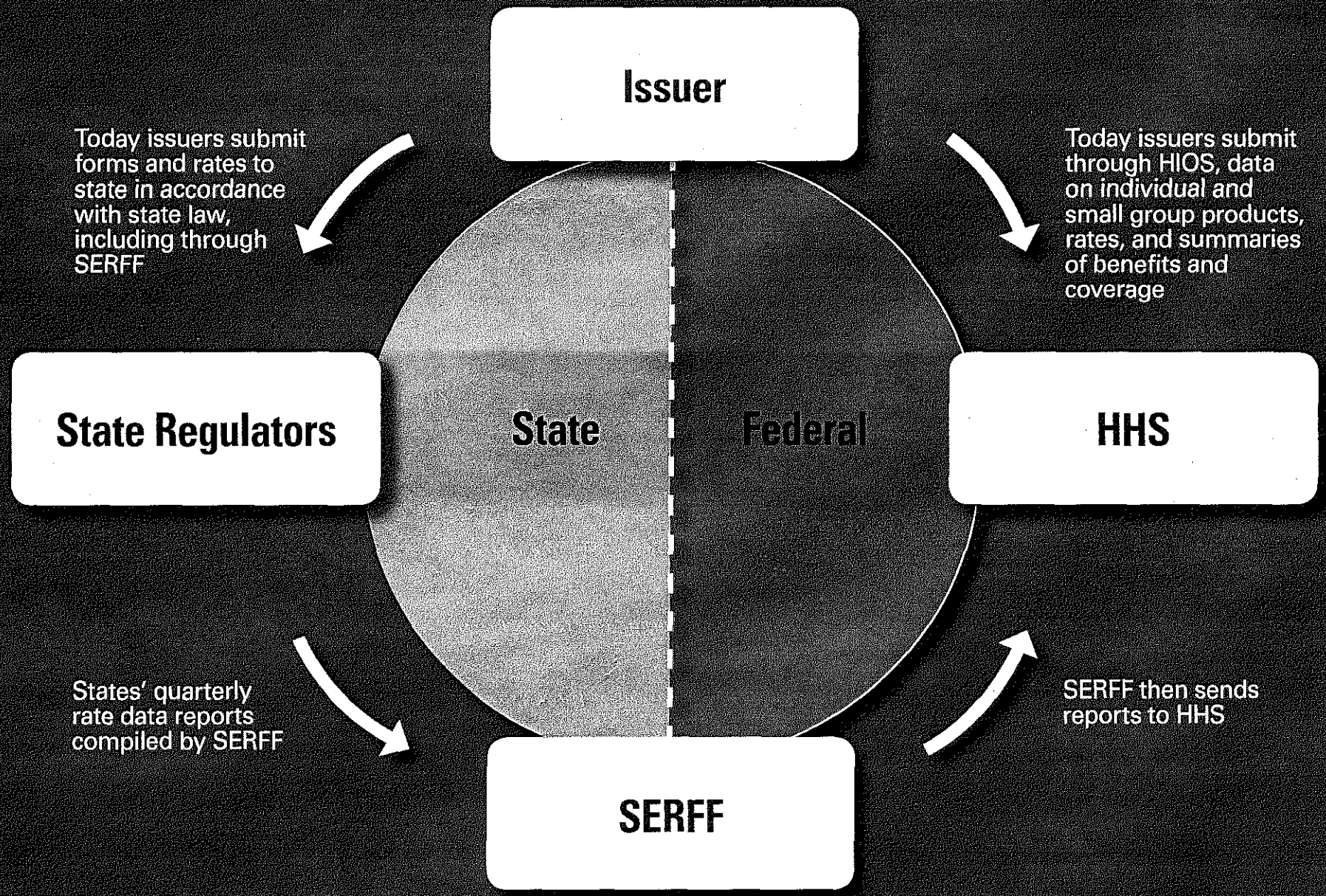
Rate Related Data is Currently Monitored



NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

December 19, 2012

Centers for Medicare &Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Attn: PRA Reports Clearance Officers
Mail Stop C4-26-05
Baltimore, MD 21244–1850

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed Paperwork Reduction Act rate review template posted on November 20, 2012. We write as the chief insurance regulators of our respective states and members of the National Association of Insurance Commissioners. The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the United States.

First, we would like to note the need for this template to be finalized and ready for use by issuers and state regulators as soon as possible. February 2013 has been suggested as a time when the template may be available; we strongly urge that it be available by mid-February, at the latest, so issuers and states can begin the daunting task of preparing for the October 2013 open enrollment period.

We are also concerned about the amount of data requested of issuers and the administrative burden and cost that is being placed on them. State insurance regulators work to ensure that the information collected from issuers is necessary to enforce laws and regulations, and that an undue burden is not placed on them. We encourage federal officials to continue to review the data and other information requested of issuers and work with state regulators to ensure that they do not result in unnecessary costs.

As for the template, although we certainly understand and appreciate the effort to expand the data collected in the rate review template in order to assist states in their rate reviews, many states believe that the proposed unified rate review template will not provide the information needed by the states for rate review. Several states are actually working on or have developed their own template. Because states have differing approaches to rate review, a single template will not meet the needs of all states. Therefore, we suggest the following:

1. Develop a data template designed to collect only the minimum amount of data CCIIO considers necessary for all non-rate review purposes.

2. Develop a separate rate review template, or alternatively create a separate section of the same template, designed specifically for rate filing review purposes.

3. Develop a separate rate review template, or alternatively create a separate section of the same template, designed specifically for Cycle II Rate Review grant reporting purposes.

4. Allow states with effective rate review programs to choose whether they want to require filers in the state to use the federal rate review template and/or the Cycle II Rate Review grant section/template. If the state chooses a different approach, using its own template or other means to collect the needed data, the issuer would only need to meet the state requirement in addition to the federal non-rate review template.

5. For states with effective rate review programs that do not choose to require the federal rate review template, do not require issuers to complete it. These issuers will be required to provide the rating information required by those states to perform their reviews.

6. For states without an effective rate review program, issuers would complete and submit to CCIIO the federal rate review template.

This would reduce the burden on issuers because, in an effective rate review state, issuers would not be required to complete CCIIO's unified rate review template in addition to providing each state's required rate review data. It may also reduce some burden on states in attempting to reconcile and explain any differences between the data provided on the federal rate review template and the rate review data required by the state.

