Why Risk Based Capital Should not be an Element of Rate Review

RBC is a financial measure used by regulators solely to determine if an issuer is in a weak or deteriorating condition. As the NAIC noted in their comments, "insurance rates should be based upon the expected needs to cover the anticipated risk assumed."

There are a number of uncertainties going into 2014 that make it critical to have sufficient reserves/capital. Pricing will be extremely challenging in 2014. For example:

- Plans must file premiums 4 to 6 months in advance of the open enrollment using claims data to project anticipated claims to a period that ends over a year and a half in the future.
- Plans do not know who will select an insurer's coverage and which metallic level they will choose. The cost of covering these individuals are unknown, especially the uninsured where no data exists on their historic cost.
- The movement of high risk pool individuals into the exchange will increase the average claims costs.
- It is unknown how effective risk adjustment will be and plans will not know whether they are a payer or a receiver for risk adjustment transfers and whether these will adequately cover the risk of high cost individuals.
- Limits on age rating can negatively impact results if a plan attracts a disproportionate amount of older individuals.
- The impact of adverse selection on the SHOP exchange if employee choice of plan is allowed.
- Regulatory unknowns further increase the uncertainty.
    - What is the definition of essential health benefits and how does that impact pricing?
    - Will rates be approved in a timely manner and will the approved rates be adequate?
    - What are the rules for risk adjustment, reinsurance and risk corridor programs?
    - What are the rules for actuarial?

In addition, millions of new individual customers will be insured and the level of benefits offered in the exchange will be richer than offered today raising the RBC formulas requirements. And if there is significant movement from self insured employer based coverage that will further raises the level of capital required for RBC.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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February 22, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services

Attention: OCIIO-9999-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Re: Comments on Rate Increase Disclosure and Review Proposed Rule

Dear Secretary Sebelius:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Department of Health and Human Services ("HHS") regarding the Notice of Proposed Rule Making ("NPRM") for "Rate Increase Disclosure and Review" issued in the Federal Register on December 23, 2010. 75 Fed. Reg. 81004.

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to nearly 98 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

While the NPRM seeks to provide deference to states in determining "unreasonable" health insurance rate increases, the proposed rule takes unprecedented steps to involve the federal government into what has long been a state process. Under the NPRM, the federal government:

- Defines the rate review process states must follow in order to be deemed "effective" and avoid the federal government becoming the default regulator;
- Adopts a one-size-fits-all threshold that triggers review of rate increases at the state and federal levels;
- Requires reporting to the federal government of all premiums exceeding the federal threshold -- even in states with "effective" review programs; and

- Establishes federal rate review for those states the federal government determines do not have an "effective" process.

Under the statute, HHS is to work "in conjunction" with the states – HHS is not required to supplant state rate review regulations – as the preamble to the NPRM recognizes. 75 Fed. Reg. at 81005. However, it is difficult to reconcile that statement with the regulation's mandates regarding the processes by which states must review rates. States have experience and expertise with issuers in their state; they understand the challenges in their insurance markets; they understand their unique regulatory environments; they have direct contact with the issuers, providers and consumers in their states and are best positioned to determine the processes for rate review in their state.

Furthermore, the NPRM does not take into account all the other major requirements in the ACA that regulate health insurance premiums. Most notably, the new federal medical loss ratio (MLR) rule sets strict standards for how premium dollars are spent so that consumers are assured that no more than 15 to 20 percent of premiums are allocated to administrative expenses, contributions to reserves and profits. To our knowledge, no other industry has such a federal standard. In addition, the new insurance rules requiring guarantee issue – including an exchange which facilitates shopping, and an annual open enrollment period - create a market place where a consumer can easily move if they feel their current issuer does not deliver the best value.

Finally, in 2014 the 10 percent threshold set out in the NPRM is likely to trigger reporting and review of most, if not all, premium increases as numerous new requirements go into place. This includes the new essential health benefits, the health insurance excise tax, new rating rules and the guarantee issue requirements, all of which will impact rates.

We offer the following major recommendations for your consideration.

1. Change the effective date for the NPRM to be July 1, 2012 so states have time to understand the requirements in the regulation once it is issued, implement the necessary regulatory and legislative changes to have an effective rate review process, and avoid the federal government becoming the default regulator;

2. Revise the NPRM so that states with an effective review process decide which rates are unreasonable and only report those unreasonable rates to HHS;

3. Amend the criteria for states to be deemed to have an effective rate review processes to provide flexibility for states to determine what is best for their residents;

4. Modify the federal one-size-fits-all threshold for rate review to reflect the interaction with the MLR provision, the current rate increases occurring in the marketplace and to reduce the excessive administrative burdens on regulators and issuers in states without an effective rate review program;

5. Ensure the form for reporting rate increases under the NPRM is meaningful to consumers and reflects the current reporting practices in the majority of the states; and

6. Maintain the decision in the NPRM to exempt the large group market from rate review.

BCBSA's detailed comments on these issues are set forth below.

I. Change the effective date for the NPRM to be July 1, 2012 so states have time to understand the requirements in the regulation once it is issued, implement the necessary regulatory and legislative changes to have an effective rate review process, and avoid the federal government becoming the default regulator.

Proposed Rule: The NPRM goes into effect for rate increases filed in a state on or after July 1, 2011, or effective on or after July 1, 2011 in a state that does not require rate increases to be filed. 45 C.F.R. §§154.200(a)(1) & 154.220.

Issue: As noted earlier, the vast majority of states do not require the level of detail outlined in the NPRM for an "effective rate review process." Once the NPRM is finalized, states will need adequate time to modify their processes. This includes changing any regulations and/or issuing insurance department bulletins with the new filing requirements and properly training regulatory personnel. Following that, issuers will need time to implement the new requirements in their rate filing processes.

This assumes that states can modify the new requirements without changes in state law. If states do need to modify their laws, many states will not be able to make changes until 2012 due to legislatures being out of session prior to issuance of the final regulation. States should be given a reasonable opportunity to meet HHS's standards.

We believe that only a few, if any states will be considered "effective" in both the individual and small group market on July 1, 2011. As a result, in a few short months, HHS will be required to review countless individual and small group product rate increases from across the entire country. Not only does this put an untenable burden on HHS, but it unfairly and unnecessarily undercuts states' regulatory authority and is at complete odds with HHS's announced intention to defer to state authority in this area.

Recommendation: Make the rate review program effective for rates filed on or after July 1, 2012. This will give states time to make the necessary changes to their rate filing processes and provide adequate notice to issuers.

In states that cannot implement the new requirements without changes in law, HHS should consider deeming existing filing requirements as "effective" states for the first two years after the regulation becomes effective. This will allow states time to make the necessary changes in law so that their insurance department can be considered to have an effective rate review process.

II. Revise the NPRM so that states with an effective review process decide which rates are unreasonable and only report those unreasonable rates to HHS.

Proposed Rule: Under the proposed regulation, a state with an effective review program will review rate increases of 10 percent or greater. The NPRM requires issuers to submit a preliminary justification for all proposed rate increases subject to review to an applicable state and to HHS. The format of the justification will be provided in forthcoming guidance. 45 C.F.R. §§154.200, 154.215, and 154.220.

Issue: While the NPRM generally defers to states on determination of whether a rate increase is unreasonable, BCBSA is concerned that the NPRM requires substantial federal involvement even in states that have effective review processes. By requiring a federal threshold that could make the majority of rate increases in the individual market subject to additional review, the NPRM adopts an approach that is inconsistent with the deference granted to states elsewhere in the ACA, ignores the local market conditions that drive rate increases, and will place an unnecessary and costly burden on issuers, states and the federal government.

State insurance departments have unparalleled experience in regulating health insurance within their jurisdictions and understand the unique concerns of their residents. According to HHS, 43 states currently have rate review processes in either the individual or small group markets, or both. 75 Fed. Reg. at 81011, 81012. In addition, the ACA provided $250 million to support states' efforts to enhance their premium rate review process and 45 states and the District of Columbia have received grants of $1 million each for that purpose.

State regulators have experience with the state's providers and understand the challenges and market dynamics faced by the physicians, hospitals and other healthcare professionals in that state. Knowledge of the provider marketplace and the state specific regulatory environment help inform a state regulator's judgment as to which rate increases should be subject to additional review.

State rate review makes sense because insurance markets and premiums are local. Premiums are based on local provider costs and utilization patterns. State-specific insurance market rules (e.g., guaranteed issue, community rating, and mandated benefits) also impact premium rates. It is unlikely that the federal government could stay abreast of these factors in all 50 states.

In addition, the need for states to be able to design their own thresholds for review is exemplified by states that do not allow rating factors like age that HHS agreed in the regulation preamble should not count towards the threshold. Reasonable thresholds need to vary by state to account for variations in the rating practices in those states. For example, community rated states include the aging impacts in the overall rate increase because the rating structure does not allow member-level differentiation by age. As such, as the population ages the average rate increases in such situations would be appropriately higher on average than states that allow age as a rating factor.

Recommendation: We recommend that States with an effective rate review process determine which rate increases are subject to review under the requirements of the NPRM. We also recommend that the information required to be reported under the NPRM would be submitted to HHS only in instances where a state determines that a rate increase is unreasonable.

III. Amend the criteria for states to be deemed to have an effective rate review process to allow flexibility for states to determine what is best for their residents.

Proposed Rule: HHS proposes to evaluate a state's review process in several general categories, including whether the state receives sufficient data and documentation to review an issuer's rates and whether the state conducts a timely and effective review. 45 C.F.R. § 154.301(a)(1) & (2). The regulation also requires that the state examine:

1) the reasonableness of the assumption used to develop the rate increase;
2) the data related to past and actual experience;

3) an analysis of the impact of medical trend changes by major service categories;
4) an analysis of the impact of utilization trend changes by major service categories;
5) an analysis of the impact of cost-sharing changes by major service categories;
6) an analysis of the impact of benefit changes;
7) an analysis of any overestimate or underestimate of medical trend for prior year period related to the rate increase;
8) an analysis of the impact of changes in reserve needs;
9) an analysis of the impact of changes in administrative costs related to programs that improve health quality;
10) an analysis of the impact of changes in other administrative costs;
11) an analysis of the impact of changes in applicable taxes, licensing or regulatory fees;
12) an analysis of medical loss ratios; and
13) an analysis of risk-based capital status relative to national standards.

