control premium increases
- Medical loss ratio information for each premium increase

The companies all agreed to make information regarding premium increases available in a way that would be meaningful and understandable both to health plan enrollees and to policymakers. We are working with our members to accomplish these objectives and are developing a format to explain the components of rate filings. Our efforts involve two separate components: (1) a format for providing information to consumers that responds to the Secretary's requests about costs and cost control efforts; and (2) a format outlining the elements of specific rate filings to help consumers better understand how a rate filing will impact them.

We suggest that various aspects of this project will be able to inform the definitions and processes in the Section 2794 implementation. As of this writing, we are in the process of ensuring that the formats and materials we have developed through these efforts are understandable and useful to consumers. We will report back shortly to the Secretary when we have completed this work.

The New Grant Funding Should Promote State Flexibility and Not Mandate a Single Approach

As a result of the Section 2794 Rate Review Process, states will be devoting more resources to the actuarial certification and monitoring of premiums. The grant funding provided by PPACA will help states defray these costs, and we encourage HHS to allocate these funds without encouraging states to adopt a particular approach to rate review.

The legislative language of Section 2794 provides states with the flexibility to determine how best to approach rate approval – whether on a file and use basis[6] or a prior approval basis. We note, however, that in prior approval states, rate approval may take *more than a year* and, as a result, respond more slowly to rate requests needed to support the benefits of health plan enrollees.[7] Previous experience with New York State's prior approval process demonstrates how

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[6] The majority of states have some form of "file and use" standards for health insurance premiums. This means that health plans file rate changes, including actuarial and trend data supporting the requested rate change, with approval deemed after expiration of the review timeframe which is generally between 30 and 60 days. This review period allows regulators the ability to target review and ask questions of health plans prior to the rates going into effect.

[7] *See Letter from State of Wisconsin, Office of the Commissioner of Insurance, to Julia Philips, Chair, Rate Review Subgroup of the A & H Working Group, NAIC,* 5/6/10, http://www.naic.org/committees_lhatf_ahwg.htm ("In a retrospective rate regulation state with a competitive market, insurers can adjust their rates more quickly to respond to market conditions resulting in lower rate increases on a year-to-year basis.").

delays in approvals can have unintended consequences for employers and consumers.[8] In addition, based on the experience of states that have a history with prior approval, we are concerned that this approach could be politicized and result in arbitrary caps that create instability in the market and put at risk the coverage on which families and employers rely.

We recommend that the grant funding be linked to three factors: the volume of rate filings in a state, the meeting of specific time frames for review, and the need for budgetary resources.

Conclusion

Thank you for considering our comments on these critically important issues. We stand ready to work with the Administration, Congress, and other stakeholders to promote the successful implementation of PPACA while minimizing disruption for consumers and employers. Please feel free to contact Julie Simon Miller, Senior Associate Counsel, at (202) 778-3250 or jumiller@ahip.org if we can provide additional information or technical assistance on the rate review process or any other implementation issues.

Sincerely,

Jeffrey L. Gabardi
Senior Vice President

[8] *See Testimony of Empire BlueCross BlueShield before the Assembly Standing Committee on Insurance (June 8, 2009)* http://www.nysblues.org/pdf/060809EmpireTestimony.pdf *and Testimony of Excellus BlueCross BlueShield before the Assembly Standing Committee on Insurance (February 9, 2010)* http://www.nysblues.org/pdf/020910ExcellusTestimony.pdf