In addition, CCIIO should give states the flexibility to expand the AV Pricing Value field (row 16 in Worksheet 2) to isolate each of the allowed plan level adjustments to the index rate. Specifically, §156.80 should allow for the following plan-level adjustments to the index rate:

1. The actuarial value and cost-sharing design of the plan;

2. The plan's provider network, delivery system characteristics, and utilization management practices;

3. The benefits provided under the plan that are in addition to the essential health benefits; and,

4. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

State (and potentially federal) regulators will likely want to confirm that each component of the plan-level adjustment is actuarially justified and appropriately consistent across plans, and that additional adjustments are not being made to rates at the plan level.

We also recommend that:

1. The SERFF ID be included in the heading;

2. The experience period should include at least one month of paid claims run-out;

3. The instructions should state that the experience period should be for just the most recent calendar year, and if more than one year's experience is needed, it should be input through the credibility manual section;

4. For worksheet 3, the historical data should include either member months or policy count each year; and,

5. The inputs for paid claims and IBNR in worksheet 3, which is highly unusual, be replaced with inputs for total projected incurred claims, which is more consistent with issuer practice.

On worksheet 3, the premiums, claims and reserves should be accumulated and/or discounted to present value if interest is a significant factor in the calculation of the loss ratio. The following is the definition of anticipated loss ratio from the NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms. We recommend adhering to this standard:

"*The lifetime anticipated loss ratio derived by dividing (i) by (ii) where (i) is the sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and (ii) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and the accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.*"

Finally, with regard to the collection of risk adjustment and reinsurance data:

1. In worksheet 2, rows 26 through 38, we recommend that section II include a row that documents the estimated net impact of the transitional reinsurance, risk adjustment, and risk corridor programs on the premium increase. For example, decreasing reinsurance payments will materially impact rate increases. Issuers may want to document the impact that these federal programs are having on rates.

2. In worksheet 1, row 39, CCIIO should consider using two different aggregate estimates of the PMPM risk adjustment impact, one for the metal level plans, and the other for the catastrophic plans, since risk adjustment for these will be based on different populations.

3. In worksheet 3, we recommend that CCIIO add a field to incorporate risk adjustment and reinsurance into the lifetime loss ratio calculation, or clarify in the instructions how to account for risk adjustment, risk corridor, and reinsurance impacts.

We thank you for your consideration of our comments; we are available to discuss these in detail and would be happy to answer any questions.

Sincerely,

Kevin M. McCarty
NAIC President
Florida Insurance Commissioner

James J. Donelon
NAIC President-Elect
Louisiana Insurance Commissioner

Adam Hamm
NAIC Vice President
North Dakota Insurance Commissioner

Monica J. Lindeen
NAIC Secretary-Treasurer
Montana Commissioner of Securities & Insurance

Sandy Praeger
Commissioner, Kansas Department of Insurance
Chair, NAIC Health Insurance and Managed Care Committee

AHIP

Center for Policy and Research

Health Plans' Estimated Costs of Compliance with Expanded Federal Rate Review and with Data Collection for Risk Adjustment and Reinsurance

December 2012

In December 2012, AHIP conducted two surveys of member health plans regarding new regulatory guidelines released by the Department of Health & Human Services (HHS) for implementation of the Affordable Care Act. Plans were asked to submit responses to surveys concerning: 1) the proposed expansion of the federal rate review and data submission process, and 2) the proposed risk adjustment and reinsurance data collection process.

In the proposed rules, HHS specifically asked for input from health plans on the cost estimates of these proposals; this report provides a preliminary response to that request. The two surveys asked plans about the expected costs associated with these proposed regulations, and allowed for open-ended comments and contextual responses.

In general, health plans estimated that the incremental cost of rate filing and data submission for federal rate review purposes would be roughly 70 percent higher than the HHS estimate. Health plans estimated that the cost per filing would be about $4,300.

Plans estimated that the cost of the data collection process for risk adjustment and reinsurance could range from about $1.3 million (median estimate) to over $5 million (average estimate) per plan. HHS had estimated that the cost would be approximately $300,000 per plan and that the total system-wide cost would be just under $600 million. However, based on the health plans' estimates, the total system-wide cost could be well over $1 billion.

1. FEDERAL RATE REVIEW SURVEY

Under current regulations, health plans are required to submit rate filings to the federal government for any comprehensive, major medical coverage in the small group and individual markets if the annual premium would increase by 10 percent or more.

Under the proposed rule and associated Paperwork Reduction Act package, insurers would be required to file their rates for *all* products in these markets with the federal government, regardless of the magnitude of the rate increase. Thus, the new policy expands the breadth of the federal rate filing process to include products with rate reductions, with rate

increases less than 10 percent, and those with static rates.

The proposed rule also requires that each rate filing include a much more extensive data submission than the current federal rate filings require. The expanded data submission requirements would be reported in a new standardized format developed by HHS.

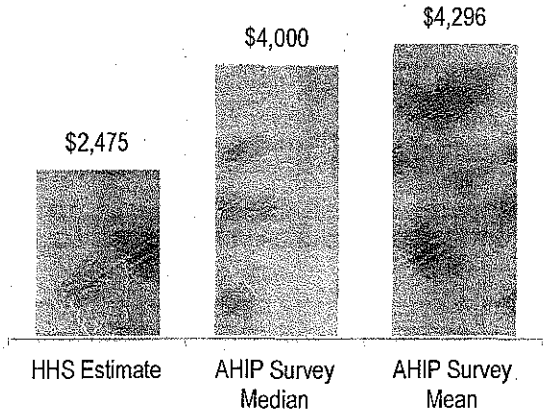
The proposed changes to the federal rate review rule were formally published in the Federal Register on November 26, 2012.[1] HHS estimates the new requirement that health plans file all rates with the federal government will increase the total number of filings and data submission episodes by about 6,450 per year at an average direct cost of $2,475 per submission.

AHIP surveyed health plans on the number of additional rate filings they expect, their estimated direct administrative costs per filing, and likely one-time systems costs of compliance with the proposed rule. Responding plans reported a wide variety of enrollment levels and geographic representations; combined small group and individual market enrollment among the responding plans ranged from approximately 1,000 to nearly 1 million (total covered lives). Responses were received from large multi-state plans, single-state plans, and local or regional plans.

Among responding plans, the median number of federal rate review filings under current regulations

[1] Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Proposed Rule, Federal Register 77:227, (26 November 2012) http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf. Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).