45 C.F.R. § 154.301(a)(3) & (4). And the state's rate review determination must also be made pursuant to a State regulation or statute. 45 C.F.R. § 154.301(a)(5).

Issue: While BCBSA supports HHS's decision to rely on state rate review processes, the extensive list of information that a state must review effectively requires states to adopt federal review standards and processes. This approach is too prescriptive and does not give states the needed flexibility to implement the ACA in a manner that best serves their residents.

Many states have reviewed rate increases for decades and understand the unique concerns of their residents. For example, the challenges of a rural state in regulating individual health insurance are likely to be profoundly different than the challenges of regulating individual health insurance in a densely populated state. These reviews are performed by experienced state regulators, who are held accountable to their governors, commissioners and communities at the local level and work diligently on behalf of consumer interests. Adding any additional requirements to the rate review process is not necessary in light of the new medical loss ratio requirements and well established state practices for reviewing rates.

Given the proposed effective date for the NPRM, many states will likely not be able to modify their rate review processes to meet these exhaustive criteria. This could result in the federal government becoming the primary rate reviewer and supplanting a traditional state role which is not the stated intention in the NPRM's preamble or the law.

HHS's requirement to examine risk-based capital (RBC) status is especially problematic for the following reasons:

- A "national standard" does not exist and would be inappropriate for evaluating every issuer. A for-profit issuer can hold lower surplus levels than non-investor owned companies as they can issue additional stock to raise capital. Non-investor owned companies need to maintain additional reserves because they do not have access to the capital markets and cannot raise funds on an as-needed basis for such things as information systems and to reinvest in their businesses. Historical risk margins are likely to be compressed by the rebate formula which could limit the ability of non-investor owned companies to maintain safe capital levels. In addition, since non-investor owned plans typically operate in a single state or only a few states, they may need to hold proportionately more capital than a national or multi-state issuer due to less diversification of risk. The end result is to add uncertainty and increase margin of error in management of capital levels for non-investor owned companies.

- RBC is a measure used by regulators solely to determine if an issuer is solvent or in a weak condition. The 2010 RBC instructions published by the NAIC says that "Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to issuers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation."

- The NAIC Risk-Based Capital (RBC) for Health Organizations Model Act specifically states in Section 8(F) that risk-based capital reports "shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance". In addition, the RBC formula is a retrospective formula based on industry-wide assumptions, not forward looking. By design, it does not incorporate such factors as the issuers company-specific business risks, future strategies, growth plans, or investment needs.

Recommendation: Rather than the extensive federal criteria for what a state must examine, HHS should rely on more general criteria when evaluating whether a state has an effective rate review program. We recommend that HHS eliminate the extensive criteria in 45 C.F.R. §154.310(4)(i) through §154.301(4)(xii). States have years of rate review experience and a detailed federal standard is overly prescriptive. We recommend that HHS use the remaining criteria in the NPRM and add an additional condition related to actuarial principles as follows:

1. The state receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination;

2. The state conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase;

3. The state's rate review process includes an examination of the reasonableness of the assumptions and the validity of the data used by the issuer to develop the proposed rate increase;

4. The state's determination is based on sound actuarial principles and rate increases that are actuarially justified, are found reasonable, and the determination is made in a timely manner; and

5. The state's determination of whether a rate increase is unreasonable is made under a standard that is set forth in state statute or regulation.

These criteria will protect consumers while allowing states to determine the best approach for their unique market. In addition, states can use the $250 million in federal funds that the health reform law makes available to states to ensure their processes meet these criteria in a manner that best serves their residents.

Instead of HHS reviewing every state's rate review processes, states should be able to self-certify that they meet the above criteria.

If HHS does not adopt our recommendations, we recommend that the RBC requirement be eliminated because it is not an appropriate measure and disadvantages not-for-profit issuers compared to for-profit competitors.

IV. Modify the federal one-size-fits-all threshold for rate review to reflect the interaction with the MLR provision, the current rate increases occurring in the marketplace and to reduce the excessive administrative burdens on regulators and issuers in states without an effective rate review program.

Proposed Rule: Under the proposed regulation, HHS will review rate increases over 10 percent. In establishing the 10 percent threshold, the NPRM preamble states that HHS "has balanced the need to set a standard that would effectively capture unreasonable increases, while avoiding unnecessary filing burdens for health insurance issuers with regard to increases that are likely to be reasonable." 75 Fed. Reg. at 81010 and 45 C.F.R. §154.200.

Issue: Under the proposed regulation, rate increases that are 10 percent or greater are subject to the additional filing, review and reporting requirements of the NPRM. We believe this threshold is too low because it presumes, without substantiation, that the majority of health plans offering coverage in the individual and small group markets institute rate increases that are unreasonable.[1] In addition, in 2014 the 10 percent threshold set out in the NPRM is likely to trigger reporting and review of most, if not all, premium increases as numerous new requirements go into place. This includes the new essential health benefits, the health insurance excise tax and the guarantee issue requirements, all of which will impact rates.

It is important to create a threshold that recognizes that the ACA also has a transparent medical loss ratio (MLR) formula to ensure "that consumers receive value for their premium payments". In addition, this threshold should be market-based, as opposed to an arbitrary, fixed threshold that would subject most rate increases in a state to review for being "unreasonable." A market based threshold will ensure proper oversight of rate increases while minimizing administrative costs to both the reviewing entities and issuers.

In contrast, the NPRM over inclusively categorizes plans as "subject to review". This will (1) increase costs for consumers, as even plans with actuarially sound rates will be forced to participate in the intrusive and expensive review process; (2) confuse consumers by labeling the rate increases for the majority of available plans as potentially unreasonable; and (3) burden both state and federal agencies with an excessive, costly review requirement.

Importantly, the arbitrary threshold in the NPRM is not required by the statute. The statute only requires a process for reporting unreasonable rate increases. Thus, HHS has authority to require an alternative that would better balance the objectives of reviewing unreasonable rates and minimizing the burden of review on health plans, states and the federal government.

Recommendation: As noted earlier, states that have an effective review process should determine which rate filings to review and then report to HHS only if found unreasonable. In states without an effective rate review program, a review threshold should be based on two conditions:

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[1] HHS acknowledges that "the majority of increases in the individual market exceeded 10 percent each year for the past 3 years."

1. The issuer failed to meet market segment medical loss ratio (MLR) for all products combined in the state in the prior year; AND
2. The issuers average rate increase for a given market segment is 50% above the member weighted average in the state in the prior year (e.g., if the average rate increase was 7%, this threshold would be 10.5%).

Rates that exceed this review threshold should be reviewed by a health actuary that is a member of the American Academy of Actuaries to determine whether the rates are unreasonable and that they are actuarially sound.

V. Ensure the form for reporting rate increases under the NPRM is meaningful to consumers and reflects the current reporting practices in the majority of the states.

Proposed Rule: Requires issuers to submit a preliminary justification for all proposed rate increases subject to review to an applicable state and to HHS. (The format of the justification will be provided in forthcoming guidance.) The preliminary justification will consist of three parts: (1) Rate Increase Summary; (2) Written Description; and (3) Rate Filing Documentation – which would only be required in cases where a state does not have an effective review program. 45 C.F.R. §154.215.

Issue: The form for reporting rate increases that was developed by the NAIC is currently under consideration at HHS. BCBSA is concerned that the form submitted by the NAIC would not provide meaningful information for consumers, is administratively challenging to produce, and exceeds what is needed for rate review. This is especially true because the NAIC form requires information to be broken out in several new categories for medical trend and on a monthly basis.

Our analysis indicates that only two states require information to be broken out into categories beyond the four that are typically used by issuers for analysis: inpatient, outpatient facility, professional and outpatient pharmacy. And the vast majority of states historically have not required any breakout of claims and trend information by place of treatment. In addition, most states have required claims information to be presented by twelve month periods to improve the credibility and remove the effect of seasonality.

Making issuers present the data at too granular of a level will not produce useful information related to the rate review while requiring health plans to spend administrative dollars that would be better spent elsewhere.

Recommendation: We recommend limiting trend reporting for place/type of treatment to the five categories that states are required to report as part of the rate review grants: inpatient, outpatient facility, professional, outpatient pharmacy and ancillary (imaging, laboratory, DME, etc.). Claims should be aggregated for 12-month periods instead of monthly to improve credibility and reduce the effect of seasonality. To provide additional information on cost drivers, the health plan could provide a brief explanation of major drivers of increased cost the plan is observing across its broader block of business in each category, where material (i.e. imaging in the professional setting).

Once the final guidance and forms are released, we recommend that sufficient time is given to clarify all terms, and that there is an understanding that there will be a learning period as issuers, HHS, and state insurance departments learn how to implement all of these new

requirements. This will also allow time for issuers to modify data warehouses to sort the data in the manner required to complete the preliminary justification.

VI. Maintain the decision in the NPRM to exempt the large group market from rate review.

Proposed Rule: Requirements apply to the individual market and small group market. 45 C.F.R. §154.103.

Issue: The NPRM seeks comments on whether the rate review process should be different for the large group market. As drafted, the NPRM does not apply rate review to large groups in recognition of their more sophisticated purchasing capabilities and greater leverage with insurers. The vast majority of states recognize this by not imposing rate review requirements on large group policies.

Recommendation: Maintain the decision in the proposed regulation to not review rates for the large group market. If HHS contemplates including the large group market in this process at some point in the future, HHS should consult with all stakeholders in a transparent process, including large employers and their benefit consultants, to determine if rate review is needed and what process would best suit this market.

VII. Additional recommendations

In additional to the above issues, BCBSA recommends the following changes, clarifications and technical changes to the NPRM.

Definitions of Individual Market and Small Group Market 45 C.F.R. §154.102

Proposed Rule: The regulation proposes to adopt state rate filing definitions of the individual and small group markets. In cases where a state rate filing law does not define the individual market, the individual market would be defined in accordance with the PHSA. In cases where a state rate filing law does not define the small group market, the small group market would be defined in accordance with section 2791(e)(4) of the PHSA; however, for the purpose of this definition, "50" employees is substituted for "100" employees in the definition of a small employer.

Issue: We strongly support HHS's deference to state definitions in this area. However, the definition as written is ambiguous as to who will regulate certain product filings in the individual and/or small group markets.

In the individual market, several issuers offer their coverage through "out-of-state" associations or group trust in many states. In this situation, a "group" policy is issued in one state and then certificates are issued to consumers that live in other states. Since many state laws that govern rate review in the individual market only apply to health insurance policies issued in the state, some state's rate review laws may not apply to these types of coverage.

Another situation that impacts both the individual and small group market is states that review rates for some issuers and not others. Some states' rate review laws only apply to Blue Cross Blue Shield plans and/or HMOs. Because of this, other plans selling in these states are not subject to rate review.

Recommendation: Regardless of state definitions, all products in the individual and small group markets (as defined by the PHSA) whose proposed rate increases meet the threshold for review should be reviewed by either the state or HHS. We recommend that HHS clarify the language in the NPRM so that it is clear that HHS will review any individual or small group rate increase that meets the criteria for review that is not subject to review by a state, including in states that review rates for some issuers and not others.

We also recommend that HHS add language to make it clear that the rate disclosure and review requirements are uniformly enforced in compliance with Section 1252 of the ACA. Section 1252 requires Title I reforms to be applied uniformly to all health insurance issuers and group health plans within a state. Section 1252 applies to standards or requirements adopted by states pursuant to the ACA and any state standards or requirements that may be different than the ACA as long as there is a relationship between the different standards or requirements. For example, if state standards are more comprehensive than the ACA standards, all carriers in such states would be subject to those standards as required by Section 1252. This will ensure that all health insurance issuers are regulated equally, all consumers are protected equally regardless of which issuer they purchase coverage from, and will promote competition and affordable coverage.

Public Disclosure of Confidential and Proprietary Information 45 C.F.R. §154.215

Proposed Rule: The NPRM requires a health insurance issuer to submit a preliminary justification for each rate increase that meets the threshold for review. 45 C.F.R. § 154.215(a). The preliminary justification must include a rate increase summary and a written description justifying the rate increase. 45 C.F.R. § 154.215(b). Both the rate increase summary and the written justification must contain detailed information including historical and projected claims experience; historical and projected expenses and loss ratios, utilization trends and service or unit costs; and employee and executive compensation data from the health insurance issuer's annual financial statements. 45 C.F.R. § 154.215(e) & (f). HHS proposes to publicly disclose all of this information. 45 C.F.R. § 154.215(i).

In addition, issuers must file detailed documentation if HHS is determining whether a rate increase is reasonable. HHS intends to disclose "any information contained in the rate filing documentation of the preliminary justification that is not designated as 'confidential' as defined in HHS's Freedom of Information Act [FOIA] regulations." 45 C.F.R. § 215(i)(2)(i). Further, for any information that is designated confidential, HHS intends to review the information to determine if it is in fact confidential under FOIA.

Issue: BCBSA is concerned that the proposed requirement to produce the volume of sensitive, proprietary and confidential data is beyond the scope of the statute which does not contain a sweeping new federal disclosure requirement. We are also concerned about the usefulness of this data to consumers.

Even the most sophisticated consumers are unlikely to find information like "the projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated" meaningful in their search for health insurance coverage. 45 C.F.R. § 215(g)(viii). Even if they did, they would be unlikely to have the knowledge to be able to assess the reasonableness of the assumptions that were made that underlie the projections and trends. Only competitors and providers will find this information valuable, because it could reveal confidential and proprietary information. Forced disclosure of trade secrets and proprietary

company information will only help competitors selectively target markets to their advantage and will actually reduce competition.

Recommendation: BCBSA strongly urges HHS to reconsider publicly disclosing the information required under the proposed regulation, particularly the information required under the rate filing documentation. Disclosure will not assist consumers in purchasing decisions but has the very real potential of reducing competition between insurers and providers which runs counter to the goals of the ACA and consumer interests.

Unreasonable Rate Increases When HHS Reviews a Rate Increase 45 C.F.R. §154.205

Proposed Rule: Where HHS conducts the review, the standard for unreasonable would be whether the rate increase is "excessive," "unjustified," or "unfairly discriminatory."

Issue: Generally, many state rate review statutes include principles that prohibit rate increases that are excessive, unjustified, unfairly discriminatory or inadequate. In the regulation, HHS does not recognize the principle of inadequate rates and that an appropriate premium must be charged in order for an issuer to pay expected medical claims for the future.

Inadequate rates can also be discriminatory if the product is not self-supporting with the rate increase and requires significant cross subsidization from other products or markets. This forces consumers enrolled in one product or market segment to subsidize the cost of coverage from another product or market segment.

Recommendation: HHS should recognize the principle that rates must be adequate in order to pay for expected medical claims. HHS should revise the NPRM to clarify that forced cross subsidization across products or market segments could be discriminatory. In addition, these requirements should also be applied to rate increases that are subject to state rate review.

Definition of Product 45 C.F.R. §§154.102 & 154.215(d)

Proposed Rule: The NPRM proposes to allow issuers to file rate review increases based on "products." 45 C.F.R. § 154.215(a). "Product" is defined as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a state." 45 C.F.R. § 154.102. The issuer can combine the claims experience for multiple products as long as the rate increase is the same across all products. 45 C.F.R. § 154.215(d).

Issue: This definition would require issuers to submit rate review filings for rate increases subject to the NPRM differently than issuers submit rate review filings with the various states. Having two different levels of aggregation in rate review filings is confusing and inefficient. In some instances, HHS's requirements may conflict with state law.

Examples of requirements in state laws include:

- Some states require all products to be filed together in a common filing, but allow the issuer to vary the rate increases by product;
- Some states require that open and closed blocks of business be bundled for rate filing purposes, but allow the rate increases to vary by product. Under the proposed regulation, grandfathered plans are not subject to rate review; as a result, under the

regulation, closed grandfathered business would not be reviewed under federal standards, but would be required to be filed as a single rate in a state; and

- Some states allow issuers to combine products in rate filings, but once combined they must be filed this way in the future.

Differing requirements imposes unnecessary costs on issuers and could create confusion for consumers. These issues can be avoided by deferring to state aggregation/filing rules and allowing rate increases to vary in the same product filing.

In addition, the experience for various products differs and issuers should be allowed to vary rate increases based on this experience without having to do a separate filing for rate increases subject to review under the NPRM. A common example is that products with higher deductibles will have a higher trend due to deductible leveraging.

Finally, the NPRM appears to allow rate increases for the same "product" to vary for different cost sharing options; however, the language does not expressly state this.

Recommendation: We recommend that in states with an effective rate review program, HHS allow issuers to file rates in the manner required by state law. Issuers would not have to adjust their state rate filing which will help to avoid confusion for consumers and minimize administrative costs. We recommend that for states without an effective review program, HHS clarify that issuers may report "products" with a discrete set of benefits and underlying rating structure.

We also recommend that HHS allow issuers to implement different increases within a "product" by policy/plan if the experience or the actuarial value of the benefit differences dictates different increases are appropriate. Issuers would then average the increases in those product options to determine whether the increase meets the threshold for review. To avoid gaming, HHS could prohibit an issuer from disaggregating product options from a filing once they have been combined, as is done in many states today.

If HHS does not adopt our recommendation to allow aggregation as permitted or required under state law, it should clarify the definition of "product" and the rules under which issuers may aggregate "products", including allowing rate increases to vary by product and cost sharing level.

Definition of Rate Increase 45 C.F.R. §154.102

Proposed Rule: The NPRM preamble states that while section 2794 of the PHSA refers to premiums, HHS has interpreted this as referring to a "rate increase" that alters the underlying rate structure for a policy. HHS notes that this is more consistent with how these terms are commonly used by state regulators and the insurance industry. 75 Fed. Reg. at 81009. For example, according to the preamble, rate increases do not include premium changes that are attributable to age, in policies that are age rated, because those changes do not change the underlying rate structure. *Id.*

Issue: The NPRM preamble clearly outlines that a "premium" is "the final amount charged to a specific insured," but it is the underlying rate and actuarial methods used that are subject to review by states that have review programs in place. Rates are established by projecting future claims costs and the premium needed to pay future claims and non-claims expenses for a particular insurance product. BCBSA agrees that a meaningful review should focus on changes

in the underlying rate structure and the actuarial methods used to arrive at the rate. Changes in premiums due to generally accepted rating practices should not be subjected to review.

In addition, several factors that could lead to a change in the rate are out of the control of issuers such as mandated benefits or new taxes.

Recommendation: BCBSA recommends that the "rate increase" definition in the NPRM more specifically reflect the distinction acknowledged in the preamble. A "rate increase" should only reflect changes in the underlying rate structure. Changes in premiums due to generally accepted rating variables in the issuer's rate table/manual should not be subjected to review. In addition, amounts imposed outside of an issuer's control, such as changes in federal and state taxes, assessments or fees, the cost of mandates or government imposed changes in rating structure should not be considered part of the rate increase for the purpose of rate review.

HHS Consideration of Projected MLR When Determining Excessive Rate Increases 45 C.F.R. §154.205(b)(1)

Proposed Rule: HHS will determine that a rate increase is "excessive" if the premium charged for the coverage is unreasonably high in relation to the benefits provided. The NPRM says HHS would consider projected medical loss ratio (MLR) as one measure to consider when making this determination (i.e., whether the proposed rate increase would result in a projected future loss ratio below the 80% MLR standard for the individual and small group markets). However, the NPRM notes that if the projected MLR for an individual market product were below 80%, the proposed increase would not necessarily be considered excessive, so long as the aggregate MLR for all products in the market were at or above the 80% standard.