Figure 1. HHS and AHIP Member Survey Estimates on Direct Administrative Cost per Rate Review Submission



Source: AHIP Center for Policy and Research (2012).

was approximately 2 or 3 in 2012 (for coverage with premium increases of 10 percent or more). However, plans' expectations for future submissions under the proposed rule requiring filings for all products varied widely, ranging from a few (between 0 and 4) additional submissions per plan to dozens more (between 20 and 40).

Based on the survey responses, there was no obvious correlation between the size of a plan (number of covered lives) and the number of additional rate review submissions expected. Although the survey did not ask plans for a rationale for responses to this question, it is possible that some responding plans may not have been required to file rates to the federal government under the current regulation, because they have not had rate increases of 10 percent or more. Thus, there may be considerable uncertainty in their estimates of the number of new filings required.

The HHS cost estimate for the direct administrative costs of each additional submission ($2,475) is comprised of an estimated 11 hours of additional

actuarial work time at a rate of $225 per hour.[2] This estimate works out to an expected cost of $7,000 per issuer, based on an average of about 2.8 additional filings from 2,294 health plans.

The HHS estimates appear to be somewhat lower than the estimates of direct administrative costs made by the responding plans, which ranged from $2,000 to $10,000 per submission. Among responding plans, the median expected average cost for each additional filing was about $4,000 and the average was $4,296, approximately 70 percent higher than the HHS estimate (see Figure 1). Most plans stated that the additional costs stemmed mostly from actuarial staff and peer review, as well as information technology (IT) resources. Plans also indicated that another cost driver would be the time and resources invested in follow-up questions or requests from regulators regarding the new data submissions, although those costs were uncertain.

The proposed rule also notes that in order to meet the new rate filing and data submission guidelines, plans would have to implement one-time upgrades to their current IT systems to "provide the data required in the standardized data template."[3]

In the proposed rule, HHS asked for input regarding the cost of one-time systems cost of automating the new data submissions for each federal rate review. According to our survey, plans' estimates of these one-time systems costs varied widely. Some plans surveyed estimated costs between $500,000 and $1 million for IT changes, and the estimated time frame to implement the system changes ranged from 100 to 1,000 hours. One plan mentioned having to hire a new staff member at an annual cost of $100,000. Another plan indicated that it did not intend to re-automate its filing and data submission system.

Based on open-ended comments received, plans generally agreed that much IT involvement will be needed to comply with the new regulation. Plans also agreed that revising the current rate filing process would consume many resources and could be viewed as inefficient, compared with other uses of IT department time and resources, because it duplicates other processes already in place. One comment noted that plans' administrative costs are already being federally monitored under the minimum loss ratio (MLR) process, and that this new filing requirement would raise their administrative costs in contradiction to the MLR requirement's stated goal of reducing administrative costs. Another plan noted that the format for the new federal rate filing and data submission system (called HIOS, for Health Insurance Oversight System, which is administered by HHS) is not the same as the common system used by the states (called SERFF, for System for Electronic Rate and Form Filing, which is maintained by the National Association of Insurance Commissioners), causing a duplication of effort and additional costs.

Selected Open-Ended Comments. The following are direct quotes from the open-ended survey questions regarding the proposed rate review rule.

> *"This is a source of additional administrative costs and appears to be a serious contradiction to proposed goals of increasing efficiency as seen in the MLR requirements."*

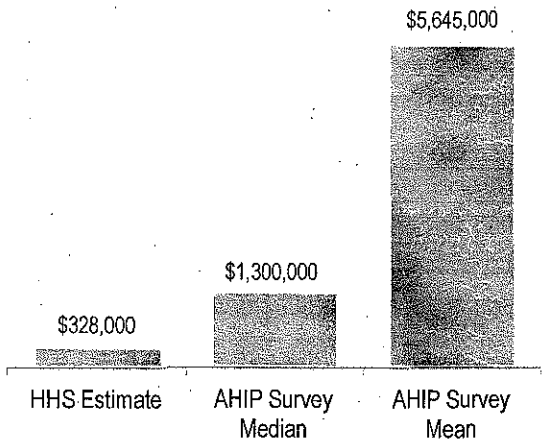
> *"[A]ctuarial resources may be tied up in filling out templates that may or may not be consistent with current rating practices."*

[2] Federal Register 77:22, (26 November 2012) p.70608
[3] Federal Register 77:22, (26 November 2012) p.70609

"Several of the data elements contained in the new rate template are not currently nor expected to be derived as a part of our normal rate review process. Therefore, additional data will need to be pulled and new reporting and data storage processes, as well as new cost allocation methods, will need to be developed and maintained with no business purpose other than to complete this template. This will add significantly to the actuarial time needed to complete a rate filing particularly in the first year."

"We have serious concerns about the increased burdens this will create on carriers while not adding any value for consumers, especially in states that have already been designated as effective rate review states. In addition, the duplicative reporting through a second system—HIOS instead of SERFF—requires carriers to report the same information in 2 different places. And given that the federal templates are completely different from state reporting requirements, it requires carriers to report the same information in a different format. The reporting should continue to be at the state level, through SERFF, and in order to meet the requirements of Section 2794 of the PHSA, the Secretary should obtain this information from the states through the reporting they get through SERFF."

Figure 2. HHS and AHIP Member Survey per Plan Estimates for Capital and Labor Costs of the Proposed Rule



Source: AHIP Center for Policy and Research (2012).

2. RISK ADJUSTMENT AND REINSURANCE SURVEY

The proposed risk adjustment and reinsurance data preparation rule was formally published in the Federal Register on December 7, 2012.[4] Under this rule, insurers would be required to comply with new regulations concerning the data elements required for risk adjustment and reinsurance.

According to the proposed rule, HHS estimates that the new requirements

> "...will affect 1,800 issuers, and will cost each issuer approximately $327,600 in total labor and capital costs (including the average cost of $15,000 for a data processing server) during the start-up year. This cost will be lower in future years when fixed costs decrease. This cost reflects an estimate of 3 full-time equivalent employees (5,460 hours per year) at an average hourly rate of $59.39 per hour. We anticipate that approximately 400 data processing servers will be established across the market in 2014, and these servers will process approximately 9

[4] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Federal Register 77:236, (7 December 2012) http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

billion claims and enrollment files. Therefore, we estimate an aggregate burden, including labor and capital costs, of $589,680,000 for all issuers as a result of these requirements."[5]

On a per-plan basis, responding companies estimated the labor and capital costs of the proposed rule would be significantly higher than the HHS estimate of $327,600. Cost estimates of the plans ranged from $391,500 to $25 million, with the median cost of about $1.3 million and the average cost being approximately $5.6 million (see Figure 2). Thus, it would follow that the overall compliance cost of this regulation would likely be far higher than the $589 million cited by HHS. (In this survey, costs appeared to be directly related to the size of the plan.) Plans estimated the hourly cost for full-time employees performing tasks related to data submission requirements would range from $60 to $100 per hour compared to the HHS estimate of $59.39 per hour. Plans also anticipated the need of hiring contract staff at a higher rate of $120.00 per hour. One plan estimated having to hire over 60 additional employees to fulfill these requirements.

Selected Open-Ended Comments: Plans responding to the risk adjustment and reinsurance data submission survey included several open-ended comments, often specifying their detailed IT costs. One company noted expenses in the following areas:

> *"Ongoing license fees for software to manage the system, job scheduler, and back up. Ongoing resources to review the files, work errors, and resubmit files. Possible development costs to change claims processing, premium billing, rating, and other up streams to meet HHS file submission requirements."*

[5] Federal Register 77:236, (7 December 2012) p.73191

DISCUSSION

Due to the short time frames between the publication of the two proposed rules and the deadline for comments, some of the results in this report should be considered preliminary. For example, we noted that several responding health plans indicated uncertainty about how many additional rate filings they would be required to submit to the federal government; other responses indicated a degree of uncertainty with regard to compliance with the broader data submission requirements that would accompany those filings.

Because of its very high cost, one key recommendation in AHIP's formal comments on these new regulations is that the minimum loss ratio (MLR) regulations be amended to allow the data collection costs associated with the risk adjustment and reinsurance system—which could amount to considerably more than the HHS estimate of $589 million—to be excluded from the definition of premium revenue. Since these costs are essentially mandated by regulation, they are not discretionary, and therefore should be considered to be more like a regulatory fee rather than the sort of administrative cost that would typically be subject to the MLR regulation.

A precedent for AHIP's recommended treatment of these costs would be treatment of other regulatory fees like the Patient-Centered Outcomes Research Institute (PCORI) fee, the federally-facilitated exchange user fee, the risk adjustment user fee, and state and federal taxes such as the Health Insurance Tax, which is a new federal premium tax imposed on certain types of health insurance coverage (small group, individual market, health insurance exchange,

Medicare and Medicaid managed care). These fees and taxes are not discretionary administrative costs for the purposes of the MLR calculations.

It is important to keep in mind that the all costs associated with these and other regulations are ultimately paid by consumers and employers in the form of higher premiums. Additional expenditures for regulatory compliance, on top of rising costs for medical benefits and other taxes and fees, will ultimately add to the cost of coverage for health care purchasers.

ACKNOWLEDGEMENTS

The survey results were compiled and analyzed by Cameron Lloyd, Research Analyst for AHIP's Center for Policy and Research.

For more information please contact Jeff Lemieux, Senior Vice President for AHIP's Center for Policy and Research, at 202.778.3200 or visit www.ahip.org/ahipresearch.

America's Health
Insurance Plans

January 23, 2013

Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Office of Information and Regulatory Affairs
Office of Management and Budget,
Attention: CMS Desk Officer

CMS–9972–P
PRA CMS-10379

Submitted to: *OIRA_submission@omb.eop.gov*

Re: Information Collection Request (ICR) on Rate Increase Disclosure and Review (PRA CMS-10379) - Related to CMS–9972–P - AHIP Comments

Dear Mr. Cohen,

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Information Collection Request (ICR) on Rate Increase Disclosure and Review. This was in the form of PRA CMS-10379 ICR Notice ("the ICR Notice") that was published in the Proposed Rule on Health Insurance Market Rules and Rate Review ("the Proposed Rule") [*Federal Register* 77:227 (26 November 2012)].

Effective January 1, 2014, the Affordable Care Act (ACA) makes numerous and far-reaching changes to the Nation's health care system. As these changes take effect, AHIP and its member health plans are focused on providing recommendations to the proposed regulations (and the processes for implementing them) that address affordability issues, as well as areas that could mitigate the potential disruption for the millions of individuals, families, and employers that have coverage today.

The statutory basis for the ICR Notice is Section 2794(b)(2)(A) of the PHS Act, which provides that for plan years beginning in 2014, "the Secretary, in conjunction with the States, and consistent with the provisions of subsection (a)(2)[1] shall monitor premium increases of health

[1] Subsection (a)(2) refers to the rate review program in effect for plan years beginning 2010.

insurance coverage offered through an Exchange and outside of an Exchange." In addition, the proposal seeks data to allow federal regulators, as 2014 changes go into effect, to "appropriately and adequately monitor issuers' products and plans with the market, minimizing any potential market disruptions." As we explain below, adequate data is already available to CMS to allow for monitoring of rate increases under section 2794(b)(2)(A) and there has been insufficient explanation of the need for a new data collection for other purposes.

The Proposed Rule and ICR Notice propose several significant revisions to the existing federal rate review requirements. Specifically, the proposal creates a new governmental database by collecting *all* health insurance rate data in the individual and small group markets offered in the states in a "unified data template" that would have to be reported with *any* rate filing. According to the ICR Notice, this format will "provide state and federal regulators the information they need in one place" for a variety of functions, including monitoring of rates, the single risk pool, financial management review for market-wide reinsurance risk adjustment programs, and Exchange-related operational functions such as QHP certification and premium tax credit and cost sharing reduction verification.[2]

We noted our concerns regarding the ICR Notice in AHIP's comments on the Proposed Regulation[3], and this letter provides the basis for such concerns. In developing our comments, we solicited hundreds of health plan policy and operations leaders across the nation to review the ICR Notice and develop specific recommendations. Based on this feedback and the experience of health plans in the states, we have concluded that the Proposed Regulation and ICR Notice conflate the rate submission and review process under section 2794(b)(2)(A) with other largely unexplained requests for data that CMS may seek for other purposes. This has resulted in a Unified Rate Review Template for submission to CMS that is not tailored to its stated uses, is inconsistent with OMB Guidance, is not required under the rate review monitoring statute, is not tied to other enumerated statutory directives, and raises competitive harm concerns.

Our comments submitted today include four key recommendations and accompanying explanations to support a simplified approach focused on the rate increase monitoring requirements established under section 2794(b)(2)(A). These four key recommendations are as follows:

- Narrow this data collection to focus solely on the section 2794 requirements and not other uses for which collecting data has not yet been justified.
- Limit CMS' monitoring function under section 2794(b)(2)(A) for rates that are already in effect as required by the plain language of the statute.
- Satisfy CMS' monitoring obligations through review of the significant amount of data already provided through existing sources.