Issue: A specific product may have a higher or lower MLR due to several factors that are reasonable. For example, high deductible health plans would naturally have a lower MLR given that administrative costs are a greater percent of the premium. Other factors such as demographics of the enrollees and risk mix could also lead to a reasonable MLR that is below the applicable 80% or 85% standard. The MLR Interim Final Regulation only requires that the aggregate medical loss ratio for all products in a market segment meet the applicable standard.

Also, it is unclear how HHS defines "projected future loss ratio" and if it applies to the upcoming calendar year, rating period or lifetime of the product.

Recommendation: A product's rate increase should not be deemed as excessive solely on the condition that it does not target the MLR standard for the reasons discussed above. In addition, if the product filing targets and meets the MLR standard, then the product should be given a safe-harbor and be deemed as reasonable as long as the assumptions in the rate filing are actuarially justified.

BCBSA also recommends that HHS clarify the definition of "projected future loss ratio."

States to Inform HHS of Determination within Five Days 45 C.F.R. §154.210

Proposed Rule: The proposed regulation would require states to inform HHS within 5 days of its determination of whether a rate is unreasonable.

Issue: The regulation implies that if a state fails to inform HHS within 5 days of a decision, HHS will review that rate. 45 C.F.R. § 154.210 (a) & (b)(2). HHS should attempt, wherever possible, to support a state's rate review process, rather than supplanting a state's review process.

In addition, the NPRM makes no reference to the state notifying the issuer of this determination. Issuers may be waiting until a final determination is made as to a rate increase being reasonable before implementing an increase. And the issuer may want to adjust the rate increase if the proposed increase is going to be labeled as unreasonable. To facilitate timely implementation, a state should be allowed and required to notify the issuer of their determination on or before notifying HHS.

Recommendation: We expect that states will inform HHS of unreasonable rates in a timely manner. In states with an effective review program, we recommend that HHS shall assume the rate is reasonable until a state informs HHS that it is unreasonable.

In addition, states should be required to notify the issuer of the determination on or before notifying HHS.

Timelines for Rate Review By HHS 45 C.F.R. §§154.210 & 154.225

Proposed Rule: The regulation proposes that states with an effective review program will review rates. In states without an effective review program, HHS will review rates.

Issue: The regulation fails to propose any timeframe by which HHS will make a decision when it is reviewing the rate increase. As a result, the regulation does not provide an issuer with an expected timeframe under which they could expect a determination. Absent an expected timeframe, issuers cannot plan when to file a rate increase if they would like a determination of reasonableness prior to implementation. Implementing a rate increase is a complex process that requires notifying consumers and brokers of the new rates as well as programming the billing, sales and customer service systems.

Another issue is if a state does not have an "effective" rate review process under the regulation, HHS will review rates in that state. However, despite HHS's determination that the state's process is not "effective," state laws, regulations and processes will continue. As a result, it is possible that HHS will be reviewing rate increases that *have already been reviewed* in that state. If HHS determines that a rate is unreasonable after state review and the rate goes into effect, HHS's "unreasonable" label will undermine the very state laws that exist to protect consumers and prevent unreasonable rate increases. A process that could label a rate increase as "unreasonable," even when that rate is permissible under state law will frustrate states, consumers and issuers.

Recommendation: In cases where a state does not have an effective review program, we recommend a review process that relies on an independent actuary under contract with HHS and includes a timeframe by which HHS will make a determination so that issuers can plan their filings accordingly. We recommend that HHS review and make a determination on the rate no later than 30 days after the receipt of the rate review filing, but in no case less than 60 days before the rate will be effective assuming the rate increase is received 90 days in advance of the effective date.

Areas of Communication Ambiguity Between HHS, States and Issuers 45 C.F.R. §154.225

Proposed Rule: If a state determines that the rate increase is unreasonable and the issuer is legally permitted to implement the unreasonable rate increase, HHS will provide the state's final determination and brief explanation to the issuer within 5 business days following HHS's receipt of such determination. Where HHS makes a determination, it must prepare a final determination and a brief explanation of its analysis and post this information on the HHS website within 5 business days of making its final determination. If HHS determines that the increase is unreasonable, it also must provide its final determination and brief explanation to the issuer within 5 business days of making its final determination.

Issue: The NPRM has several areas of communication ambiguity which creates uncertainty for issuers. First, there is no timeline for when HHS must communicate determinations that rates are "reasonable." Second, the communication from the state appears to go through HHS prior to being communicated to the issuer by HHS. This process puts HHS in the middle of communication between state regulators and issuers which is inconsistent with the state-level regulatory framework. These communication gaps create inefficiencies and additional administrative burdens that can be easily avoided.

Recommendation: Once HHS determines that a rate increase is reasonable through an independent actuary, it should notify the issuer within five days. Correspondingly, if a state determines that a rate increase is reasonable or unreasonable, it should notify the issuer at the same time or prior to notifying HHS. If the rate review process has a predictable schedule, it will be more efficient and more responsive to consumers.

States Required to Provide Explanation of Determination to HHS 45 C.F.R. §154.210

Proposed Rule: The NPRM requires states with an effective review program to provide an explanation of how its analysis of a rate increase caused it to arrive at its determination of reasonableness.

Issue: The statute requires only that issuers justify unreasonable rate increases. It does not require states to justify their determination to HHS that a rate increase is reasonable or unreasonable. We do not believe that HHS has the resources or the specific state-level expertise to oversee the decisions of states' Departments of Insurance.

Recommendation: The state's decisions should not be subject to further review by HHS. While we recommend that states self-certify that they have an effective process, unless this change is adopted HHS will have already reviewed a state's review process when making its determination that a state's review is effective. Accordingly, we recommend that the regulation be revised to omit these requirements on states. States should only be required to report information about rate increases that have been determined to be unreasonable.

Disclaimer Language 45 C.F.R. §154.215

HHS Request for Comments: HHS solicited comments on the wording of the disclaimer.

Issue: HHS recognizes that under the NPRM a "range of proposed rate increases [will be reviewed], some of which ultimately would be determined to be unreasonable, *while others would not.*" 75 Fed. Reg. at 81010 (emphasis added). The regulation, through its preliminary justification requirement, requires issuers to justify increases that are not yet—and may never be—considered unreasonable.

We believe that this "preliminary justification" requirement will increase issuer costs without providing additional value to consumers. This will also confuse consumers because products with rate increases that are not unreasonable are required to be posted on the HHS web site. Notwithstanding HHS's proposed disclaimer, the effect of posting the preliminary justification will be to signal to consumers that this rate is presumptively unreasonable.

Recommendation: We recommend that preliminary justification not be posted to the HHS website. If this ultimately is required we suggest that HHS revise the disclaimer as follows: "The preliminary justification is the initial summary information regarding the rate increase subject to review. Requiring this information in no way indicates that this rate increase is considered 'unreasonable'. Information regarding the claims utilization in relation to the premium that is being proposed is being reviewed to determine the appropriateness of this increase."

Additional Requirements to Effective Rate Review Programs 45 C.F.R. §154.301

HHS Request for Comments: HHS solicited public comment on whether the public's ability to comment on unreasonable rate increases during the review process should be considered as a criterion for an effective rate review program.

Issue: Any additional requirements should carefully weigh the additional administrative costs against the protections already in place to protect consumer interests. For example, a rate review process that provides for a 90 day notice period and public hearings could take five to six months to complete. Such a process would be a significant undertaking by state regulators who already review these rate increases.

Finally, insurance companies need rate approvals with adequate time before they take effect in order to notify consumers and brokers as well as to program their billing, sales and customer service systems. While some may believe there are short term benefits for consumers, this regulatory approach often proves counter-productive over the long-term as delays in rate increases result in larger rate increases later on.

Finally, given the MLR requirements that are also a component of ACA, rate increases are not a function of an insurer charging excessive rates. Rather, they are a reflection of increases in the underlying medical prices, changes in utilization and changes in technology. Rate hearings only focus on issuers without highlighting the role of other stakeholders (e.g., medical device companies, pharmaceutical manufacturers, physicians and hospitals) and the increasing prevalence of chronic disease (e.g., obesity rates). This will only frustrate and mislead consumers without fully addressing the underlying cost drivers of rate increases.

Recommendation: We urge HHS to allow states to make their own decisions about which rate review policies are in the best interests of their residents. State regulators are most

knowledgeable of their local communities and circumstances and states are in the best position to weigh important trade-offs between various rate review policies.

Structure and Competitiveness of a Market 75 Fed. Reg. at 81009

HHS Request for Comment: HHS specifically solicited public comment regarding other factors that should be considered in determining whether a rate increase is unreasonable, noting that factors other than those addressed in the NPRM may impact the reasonableness of a rate, such as the structure and competitiveness of a market.

Issue: Issuers do not control the regulatory structure of the market. Issuers remaining in a regulated market that has led to fewer issuers should not have necessary rate increases denied because of the regulatory structure. Such an approach could have the unintended consequences of the particular market having even less competition as issuers exit due to insufficient rates.

Recommendation: HHS should not consider structure and competitiveness of the market when determining whether a rate increase is unreasonable. States are in the best position to determine the health of their state market and HHS should not attempt to displace state regulatory expertise and authority in that area. Instead, the final regulation should continue to rely on state law standards and not impose a federal standard regarding the structure and/or competitiveness of the market.

* * * *

We appreciate your consideration of our comments on the NPRM. We look forward to continuing to work with HHS on implementation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com .

Sincerely,

Justine Handelman

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May 2, 2011

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development

Attention: Document identifier/OMB Control No. 0938-NEW (Form Number CMS-10379)

Submitted via http://www.regulations.gov

Re: Agency Information Request - Rate Increase Disclosure and Review Reporting Requirements OMB Control No. 0938 NEW (Form Number CMS 10379)

Dear Sir or Madam:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) collection request for "Rate Increase Disclosure and Review Reporting Requirements" issued in the Federal Register on March 1, 2011 (76 Fed Reg 11249).