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[2] 77 Fed. Reg. 70584, 70602 (Nov. 26, 2012).

[3] AHIP's Comment Letter on Health Insurance Market Rules and Rate Review can be found at http://www.ahip.org/CommHIMktRulesRateReview12212012

- Further minimize the risk of competitive harm with a more targeted data collection approach.

This letter also offers specific feedback on the proposed new federal rate review standards and the Appendix details comments on the Unified Rate Review Template itself.

I. AHIP's Four Key Recommendations

We appreciate that the Preamble to the Proposed Rule welcomes "comments on the need for and impact of the extension of the reporting requirement below the review threshold and whether alternative approaches to monitoring and oversight should be considered." While this process is "intended to create greater uniformity for effective rate review information, creating efficiencies and also providing issuers with a standardized, electronic format for submitting," it appears to do the opposite by increasing the burden on health insurers and failing to identify what specific information is needed to fulfill the statutory directives cited as the basis for the ICR Notice. What follows are suggestions for alleviating some of the unintended consequences that will stem from the current proposal while also offering alternative approaches for consideration.

AHIP's four key recommendations are:

1. ***Narrow this Data Collection to Comply with Section 2794 Requirements and not Other Uses for Which Collecting Data Has Not Yet Been Justified***

   Description of Issue:

   The ICR Notice introduces new functions, outside of Section 2794, to justify the new data collection under the Unified Rate Review Template. Specifically, the ICR Notice describes that this format will "ensure the effective review of rates (including review of the single risk pool and other rating requirements), the adequate monitoring of rate increases and provide necessary information to support financial management review for market-wide reinsurance and risk adjustment programs, as well as SCSR and APTC validations, and will assist in outlier testing for QHIP certification purposes."

   It appears that the Unified Rate Review Template has been developed to cast a very wide net and collect information for multiple purposes that are unrelated to the ACA rate review requirements. However, neither the Proposed Regulation nor the ICR Notice explain which data elements are needed for which purpose(s). Instead the ICR Notice appears to enlarge the current rate review collection process to apply to all rates so as to sweep in information about all rates in the individual and small group markets. This would facilitate the creation of a database of information that might potentially prove useful to CMS for purposes outside of Section 2794.

Conflict with OMB's Stated Objectives

The approach proposed in the ICR Notice is contrary to the Administration's stated paperwork reduction and regulatory relief goals. Recent OMB guidance, dated June 22, 2012, focuses on reducing reporting and paperwork burdens.[4] This guidance directs agencies to take meaningful steps to reduce paperwork and reporting burdens, including unnecessary and redundant collections, use of sampling where appropriate, and maximizing the re-use of data already collected. Previous OMB guidance, dated March 20, 2012, requires agencies, to the extent permitted by law, to take active steps to take account of the cumulative effects of new and existing rules and to identify opportunities to harmonize and streamline multiple rules, including the engagement with state agencies "to identify opportunities for harmonizing regulatory requirements, reducing administrative costs, avoiding unnecessary or inconsistent requirements, and otherwise improving regulatory outcomes." [5]

Unnecessary Administrative Costs When Other Compliance Costs Have Soared

Further, the expansive scope of the Unified Rate Review Template will result in the creation of a burdensome and expensive data collection process. The Preamble of the Proposed Rule estimates a per rate filing cost of $2,475[6] and also seeks input on the extent of the costs of systems adjustments to provide the data required in the standardized data template. At the outset, we note that this estimate varies widely from health plan estimates. Just recently AHIP conducted a survey of member health plans about expected costs associated with the expanded rate review process and the proposed filing standards under the ICR Notice.[7] The results of our survey show an average per filing cost of $4,296 - about 73 percent higher than the CMS estimate. In addition, survey respondents estimated that implementing the one-time systems changes for each health plan – not including any ongoing costs – are expected to cost between $500,000 and $1 million.[8] These costs are significantly higher than those estimated by CMS and demonstrate realistic costs of such broad data collection efforts.

Recommendation:

To properly limit the scope of data collection and minimize burden, CMS should narrow the scope of this collection to comply with its obligations under Section 2794. A separate, targeted data collection process, with a more complete justification of the need

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[4] http://www.whitehouse.gov/sites/default/files/omb/inforeg/memos/reducing-reporting-and-paperwork-burdens.pdf
[5] http://www.whitehouse.gov/sites/default/files/omb/assets/inforeg/cumulative-effects-guidance.pdf
[6] This estimate is based on 11 hours of additional actuarial work time at a rate of $225 per hour. See Supporting Statement for Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).
[7] Paperwork Reduction Act Submission: Rate Review Information Collection, 45 CFR Part 154, CMS Form Number: 10379 (November 20, 2012).
[8] AHIP Center for Policy and Research. (2012, December). Health Plans' Estimated Costs of Compliance with Expanded Federal Rate Review and with Data Collection for Risk Adjustment and Reinsurance. Available at http://www.ahip.org/HPCostsCompliance2012/

for the individual elements requested, should be pursued for the other multiple purposes set out in the ICR Notice that are unrelated to rate review, if needed.

Any new data collection (if needed) should limit data collection frequency and otherwise minimize the paperwork burden in accordance with OMB guidance on data collection. CMS should develop a template of the amount of minimum necessary data so as to minimize burden and expense.

2. ***Limit CMS' Monitoring Function Under Section 2794(B)(2)(A) To Increases To Rates That Are Already In Effect***

Description of Issue:

The plain language of Section 2794 limits the authority to "monitoring" of rate increases inside and outside the Exchanges *in conjunction with states in a manner consistent with the existing program for reviewing unreasonable increases.* But, the Proposed Rule and ICR Notice go far beyond the statutory language to overreach in areas that Congress did not intend. For example:

- The proposal would require submission of data for *all* rates in the individual and small group markets for non-grandfathered coverage prior to implementation. Thus, the proposal fails to distinguish between the "monitoring" contemplated by Section 2794(b)(2)(A) and the existing rate review process and justification process (for rate increases of over 10% or other state defined percentage) which occurs "prior to the implementation of the increase" under Section 2794(a)(2). These are different provisions with different purposes. The "monitoring" provision for "rate increases" is properly read to apply to increases that are already in effect – not those that have not yet been implemented as required under Section 2794(a)(2).

- The clear statutory language applies only to rate increases and not "all rates", so static rates and rate decreases are intended to be exempt from this monitoring provision. Also, rates for newly filed products in 2014 cannot be construed to be "increases" as there is no baseline to compare them against. As a result, the type of marketwide data collection contemplated by the Proposed Regulation and the ICR Notice is clearly not anticipated by the language in ACA that requires "monitoring" of rate increases.