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to nearly 98 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

We provide detailed comments on the Rate Increase Disclosure Form below. However, as you finalize the rate review regulation, we want to reiterate our key recommendations (all included in our formal comment letter) for the Notice of Proposed Rulemaking for Rate Review and Disclosure ("NPRM") that are relevant to the Preliminary Justification.

First, the effective date for the NPRM should be July 1, 2012 in order to give states and plans the time necessary to make the required changes and to decrease the number of required Part III Preliminary Justifications that are filed with HHS. Many states have either already finished their 2011 legislative sessions, or have passed deadlines to introduce new bills, that would include the necessary changes to assure their rate review process would be considered "effective."

Since the final regulations for rate review have not been released, it will be almost impossible for states to change their laws and regulations to be effective by the July 2011 timeframe in the NPRM. The result: the federal government would become the default rate reviewer, which is not the desired outcome for states or the federal government. And health plans with rate increases above the threshold for review for "reasonableness" will have to submit Part III of the Preliminary Justification to HHS in an entirely new

format that will take time to adapt to since it contains data elements not historically reported in a state rate filing.

Second, states with effective review processes should decide which rates are unreasonable and only report those unreasonable rates to HHS. Once the rate has been determined to be unreasonable the health plan would then file the Preliminary Justification with HHS and the state. State regulators know their local markets best and understand the challenges and market dynamics faced by insurers, physicians, hospitals and other healthcare professionals in their state. Knowledge of the local marketplace helps inform a state regulator's judgment as to which rate increases should be subject to additional review.

HHS should give states the flexibility to determine what is an "effective" rate review program based on broad requirements rather than the extensive criteria contained in the proposed rule. Establishing a federal threshold triggering reporting to HHS in states that have an effective rate review process is inconsistent with the deference to states provided by the Affordable Care Act ("ACA").

Specific Comments on the Rate Disclosure Form

Overall, we believe that HHS has presented the required "justification for an unreasonable premium increase" in a manner that the average consumer can understand. The Consumer Disclosure as proposed does an excellent job of taking the actuarial information related to the rate increase provided on the Rate Summary Worksheet and translating this into outputs that informs the average consumer, who is not an actuary, about the reasons their health insurance premiums are increasing. We support HHS' approach of requiring detailed information necessary for actually reviewing the rate increase in Part III of the requirements, or in a rate filing provided to the state, and maintaining the integrity of the consumer friendly information in the Consumer Disclosure and Parts I and II of the Preliminary Justification.

We offer the following key recommendations for your consideration in order to further improve the various components of the Preliminary Justification.

I. **To ensure consistent and accurate information, calculate the average increase for both the Consumer Disclosure and the threshold that triggers review as to whether a rate increase is "unreasonable" using the weighted average per member per month ("PMPM") rate increase based on the same population.**

Summary: The methodology used for the Consumer Disclosure calculates the average rate increase using the future average rate and the prior estimate of current rate from the previous rate filing, per the instructions for Part I. The methodology described in the NPRM calculates the "average" rate increase by taking the weighted average percentage increase for each rating cell.

Issue: The methodology for calculating the "average" rate increase in the Rate Summary Worksheet differs from the methodology that triggers submission of an increase for an unreasonable rate increase described in the preamble of the NPRM.

- The methodology used for the NPRM calculates the "average" rate increase by taking the weighted average percentage increase for each rating cell without taking into consideration the rate for each rating cell.
- The methodology used for the Consumer Disclosure (as described in the Rate Summary Worksheet and the Instructions) calculates the rate increase using the future average rate and the prior estimate of current rate from the previous rate filing. Using the prior estimate of current rate from the previous rate filing reflects a different population of demographics and product mix than that used in developing the future average rate. Thus, if the current rate from the previous

filing is used without adjusting for the change in population, the rate increase calculated will include any effect of population mix change (change in demographics and product mix) between the two periods.

In addition to being different, neither methodology for calculating the average rate increase results in an answer that correlates to the increase in claims and other expenses on a PMPM basis that is actuarially appropriate.

Recommendation: The weighted average rate increase should be calculated for both the threshold that triggers review as to whether a rate increase is "unreasonable" and the Consumer Disclosure (which is transferred from Part I) using the methodology the American Academy of Actuaries (AAA) recommended in their February 22, 2011 comment letter on the NPRM. The AAA recommended the average increase be "equal to new revenue divided by old revenue minus 1.0. Old revenue refers to the sum of all current premiums for each insured person affected by a rate increase filing; new revenue refers to the sum of all new premiums over the same population". Thus, the rate increase reflects changes to the *rate tables* and not demographic changes nor choices made by insureds which are outside of the control of the issuer (such as switching areas or benefit plans). "

The claims projections on Part I (Rate Summary Worksheet) for both Section B1, Adjustment to Current Rate, and Section B2, Claims Projection for Future Rate need to be adjusted to the same demographic and product mix as used for the average rate increase calculation. This is necessary as the Base Period experience does not reflect the persons currently in the pool of those receiving a rate increase; rather it reflects an average of the demographics of the members and the products they were enrolled in over a period of time in the past. To make this adjustment, we recommend HHS include instructions that adjustments to the demographics and product mix moving from the average over the experience period to the single population used in the development of the future rates need to be made by the issuer, and that an explanation of this adjustment should be provided in Part II of the Preliminary Justification.

In addition, the same population (demographics and product mix) needs to be used for the calculation of the net claims and total rate PMPM in section C for the prior estimate of current rates. The calculation of the prior estimate of current total rate PMPM would be accomplished by using the current premium rate tables and calculating the average premium rate PMPM using the new population used in the future rate development process. This provides the appropriate comparison of the total rate on a PMPM basis for the prior estimate of current rate and future rate, as shown in the increase percentage in line 5 of Section C, Overall Rate Increase.

However, the prior estimate of current rate PMPM input items do not include the total rate, but rather the net claims PMPM, the administrative costs PMPM, and the underwriting gain/loss PMPM. Therefore, the issuer will need to re-evaluate the separate items in the total rate PMPM using the same population (demographics and product mix) in order to input the appropriate values for comparison.

Using this methodology for both the Consumer Disclosure and the determination of whether a rate increase is above the threshold has several advantages, including consistency throughout the rate review process; eliminating the distortion in the methodology used for the Consumer Disclosure form for changes in demographics and product mix; and capturing the impact of adjustments to rating factors such as age and area.

This change impacts sections A, B1, B2 and C of the Rate Summary Worksheet, the instructions for those sections and the corresponding outputs on the Consumer Disclosure. In addition, the same type of instructions related to calculating the rate before and after the increase using a single population (demographics and product mix) should be included in the instructions for Part III.

II. To minimize consumer confusion, set the expectation that the information included in Parts I, II, III and the Consumer Disclosure are not intended to be consistent with the medical loss ratio ("MLR") rebate calculation by including a disclaimer as such on the appropriate forms.

Summary: The information presented on the Consumer Disclosure and on Parts I and II of the Preliminary Justification does not include information on several elements that are part of the MLR rebate calculation, including quality improvement expenses, provider incentives and federal and state taxes and licensing or regulatory fees.

Issue: Consumers who are viewing the Consumer Disclosure are also likely to be aware of the MLR rebate requirements of the ACA. Presenting the information without a disclaimer that the information is presented in a manner that does not correlate with the MLR rebate calculation will lead to consumer confusion. For example, in the MLR rebate calculation activities that improve health care quality are included along with the cost of clinical services in the numerator for the MLR calculation. Also federal and state taxes and licensing or regulatory fees are excluded from premium. A consumer looking at the pie chart in Section 3 might interpret the 76.2% for "Cost of Medical Services" to be below the threshold for the MLR rebate when in actuality the product filing likely would have an MLR above the federal threshold based on the methodology used for the MLR rebate calculations. There are numerous other reasons the information is not consistent with the MLR rebate calculation.

Recommendation: Disclaimers should be included on all forms that say that the values presented in the forms do not and are not meant to be consistent with the federal MLR rebate reporting as the methodologies are different.

In addition, information should be broken out on Parts I and II of the Preliminary Justification and then be presented on the Consumer Disclosure for cost associated with quality improvement expenses and federal and state taxes and licensing or regulatory fees. These values should be reflected in section C, item 2, administrative costs, of Part I (Rate Summary Worksheet) allowing a break down for these items. These would then be presented in the Consumer Disclosure in a separate pie chart for administrative cost showing three categories: quality improvement expenses and federal and state taxes and licensing or regulatory fees and other administrative costs. The instructions should also specify that provider incentives are considered medical costs.

III. Ensure that language in the Consumer Disclosure clearly explains that the information relates to increases in rates as opposed to premium and present this information in a manner appropriate for the specific market segment.

Summary: The first bullet in the answer to the question on page 2 of the Consumer Disclosure, "How will this rate increase affect the premiums people pay?", does an excellent job of explaining the differences between a "rate" and a "premium." However, in the second bullet the explanation states "that the minimum premium *[emphasis added]* increase any customer will receive will be 5% and the maximum is 13.6%.

Issue: The NPRM made it clear that the determination of an unreasonable rate increase would be based on the change in rates and not premium. The Consumer Disclosure follows this except for the above language. In addition, in small group the employee's change in the amount they pay can vary due to changes in the amount of contribution an employer makes towards the employee's coverage and, in most states, due to a change in the group's health status or other allowable rating elements.

Recommendation: The language in the second bullet should be re-worded to read: "The 11.8% is an average rate table change on a PMPM basis for all policyholders. The insurance company has stated

that the minimum rate increase of any cell in the rate table as a result of the rate changes will be 5% and the maximum 13.6%. However, an individual may not see their rate change within this range due to other changes, such as aging of the individual, changes in area, changes in duration or health status, or changes in family status." In addition, for the reasons described above and later in our comments HHS should develop a separate version of the form that includes language that is specific to small group.