Recommendation:

Consistent with the statutory language, the regulation implementing the agency's new monitoring function under Section 2794(b)(2)(A) should be limited to rate increases that are in effect for coverage offered both inside and outside the Exchange.

3. ***Satisfy CMS' Monitoring Obligations Through Review of the Significant Amount of Data Already Provided Through Existing Sources and Not Vitiate State Authority in this Area***

Description of Issue:

The statutory language does not direct the Secretary to require independent submissions by issuers relating to rate increases. Such information is already being collected and provided by the states to CMS today.

As a result, sufficient information already exists for CMS to exercise its monitoring functions. Specifically, the quarterly reports shared between the states and HHS via the NAIC System for Electronic Rate and Form Filings (SERFF) provide CMS with ample information for monitoring rates in the markets both inside and outside exchanges. This quarterly data sharing of rates drawn from the states (pursuant to Memoranda of Understanding between the states and SERFF), is one of the primary ways in which, as the NAIC suggests, states can provide information about insurance rates without the addition of new or duplicative administrative burdens on insurers.

In addition, there is a significant amount of plan-specific information currently being provided to the Department through the Health Information Oversight System (HIOS) web portal on products and rates in the individual and small group markets. These data are being provided through the Plan Finder, which will continue to provide a significant stream of data relating to new premiums, as well as premiums as they change over the years.

Another reason not to interpret the monitoring obligation as being an independent CMS data collection is that the current proposal appears to intrude on state authority over rates in the marketplace. It is clear that, under ACA and its implementing regulations to date, state regulators, not HHS, have primary responsibility for exercising authority over rates in the state marketplace. Further, HHS has previously taken the view that that it will defer to the authority of states in rate review in states deemed to have "effective" rate review programs. Now, HHS appears to reverse this policy by second guessing the rate information collection requirements in both states with effective rate review programs and those without. Indeed, the proposed standardized data capture and collection approach in the Proposed Rule and ICR Notice disrupts the States' ability to capture and collect information to review rates and will result in additional burden for States and issuers.

This view is shared by the National Association of Insurance Commissioners (NAIC). The NAIC's comment letter on the Proposed Rule notes that some state departments of insurance will continue to use their own data collection templates and formats in order to maintain effective rate review. Other states have noted that they do not find the proposed CMS template adequate or useful for rate review and therefore are developing (or planning to develop) new templates. As a result, according to the NAIC, "the proposed rule would require issuers to file rates using different templates and formats" and create "an unfair and unnecessary burden, especially to small issuers and new entrants."

Further, the NAIC asserts that "[i]n states deemed to have an effective rate review program, filing only with the state will provide the necessary degree of regulatory oversight that is the

objective of this section." The NAIC has proposed that in states with effective rate review programs, if CMS needs further information to monitor rate increase patterns, it should seek it from the states and not directly from the issuers.

Recommendation:

CMS should satisfy Section 2794(b)(2)(A) through the review of data from existing sources, such as the quarterly reports submitted by the states to HHS via SERFF and the data submitted by issuers through HIOS.

4. ***Further Minimize Risk of Competitive Harm By Using a More Targeted Data Collection Approach***

Description of Issue:

The Proposed Rule and ICR Notice create a significant risk of harm to competition in the health insurance marketplace, without apparent consideration of whether the stated goals could be achieved without inflicting such harm. It is well-established that the dissemination of certain types of information, normally treated as confidential, can harm competition, and ultimately consumers, in markets. The potential for such harm has been widely recognized and explained, most notably perhaps by the agencies responsible for enforcing the federal antitrust laws, the United States Department of Justice (Department of Justice) and the Federal Trade Commission (FTC).[9] Unfortunately, the Proposed Rule and ICR Notice appear to risk exactly the types of harm that these agencies have warned against.

As a general matter, information about prices (in this case, premiums prior to implementation) is the most sensitive type of information under antitrust law and competition analysis. The risks from the dissemination of such information, when previously kept confidential, increase when the information becomes more granular and timely. Thus, the federal antitrust agencies have warned about the likely harm from releasing previously non-public pricing terms contained in specific contracts and have offered guidance for providers conducting surveys that guard against the identification of the prices charged by specific providers and against the dissemination of current, or worse, future pricing information.[10]

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[9] *See, e.g.*, FTC, *Letter to New Jersey General Assemblywoman Nellie Pou* (Apr. 17, 2007)("FTC Letter to Nellie Pou"), *available at* http://www.ftc.gov/be/V060019.pdf (negative effects of release of non-public pricing information related to pharmaceutical contracts).

[10] *See, e.g.*, *See, e.g.*, FTC Letter to Nellie Pou; FTC, *Letter to Virginia House of Delegates Member Terry G. Kilgore* (Oct. 2, 2006), *available at* http://www.ftc.gov/be/V060018.pdf ; FTC, *Letter to California Assembly Member Greg Aghazarian* (Sept. 7, 2004), *available at* http://www.ftc.gov/be/V040027.pdf; and U.S. Dep't of Justice & FTC, Statements of Antitrust Enforcement Policy in Health Care, Statement 6 (1996), *available at* http://www.ftc.gov/reports/hlth3s.pdf.

Disclosure of Competitively Sensitive Information

The information collection included in the Proposed Rule and ICR Notice involves a high volume of highly-sensitive information. By requiring insurers to provide detailed information about *every* rate for each of their new products in the individual and small group markets each time a new rate is filed whether higher, lower, or static as well as any rates filed for new products, the Proposed Rule and ICR Notice potentially creates real time, granular information about current and future rates for each of an insurer's product offerings. Antitrust policy and economic analysis suggests that putting such information into the marketplace is likely to distort competition and harm consumers in myriad ways, in insurance, provider, and related markets.

There are several solutions to this problem. First, the information collected should be limited to that necessary to accomplish the appropriate and desired objectives. A great deal of such information is already collected and therefore could be obtained without substantially increasing the risk of competitive harm. Second, where the objectives can be accomplished using more or less sensitive information (e.g., information about a single product rather than an entire portfolio or information about approved rates, rather than prospective rates), the less sensitive information should be used; here such information is already available through the quarterly reports shared between the states and HHS via the NAIC System for Electronic Rate and Form Filings (SERFF) . Third, confidential information should be afforded the full protections of the Freedom of Information Act and other laws that can prevent such information from becoming public. Unfortunately, given the myriad categories of information, entities potentially handling such information, and rules governing the release of such information, such laws are not guarantees against competitive harm (which is why the collections should be limited as indicated above), but their protections nonetheless should be applied. Finally, CMS should consult with the FTC and the Department of Justice to draw upon their expertise with respect to the potential competitive harms from the dissemination of the types of real time, granular, sensitive information contemplated here, as well as the best approaches for avoiding, or at least mitigating the risk of such harms.

Recommendation: To avoid or mitigate the risk of competitive harm from the contemplated collection and potential dissemination of large amounts of competitively sensitive information, CMS should: (1) reduce the collection of such competitively sensitive information to that information necessary and appropriate to achieve the relevant statutory directives; (2) use data that is already collected and is not competitively sensitive; (3) provide the greatest possible amount of protection to any competitively sensitive information produced to ensure that it does not cause competitive harm through its publication; and (4) consult with the FTC and the Department of Justice on ways to further mitigate the risk of competitive harm related to the contemplated collection of data.

II. Recommendations and Comments on the Federal Rate Review Standards

1. *Defer to States with Effective Rate Review Programs*

Description of Issue:

The current Rate Review regulations[11] correctly defer to the authority of the states with effective rate review programs to monitor and regulate rates and their markets. The proposed revisions to the effective rate review regulations provide for states' continued role in the rate review process; however, it also creates duplicative filing requirements and potentially inconsistent data submission requirements across all states (including those with effective rate review programs).

We urge you to adopt an approach consistent with your previously stated objectives that recognizes state authority in rate oversight and that leverages state regulatory expertise and knowledge of their markets and consumer needs, while affording states flexibility to demonstrate an effective rate review program. In our comment letter[12] on the Proposed Rule we recommend that the language of the rule be revised to reflect that states with effective rate review programs will receive rates reported, and we recommend the elimination of the dual reporting requirement.

This approach would appropriately continue to defer to states when they have effective rate review program authority, and only in those limited circumstances when they do not, for HHS to receive that information. It would also avoid duplication of effort and minimize any additional unnecessary administrative costs. As noted above, health plans will incur costs for each additional rate filing far in excess of the cost estimated by CMS, as well one-time and ongoing systems cost to comply with the expanded requirements for reporting all rates (whether higher, lower, or static) to CMS using the Unified Rate Review Template, as envisioned in the ICR Notice.

Recommendation: As detailed earlier in our letter, we are concerned with the proposed expansion in the ICR Notice that extends these burdensome and unnecessary reporting requirements to *all* rates –which include not just increases but would also include rate decreases and static rates. These burdensome requirements include the unnecessary request to report *all* other rates in that market by that issuer in a worksheet within *each* individual and small group rate filing. This creates an excessively onerous reporting request which, as previously noted, is not justified.

In addition, CMS should provide states with flexibility in demonstrating an effective rate review program by: accepting state regulators' attestations that they are

[11] 45 CFR Part 154 Federal Register Vol. 76, No.99 (May 23, 2011)
[12] AHIP's Comment Letter on Health Insurance Market Rules and Rate Review can be found at http://www.ahip.org/CommHIMktRulesRateReview12212012

reviewing the new criteria related to review of the 2014 individual and small group market adjusted community standards (found in §154.301 (a)(3) (iii),(iv), (4) (iii - v), and (xii - xvi); and by allowing states that need to amend their statutes, regulations or filing guidance to meet the new requirements a sufficient period of time to do so.

2. ***Utilize the Revised Template Only for Rate Increases Subject to Federal Review***

Description of Issue:

The Proposed Rule and ICR Notice appear to extend the use of the Unified Rate Review Template to include rate filings in those states that have been deemed to have an effective rate review program.

The existing Rate Filing Justification Form for rate increases subject to review under the Federal Rate Review Rule (FRRR) should continue to be utilized – rather than adopting the new proposed Unified Rate Review Template. To support that approach, the proposed revisions to the FRRR in the Proposed Rule should be revised, as follows.

Recommendation:

The existing Rate Filing Justification Form (with appropriate updates) should continue to be used for those rate increases subject to federal review – rather than adopting the new proposed Unified Rate Review Template. It should be required only for rate increases subject to review under 45 CFR Part 154 (i.e., for rates over 10% or such other threshold approved for a state). We support the continued use of the name "Rate Filing Justification Form" to minimize confusion and clarify that it is not intended for broader purposes.

To support this approach, we offer the following amendments to §154.215 and §154.220 for consideration:

> ***§154.215 Submissions of disclosure to CMS for increases subject to review - a rate filing justification.***
>
> *(a) ~~If any product is subject to~~ ~~a~~ For each rate increase subject to review, a health insurance issuer must submit a Rate Filing Justification ~~for all products on a form and~~ in a manner prescribed by the Secretary.*
>
> ....
>
> ***§ 154.220 Timing of providing the rate filing justification.***
> *A health insurance issuer must submit a Rate Filing Justification for ~~all~~ rate increases subject to review that are filed in a State on*

or after April 1, 2013, or effective on or after January 1, 2014 in a State that does not require the rate increase to be filed, as follows:
(a) If a State requires that a proposed rate increase be filed with the State prior to the implementation of the rate, the health insurance issuer must submit to CMS and the applicable State the Rate Filing Justification on the date on which the health insurance issuer submits the proposed rate increase to the State.
(b) For all other States, the health insurance issuer must submit to CMS and the State the Rate Filing Justification prior to the implementation of the rate increase.

3. ***Eliminate Worksheet III of the Unified Rate Review Template***

Description of Issue:

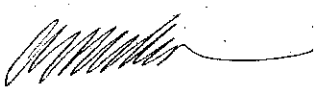
The Supporting Statement for the ICR Notice indicates that the proposed revision to the Rate Filing Justification Form "includes data supporting the potential rate increase(s), and the impacts to all other products in the single risk pool for that health insurance issuer in that market for that state". The referenced data related to all other products in the single risk pool for that health insurance issuer in that state is the new Worksheet III of the Unified Rate Review Template - essentially a data reporting template, *not* necessary for the review of that rate filing. However, today the five states with community rating rely on insurers' qualified actuaries attestations regarding their use of a single risk pool. As indicated above, the unified data template includes more information than is necessary for a single rate filing, and would create enormous administrative challenges and costs to plans, magnifying the time and costs of each rate filing submitted.