IV. Allow different benefit configurations included in the same product package or packages included in the same rate filing to reflect different rate increases based on actuarially justified reasons, such as fixed cost/deductible leveraging, with the rate increases for the entire package of benefit configurations resulting in the average increase.

Summary: The fourth paragraph on Page 1 of the instructions could be interpreted to require separate rate filings for different benefit configurations within a product package or multiple product packages within the same rate filing unless the same rate increase is applied across all products.

> *If an issuer has a rate increase that meets or exceeds the reporting threshold for multiple products, the issuer may submit a single Preliminary Justification for those products, provided that: 1) the experience of all combined products has been pooled to calculate the rate increases; and, 2) the rate increase is the same across all combined products.*

Issue: The NPRM describes a product as a "package of health insurance coverage benefits with a discrete set of pricing methodologies..." Because of deductible and fixed cost leveraging, along with other benefit differences, it is appropriate that different benefit configurations within a product grouping that would appear to have a discrete set of pricing methodologies would require different rate increases over time.

Further complicating this, many states require all products (that is, products as defined in the proposed rule and benefit configurations within the products) for a market segment to be combined in the same rate filing so that the rate increases applied to different products and benefit configurations can be evaluated in totality for the segment. This can include products with fixed dollar copays and/or relatively low deductibles being combined in a filing with high deductible health plans.

Given the requirement noted above, it would appear that the Preliminary Justification for products and benefit configurations with different rate increases would have to be filed separately.

Recommendation: Allow rate increases to vary by "benefit configuration" for a Preliminary Justification in a single or combined rate filing, as they have historically, as long as the increases are actuarially justified and the differences are explained in Part II of the justification.

V. Risk based capital (RBC) should not be included in Part 3 of the Preliminary Justification or as a measure of whether a state has an effective rate review process.

Summary: RBC is included as an element that is required to be reported in Part 3 of the Preliminary Justification. It also is an element that the NPRM states should be included in rate filings in order for states to have an effective rate review process.

Issue: RBC is a financial measure used by regulators solely to determine if an issuer is solvent or in a weak or deteriorating condition. The 2010 RBC instructions published by the NAIC says that "Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to insurers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation." In particular, the NAIC Risk-Based Capital (RBC) for Health Organizations Model Act specifically states in Section 8(F) that risk-based capital reports "shall not be used by the

commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance." The NAIC in their comments on the NPRM recommended RBC be removed from the required elements for a rate filing. In addition:

- Health care reform significantly changes insurers' business models and imposes much unpredictability (e.g., insurers will have to develop premium rates months in advance of knowing who their customers will be, how the risk mitigators will work, etc.).

- The addition of millions of new individual customers that will raise the required additional reserves per RBC formula requirements.

Recommendation: Remove the RBC requirement from Part 3 of the Preliminary Justification as well as being a criterion for states to have an effective rate review process.

VI. Additional recommendations

In addition to the above issues, BCBSA recommends the following changes, clarifications and technical changes to the Preliminary Justification.

Consumer Disclosure Issues and Recommendations		
Page/Section	**Issue**	**Recommendation**
Page 1, third bullet	The statement "The law requires a review of these proposed rate increases by States, or if a State does not review insurance rates, by the federal government, to determine if the proposed increase is unreasonable" is not accurate.	We suggest the following modification to the statement: "The law requires a review of these proposed rate increases. If a state is determined by HHS to have an effective rate review program, the state will determine whether the proposed rate increase is reasonable. Otherwise, the federal government will make the determination."
Page 2, *When will this take effect?*	The disclosure form only identifies one date when rates will become effective. Many rate schedule changes included in a rate filing take effect monthly on the policy's renewal date and rates are effective for new coverage first delivered for effective dates on or after some specified date. A single date is misleading.	HHS should change the language to describe the fact that rate changes can occur on anniversaries or other renewal dates. Therefore, the rate increase will take effect based on an individual's or small group's renewal date between start date (taken from Rate Summary Worksheet) and end

Consumer Disclosure Issues and Recommendations		
Page/Section	**Issue**	**Recommendation**
		date (taken from Rate Summary Worksheet).
Page 3, *Section 1: What is Causing the Proposed 11.8% Rate Increase* Factors Impacting Proposed Rate Increase—Profit or Retained Earnings And Page 5, *Section 3; New rate*	The values presented in the Rate Summary Worksheet use the term "underwriting gain/loss" rather than "profit or retained earnings." The former is better terminology than "profit or retained earnings" as the value is neither profit nor retained earnings.	HHS should use the term "gain/loss" instead of "profit or retained earnings," as the values do not represent either profit or retained earnings.
Page 4, *Section 2: Rates and Medical Costs*	The categories listed on the disclosure form do not match the categories in part 1 (the Rate Summary Worksheet).	HHS should use the same categories on both the Consumer Disclosure form and the Rate Summary Worksheet. For example, do not combine "capitation" into "other", and do not use "ancillary" since "ancillary" is not on the Rate Summary Worksheet. The corresponding footnote for "other costs" should be updated to reflect any changes.
Page 5, *Section 3: New Rate*	The categories for medical costs, hospital inpatient, outpatient facility, professional services, prescription drugs, ancillary services, and other are not the same categories as in Part I of the form, and the percentages are not actually calculated on Part I - Rate Summary Worksheet.	HHS should use the same categories in both the Rate Summary Worksheet and the Consumer Disclosure. In addition, it would be helpful if HHS could include the calculated percentages of the medical services on the Rate Summary Worksheet as this will allow companies to review all their information for accuracy.
Page 6, *Section 4: Past Rate Increases*	In some cases, such as with new product offerings, rate increase history may not exist for three years.	HHS should clarify how to handle these situations and ensure the input on the Rate Summary Worksheet transfers to the Consumer Disclosure.

Consumer Disclosure Issues and Recommendations		
Page/Section	**Issue**	**Recommendation**
General	In several places the word "policyholder" is used, which is problematic, as the calculations in the rate summary worksheet are on a per member basis. In addition, for group business the policyholder would be the employer.	HHS should make the following changes to language in the Consumer Disclosure to address issues related to the use of the term "policyholder". • Page 2, second question, first bullet, second sentence – should read: "…factors like their age, where they live and how many people are covered. • Page 2, last bullet – delete "personal" • Page 3, Medical Services – change "policyholder to "a member" or "an enrollee" • Page 5, first section - change "policyholders" to "members" or "enrollees" • Page 5, footnote 2 - change "policyholder's to "member's" or "enrollee's" • Page 6, title of pie chart – Change this to read: "This chart shows the costs that will make up the average rate for a member". Alternatively say "enrollee". For group business change the word "policyholder's" to "certificate holder's"

Rate Summary Worksheet (Part I)		
Page/Section	**Issue**	**Recommendation**
Section A: Base Period Data	Instructions say to include an estimate of unpaid claims (IBNR) by service category, which not all health plans will have available, particularly for allowed claims. IBNR values are typically only developed for paid claims. In addition, this form does not seem to accommodate riders or benefit coverage options, such as prescription drug coverage, where the membership may not be the same for each service category. The form seems to assume the same level of membership for all service categories, and adds PMPMs based on that assumption. If the total membership is used for all riders and optional service categories, the PMPMs for those claims will be lower.	HHS should recognize in the instructions that many issuers do not develop IBNR values on an allowed basis, and that the company can adjust their data and provide a description in Section 2. Also the instructions should recognize that this form may not accommodate optional benefit categories or riders and the appropriate approach to complete the worksheet is to use the total membership for all service categories for purposes of Parts 1 and 2 and the Consumer Disclosure when inputting values.
Section B1 and B2: Claim Projections	Capitation is separated out from other service categories; however, encounter and cost sharing data is sometimes not captured for capitated services. This may have been anticipated as the sample shows no cost sharing amount for capitation.	HHS should include in the instructions the potential problems issuers may have in capturing encounter data for capitated services and include instructions to explain any understatement of cost sharing values in Part II.
Section C. Components of Current and Future Rates	It is unclear from the worksheet whether it accommodates rate increases that occur on a frequency different than 12 months apart or if the company needs to adjust the inputs.	HHS should expand the instructions to reflect all 12 months of prior rates and increases, or what to do if the time period between rate increases is more or less than 12 months. Providing an example in the instructions would also be helpful.
	In the instructions, under Section C, the second sentence states, "The administrative and underwriting gain/loss components should be reported consistently with how terms are determined for state rate filings and financial reporting and should adhere to Generally Accepted Accounting Principles (GAAP)." Many companies	HHS should modify the language to, "The administrative and underwriting gain/loss components should be reported consistently with how terms are determined for state rate filings."

Rate Summary Worksheet (Part I)		
Page/Section	**Issue**	**Recommendation**
	do not report financials on a GAAP basis.	
Section D. Components of Rate Increase	The instructions for Section D: Components of Medical Claims Changes, Line 7 – Cost Share Change say this item is automatically calculated by summing the products of: the difference in cost sharing amounts entered in B2 and B1 for each service category and the net claims in B2 for each service category. This is different from how it appears to be calculated on the worksheet.	HHS should evaluate the instructions, and if appropriate, modify the instructions to reflect the calculation being the sum of the products of: the difference in cost sharing amounts entered in B1 less B2 for each service category and the Allowed PMPM in B2 for each service category.
Section F: Range and Scope of Proposed Increase	The language on the Rate Summary Worksheet in Section F surrounding the minimum and maximum "premium" increase should be "rate" increase to be consistent with the approach outlined in the NPRM. In addition, as noted earlier the Consumer Disclosure will need appropriate disclaimers.	Change the language in Section F to reference "rate" instead of "premium" and modify the instructions to be consistent. Include the appropriate disclaimers in the Consumer Disclosure.
	According to the instructions for the minimum and maximum current and proposed premiums, the values to be entered are the lowest and highest "premiums," which likely does not correspond to the rating cells that are receiving the lowest and highest percentage "rate increases."	The instructions should require values that reflect the minimum and maximum rate increases from the rating table. Also, while it appears this should be determined on a percentage basis, the instructions should clarify this.
General Concerns	The worksheet appears to have rounding discrepancies.	HHS should include a disclaimer explaining that values may not match due to rounding.
	The proposed rule states that grandfathered business is excluded from these requirements. Many issuers will combine, and some states require, pooling the experience of grandfathered and non-grandfathered business for rate filing purposes. Therefore, the experience of both would need to be included in the rate filing, and thus, would be included in the information for Parts I, II and III of the Preliminary	HHS should modify language in the instructions to reflect the fact that although the regulations/rules do not need to be applied to grandfathered business, that if the state requires, or if the issuer combines grandfathered business for purposes of credibility or other reasons, that the issuer explain this in Part II.

Rate Summary Worksheet (Part I)		
Page/Section	**Issue**	**Recommendation**
	Justification.	
	Allowed claims will need to be adjusted for the value of coordination of benefits (COB) appropriately in Parts I and II of the Preliminary Justification. If the value of COB is not removed from Allowed Claims, it would, by default, be included in Member's Cost Sharing and, thus, overstate the cost-sharing amount.	The instructions should state to remove COB from the development of *Allowed Claims*.

Rate Filing Documentation (Part III)		
Page/Section	**Issue**	**Recommendation**
Instructions, second paragraph, *Reporting elements*	There are a number of items on the required reporting elements list that do not seem to make sense for individual and small group health insurance and some only are applicable to individual or small group.	The list of required elements should be edited to include only relevant items for each market and exclude items that are irrelevant to a rate increase. If a company does not use a required element, they should explain. The items that are not appropriate for either market include: risk based capital and surplus (company financial condition); evaluation period; mortality (typically included in overall lapse assumption as company is frequently not aware whether death is reason for lapse). The items typically not used for small group filings and often not used for individual include interest rate assumptions and lifetime loss ratio.
List of Part III Reporting Requirements	There are no definitions of any of the reporting requirement items.	HHS should provide definitions as appropriate. For example it is not clear what the terms "Premium Classifications" or "Evaluation Period" mean.
Item 3, *Average annual premium per policy, before and after rate increase*	For comparisons to be appropriate, the same set of covered lives and elected plans should be used for calculating the "before" and "after" average rates.	HHS should instruct issuers to use the same population (i.e. same age, underwriting level, product and area) when calculating the "before" and "after" average annual rate. In addition "rate" should be used instead of "premium."
Item 4.e.i. *Cumulative Loss Ratio* and Item 6. *Cumulative loss ratio*	It does not specify if this is to be shown as it has historically been calculated or by the method used for the new MLR rebate calculation, and the instructions will need to clarify this. In particular, all the adjustments required to be made to the MLR for reporting and rebate purposes may not be available to a company on an historic basis. In addition, this value is not typically used	HHS should not require this in Part 3. If it is required, the instructions should recognize that historical data may not be available.

Rate Filing Documentation (Part III)		
Page/Section	**Issue**	**Recommendation**
	in the rate development process, and, therefore, should not be required to be included in Part 3.	
Item 5.a.i, *Profit and Contingency*	The level of detail HHS wants is unclear.	HHS should clarify in the instructions that this item should reflect target risk and contingency. HHS also should request an explanation on the level assumed.
Item 5.d, *Descriptive Relationship of Proposed Rate Scale to Current Rate Scale*	The definition of rate scale is unclear.	HHS should more fully define this term—for example, "Please describe any rating factor slope changes individually, as well as their overall effect."
Item 5.e.iv, *Interest Rate Assumptions*	Interest rate assumptions are not relevant unless there is a premium rate guarantee period. There are, however, states that do request this information when calculating a lifetime loss ratio for individual business.	HHS should note in the instructions that this item is not relevant for small group business. In addition, HHS could clarify that any relevant interest rate assumptions for individual business should be included in the descriptions under Item 5.e.i.1 and 2 and remove this as a separate item.
Item 5.e.v, *Other Assumptions, including Morbidity, Mortality and Persistency*	When relevant, mortality typically is included in overall lapse assumption as the company often is not aware whether death is reason for lapse. This section, however, allows the opportunity to include discussion on items such as change in risk mix (expected with new exchange members), persistency, and other contributing factors.	HHS should describe this section as *Other assumptions, including impact of changes in persistency, risk, and product mix.* Also, indicate that an insurer can identify which assumptions are not appropriate for the subject filing.
Item 5.f, *Company Financial Condition—Risk Based Capital and Company Surplus*	These items should not be considered as part of a rate review process. The 2010 RBC instructions published by the NAIC says that "Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to insurers that show indications of weak or deteriorating	HHS should remove these items from the list.

Rate Filing Documentation (Part III)		
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	conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation." In particular, the NAIC Risk-Based Capital (RBC) for Health Organizations Model Act specifically states in Section 8(F) that risk-based capital reports "shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance." It was never calibrated as a strength measure and ratios can be very misleading. The HRBC formula is a retrospective formula based on industry-wide assumptions, not forward looking. By design, it does not incorporate such factors as the insurers company-specific business risks, future strategies, growth plans, or investment needs.	
Item 7, *The projected future loss ratio and a description of how it was calculated*	This should be defined to be the projected loss ratio over the coming rating period for which the rates are being proposed.	HHS should provide a definition of future loss ratio to include the projected loss ratio over the coming rating period for which the rates are being proposed.
Item 7.a, *Loss Ratio Exhibit*	This item appears to be the same as Item 8.	HHS should modify the description to exclude 7.a.
Item 8, *The projected lifetime loss ratio that combines cumulative and future experience and a description of how it was calculated*	Lifetime loss ratio is not relevant for small group and typically is not relevant for individual.	Although lifetime loss ratios may be relevant for some individual products in an underwritten market, this would not be the case after 2014. As such, this item should be identified clearly as for the individual market only through 2013 and only required where relevant.
Item 9.a.i, *Anticipated loss*	These sections seem to presume that the calculations of MLR on the form are	HHS should eliminate Sections 9 and 10.

Rate Filing Documentation (Part III)		
Page/Section	**Issue**	**Recommendation**
ratio presumed reasonable according to the guidelines including adjustment for credibility if applicable and Item 9.a.ii, *Quality Improvement Costs* and Item 10, *If the result under 7 is less than the standard under 9, a justification for this outcome is required*	consistent with the MLR calculation for rebates. As noted earlier, they are not. The MLR rebate calculation methodology is not appropriate for rating since it does not include taxes and regulatory fees, has credibility adjustments and will be on a 3 year rolling average in 2013, among other differences.	

On a final note, we recommend that HHS issue these forms and instructions in a manner that provides regulatory flexibility to update the form as necessary given the complexities and the changes that will be necessary in preparation for 2014, when the major Affordable Care Act reforms become effective.

We appreciate your consideration of our comments on the Rate Increase Disclosure Form. We look forward to continuing to work with HHS on implementation issues related to the ACA. If you have any questions, please contact Richard White at (202) 626-8613 or at richard.white@bcbsa.com.

Sincerely,

Justine Handelman

Justine Handelman
Vice President
Blue Cross and Blue Shield Association

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

February 28, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madame Secretary:

We submit the following comments on the Rate Increase Disclosure and Review Notice of Proposed Rulemaking (NPRM), as published in the *Federal Register* on December 23, 2010, on behalf of the National Association of Insurance Commissioners (NAIC).

Section 154.200

Section 154.200 sets out the standards for rate filings that are subject to review. Section 154.200(a) states, "rate increases filed in a State on or after July 1, 2011, or effective on or after July 1, 2011 in a State that does not require rate increases to be filed," that are 10% or more are subject to review by HHS to determine if they are unreasonable rate increases. Section 154.200(a)(2) similarly states that rate increase filings for calendar year 2012 or thereafter that meet or exceed the state-specific threshold determined by the Secretary under section 154.200(a)(2)(i) or (ii) are subject to review.

The NAIC recognizes the value of and supports efforts to enhance market transparency and is very appreciative of HHS' recognition that state-specific thresholds are more appropriate for determining potentially unreasonable rate increases. There is concern that the 10% threshold proposed by HHS for use until 2012 is low and would require a vast majority of rate increases to be filed. Some commissioners recommend that the 10% threshold be increased. Some commissioners recommend that HHS delay the effective date of the regulation to six months following promulgation of the final regulation to allow adequate time to establish state-specific thresholds and to determine which states have effective rate review programs. Some commissioners agree with HHS's recommendation that a 10% threshold be used until state-specific thresholds are established for 2012.

While there is no consensus on when to transition to state-based thresholds, commissioners agree that we should move quickly. The proposed regulation does not indicate how the Secretary will determine the state-based threshold, but since individual states understand their health insurance markets best, maximum flexibility in determining a threshold amount should be given to the states. HHS should continue to work closely with the individual states and the NAIC to determine the best way to transition to the state-specific thresholds that will be used.

Section 154.205

The consideration listed in Section 154.205(b)(1) is ambiguous as to the level of aggregation and the duration of the projection period at which the medical loss ratio is to be considered. We suggest that Section 154.205(b)(1) state clearly that the medical loss ratios are to be evaluated at the level of aggregation specified in 45 CFR 158.220(a).

Section 154.210

Section 154.210(b)(2) states "The State provides to HHS, on a form and in a manner prescribed by the Secretary, its final determination of whether a rate increase is unreasonable, which must include an explanation of how its analysis of the relevant factors...." A requirement to develop detailed analysis of each filing is unnecessary and adds potentially significant additional work for state regulators. If a state has an effective rate review program, the states should not be required to prepare more than the same "final determination and a brief explanation of its analysis" that HHS prepares and posts under § 154.225(1)(a) when HHS is conducting the reviews itself.

Section 154.215

1. Section 154.215(e)(8) requires submission of employee and executive compensation data. It should be noted that employee and executive compensation is a total company expense and not a state-specific or coverage-specific expense. In addition, removing all top executive compensation from medical rates would in most cases make a difference of less than a tenth of a percent. Although not a significant factor in evaluating rate changes, public disclosure of executive compensation seeks to achieve more transparency.