Recommendation:

Worksheet III of the Unified Rate Review Template should be eliminated, as it is unnecessary for meeting the stated objective. Instead, a certified actuarial attestation of use of a single risk pool should be accepted in place of Worksheet III. Where filings include the total pool experience, it should be accepted as the total risk pool, and there should not be any requirement to also include an actuarial report of all other policies' experience with each rate filing.

We appreciate the opportunity to provide recommendations from health plan operations and policy leaders who are preparing for 2014 by designing benefits, developing products, and pricing offerings, and appreciate your serious consideration of these comments.

Sincerely,



Colleen M. (Candy) Gallaher

cc: Teresa Miller, Director, CCIIO Oversight Group
Douglas Pennington, CCIIO Oversight Group, Director of Rate Review

Attachment

Appendix
Comments on the Rate Filing Justification Form
(The Notice's Proposed "Unified Rate Review Data Template")

We recommend "Rate Filing Justification Form" replace the title "Unified Rate Review Data Template." Many of the changes made to the Rate Filing Justification Form are helpful improvements that will assist both regulatory reviewers and insurers. We appreciate those improvements. We also note that the effort to clearly identify the columns and data required will assist regulatory reviewers and filers. Clear definitions will be needed in the related "Draft Rate Review Data Template Instructions Outline" ("the Instructions") to assure consistency. Those will make the form easier to complete and will reduce unintentional data input errors. We recommend that after the PRA ICR Notice comment period concludes and revisions are final, further clarification should be added to the Instructions addressing questions or requests for clarification that are received through the PRA ICR Notice process.

Worksheet 1 - Market Experience

- Generally - Worksheet 1 is an improved version.

- Worksheet 1 - "Market Experience": There is no allowance for policy reserves in the historical or projected periods. Since the intent of the exhibit is to build up to the ultimate premium level, there should be an allowance for policy reserves since those are common in the individual market.

- In Worksheet 1 - "Market Experience", Section I: This displays "Premiums (net of MLR Rebate) in Experience Period". However, in the MLR calculation, rebates are added to the numerator of the calculation as opposed to subtracting from the denominator. Therefore, this should be the actual premiums and there should be an allowance for rebates separately.

- Worksheet 1 Section I - Row 20 in Cell H20: We note that Allowed Claims as a percentage of premium is not a very useful measure. We recommend it show the historical paid to allowed ratio, which will allow easier comparison to the projected paid to allowed ratio which is shown in Row 37 in Cell V37.

- Worksheet 1 Section I – Row 21: We recommend the addition of an Index rate for the experience period. The draft outline of the Instructions indicates that the experience period is determined by the issuer, but must be a 12 month period. Thus, the experience period could include parts of more than one calendar year. Therefore, this field could either specify that it is the <u>average</u> index rate of the experience period, or it could be the <u>most current index rate</u>, which may be useful to calculate the year over year increase.

  The "% increase over the experience period" and the "% increased annualized" do not provide the information that most people reviewing this form would want to know, which would be "what is the percentage increase over the previous year's index rate?" Due to the timing of when filings need to be submitted, the experience period will be more than a year

prior to the projected period. The addition of the current index rate to the form would allow for the increase from the previous year to be calculated.

- Key sections of the template that require claims data will not provide for the comparability of results, and thus undermine one of the key purposes of the form for regulatory review of rates. In particular, two core parts of the current template are unnecessary to achieve the goal of making rates more transparent. One is in Worksheet 1, and one in Worksheet 2:

  Worksheet 1, rows 24-34, columns I-Q, could be removed without affecting the intended purpose of the form. We recommend these be removed for integrated delivery systems, This is particularly challenging for integrated care models, which do not always collect episodes as "claims", but also important for consideration as ACOs and other innovative models within insurance plans evolve. Such breakout of "claims" may provide even more challenging in using the proposed format. We thus recommend the elimination of those columns, and instead recommend dependence on the details in the actuarial memorandum filed with each rate filing, where the inclusion of a description of the information in this section would allow the different business models to describe their trending and cost projections and other information in a way that is consistent with their systems.

  Alternatively, a separate format should be developed to address this issue in a more uniform fashion moving forward where those elements would not be broken down by utilization and cost components.

Worksheet 2 - Plan Product Information

New Elements Recommended: The threshold rate increase percentage used to determine if a rate change is subject to review under the Federal Rate Review Rule (FRRR) standard is not clearly identified on this template. This is important for regulators reviewing the form. The FRRR threshold test occurs at the ***product*** level. However, Worksheet 2 shows a cumulative 12 - month rate change, at a ***plan*** level.

  - We recommend there should be a field on the form to indicate whether the rate changes are subject to FRRR threshold for review.

  - There should also be a field to indicate whether these are new product rates - which would ***not*** be subject to the FRRR.

- Worksheet 2 - Section I Row 16: The Instructions related to this section will need to provide a clear definition of a "Benefit AV Value". That will be particularly important if you are considering adding any addition requirements, such as "AV Pricing Value". For example, questions we received from insurers indicate an uncertainty on whether that would be the insurer's benefit plan factor used to derive a premium rate, using the insurers own benefit "slope." As noted in the general comments, clarifications in the Instructions will be critical in assuring that information is reported in a uniform way.

- Key sections of the template that require claims data will not provide for the comparability of any results, and may thus undermine one of the key purposes of the form for regulatory review of rates. One is in Worksheet 1 as noted previously. The issue also occurs also in Worksheet 2:

  Worksheet 2, section II in rows29-34 could be removed without affecting the intended purpose of the form, with the details in the actuarial memorandum provided the necessary descriptions and details. As noted, in our comments on Worksheet 1, we thus recommend these be removed, or alternatively, a separate format developed to address the issue when integrated delivery systems are submitting the rate filing justifications.

- Worksheet 2 Section III - Rows 52-54 related to the breakout of premium information related to covered benefits by Essential Health Benefits (EHBs): State mandates that are other than the EHB and other benefits outside the EHB, and the claims information requested on those same dimensions Rows 56-58 would appear to be needed only for individual market QHPs in Exchanges, where such information must be broken out.

  - We recommend that the instructions indicate that the rates only require this breakout is only needed for *those* rates, and not all others. The instructions are silent with regard to the rationale for this reporting.

  - We also note that information should be waived in the first 2 years of individual QHP rate filings, since the prior years experience would not have been calculated at those levels in the 2012 or 2013 experience years.

Worksheet 3 - Financial Information

Recommendation: This worksheet should be eliminated as unwarranted and unnecessarily burdensome. Data in this worksheet that is requested for the individual market rates only can be included in the actuarial memoranda submitted with those individual market rate filings.