2. The data submission listed in Section 154.215(e)(6)is ambiguous as to the length of time over which loss ratios are to be provided. We suggest amending Section 154.215(e)(6) to read as follows:

   "Loss ratio for the experience period upon which the rate increase is based, and the projected loss ratio for the period during which the proposed rate is projected to be in effect;"

3. The data submission listed in Section 154.215(g)(1)(vii) is ambiguous as to the length of time over which loss ratios are to be provided. We suggest amending Section 154.215(g)(1)(vii) to read as follows:

   "The projected loss ratio for the period during which the proposed rate is projected to be in effect and a description of how it was calculated;"

4. We suggest the deletion of data submission Section 154.215(g)(1)(viii), because lifetime loss ratios involve projections over a long period of time and are not reliable indicators of whether a rate increase is reasonable, especially in light of the changes that will be required by the ACA.

5. Section 154.215(i)(1) requires HHS to post on its website the information contained in parts one and two of each preliminary justification, which means that all preliminary justification will be posted for all premium increases over 10%. In many states, rate filings are not public until they are approved. Posting the rate increases may require states to modify their laws to avoid the inconsistency with state law.

   Certain States have expressed concern about the timing of the posting of rate justification information by HHS prior to the actual determination of whether or not a rate increase filing is reasonable. They are concerned that HHS posting this information before that determination would result in consumer confusion, and has the potential for market dislocations and unsuitable replacements of coverage if consumers are convinced to replace perfectly suitable coverage just because a rate justification posting by the consumer's current insurance carrier showed up on the HHS website.

   Certain States already are making rate filing information available to their consumers on all rate filings, not just on those that exceed a specific threshold, and as a result of the rate review grants, many more States will be doing so. However, the NAIC shares the concerns HHS has expressed regarding the usefulness to consumers of the information disclosed under section 154.21(i)(1) and the potential for confusion. Therefore, we suggest that great care be taken on how the postings are characterized and labeled. NAIC therefore suggests the following:

   1. Title of Webpage: **Health Insurance Preliminary Rate Increase Information**

   2. Disclaimer: **These postings are to provide consumers with valuable information to assist them in evaluating their current health insurance coverage and its associated costs. They are for informational purposes only. The analyses on these filings, either by HHS or the applicable State insurance department, are not yet complete. Further information may be posted upon their completion.**

Section 154.225

Section 154.225(c) states that "... HHS will provide the State's final determination and brief explanation to the health insurance issuer within five business days following HHS's receipt thereof." If a state reviews rates, the state is already communicating with the insurer when reviewing the rate filing. It is unclear what purpose the additional communication with the insurer by HHS serves. We suggest deletion of this provision.

Section 154.301

States should retain wide latitude to conduct rate reviews in accordance with conditions in each state's market, subject to broad minimum requirements. As HHS points out in the preamble to the proposed regulation with respect to using the State's definitions for rate filings, HHS seeks to ensure that the State's rate filing processes and statutory framework are not disrupted by the proposed regulation. Section 154.301(a)(4) imposes criteria for an "effective rate review program" that are more extensive than those that will be utilized by HHS in its review of rates. It is unclear what purpose the additional criteria for evaluating a state's rate review program serve. Therefore, we suggest that Section 154.301(a)(4) be deleted in its entirety.

If Section 154.301(a)(4) is retained, the reference to risk based capital should be removed. Section 154.301(a)(4)(xii) of the proposed regulation requires that a state's rate review program include a review of the issuer's risk-based capital status relative to national standards. While extensive analysis and regulatory action can be based upon an insurer's risk-based capital, we are opposed to including this condition in determining whether a state has an effective rate review program.

Risk-based capital is a financial analysis tool, and financial analysis has a limited role in the rate review process, although it can be an important consideration when the issuer's financial condition is precarious. States with rate review authority use a variety of tools to determine whether rates are excessive or inadequate. Looking at an insurer's financial condition may be used by some states as one of many consideration for profit and risk guarantees in rates. States with non-profit insurers also look at an insurer's financial condition. However, insurance rates should be based upon the expected premium needs to cover the anticipated risk assumed. Risk-based capital does not provide a measure of future capital needs.

General

Public Comment

HHS has solicited comments concerning whether the public's ability to comment on unreasonable rate increases during the state's review process should be a criterion for an effective review program. This is a decision that should be left to the states. Each state has different laws relating to trade secrets and public information, and a public comment process during the review period is not possible if the rates or the insurer's supporting information are still confidential at that time. HHS should not include this requirement in section 154.301. As states implement ACA, many are reviewing current processes and looking for ways to improve consumer participation and transparency.

Use of State Definitions of Individual, Small Group and Large Group Markets

As HHS notes in the preamble, using the states' definitions for rate filings ensures that each state's rate filing processes and statutory framework are not disrupted by the proposed regulation. We support HHS's use of the states' definitions for this proposed regulation. Not doing so would significantly disrupt states' rate review programs, create confusion about protections available for consumers, and add costly compliance requirements to industry.

Disclaimer Regarding Preliminary Justifications

HHS has solicited comments on the disclaimer language regarding the preliminary justification. It is important to avoid the misleading impression that all significant rate increases are unreasonable. The statement that posting the preliminary justification does not represent a determination that the rate increase is unreasonable should be made more prominent, perhaps in boldface type.

As discussed in our comment at item 5, we strongly urge HHS to delineate clearly different categories of rates that are being posted on its webpage. For example, one category could be "proposed rates;" another category could be "rates determined to be unreasonable by HHS;" and a third category could be "reasonable rates." This would allow HHS to provide more information to the public about each category, what will happen and to understand that what may appear to be unreasonable is in fact reasonable because of increasing health care costs.

Paperwork Reduction Act of 1995 Requirements

In addition to the comments referenced above with respect to the threshold level, employee and executive compensation, and risk based capital, we offer the following comments:

- The estimate that only 1/3 of rate increases will be over the threshold may be low. In 2009 and 2010, the vast majority of rate increases were over the proposed 10% threshold. However, in some states recent filings reflect less than 10%.
- Reporting via a web-based program including automated collection techniques would be best to minimize the information collection burden on the affected public.

Due Process

There is no due process specified in the proposed regulation for an affected party to challenge a determination made by HHS as to whether or not a rate increase is unreasonable, for a state to challenge a determination made by HHS that its rate review program is not effective, or for a state to challenge a state-specific threshold. Generally, entities affected by a state agency's determinations or findings have a due process right to challenge such findings. We therefore suggest that the proposed regulation provide a mechanism for affected parties to ask for reconsideration or to appeal HHS's determinations through an administrative process (and not be forced to appeal agency determinations to federal court).

Large Group Rate Increases

HHS has solicited comments on "Whether, in the future, if rate increases in the large group market were subject to a review process under section 2794, if that process should differ from the process provided for in this proposed regulation for the individual and small group markets". The NAIC appreciates and strongly supports the decision by HHS to exclude large group from this proposed regulation, because large group rating differs significantly from individual and small group rating. This business is experience rated because the number of insured lives makes each group at least partially credible for rating purposes. This type of rating plan is not amenable to evaluation on the basis of percentage increases, so a different process will be necessary if a future regulation addresses large group rates. A large majority of states do not regulate large group rates. If HHS decides to develop a review process for large group rates in the future, some important considerations include:

- Greater emphasis should be placed on the credibility of the experience used in the experience-rated coverage.
- Groups as small as 51 employees are considered large employers and yet these groups are not really large enough to self-fund or have fully experience rated plans. To the extent that large group rates are subject to review, at a minimum, consideration should be given to the size of the group and the degree to which the group is experience rated.
- Current rules for the individual and small group markets would need to be modified to accommodate the large group market. Until the final format of the disclosures is published, it is difficult to suggest modifications for the large group market.

Other Factors Impacting the Reasonableness of Rates

HHS has solicited comments on "Other factors potentially impacting the reasonableness of a rate, including the structure and competitiveness of the market." Currently, it is deferred to each state to use any applicable standards set forth in statute or regulation for determining whether a rate increase subject to review is unreasonable. Many states have effective review. This HHS regulation should complement that review process, not override it. That said, the following factors should be considered with the understanding that this is not an exhaustive list and states must have flexibility in applying such factors, as state regulators are best qualified to judge which factors are germane to their particular state.

- Credibility/life years should be considered in reviewing the reasonableness of rate increases. Statistical fluctuation in the claims experience for small blocks can be significant and must be considered. Note that credibility was considered to some extent in the medical loss ratio rebate calculation in 45 CFR Part 158, and should be considered for rating purposes as well, although a smaller volume is needed to be credible for rating purposes than for rebate determinations.
- Because of the extremely high cost of health care in some states, many individual insurance plans sold in these states are high deductible plans. Factors that should be considered with respect to high deductible plans:
    - Statistical fluctuation: As discussed in the *Patient Protection and Affordable Care Act Medical Loss Ratio Model Regulation* (#190), as submitted by the NAIC concerning the medical loss ratio rebate credibility factors, these plans experience greater variability because high-cost claims are a larger portion of the total claims.

- Deductible leveraging: As the cost of health care increases, the value of the "high" deductible becomes smaller and therefore higher rate increases may be needed on these plans.

- When Medicare/Medicaid reimbursement rates change and do not reflect the cost of health care in a state, the reimbursement rates for private insurance plans are impacted.
- Changes in the health care system, such as loss of providers in a market, decrease competition and increase reimbursement levels.
- As HHS suggested, HHS should consider the degree of competition in the market in making its determination, in addition to the factors already listed in the proposed regulation.

Sincerely,

Susan E. Voss
NAIC President
Iowa Insurance Commissioner

Kevin M. McCarty
NAIC President-Elect
Florida Insurance Commissioner

James J. Donelon
NAIC Vice President
Louisiana Insurance Commissioner

Michael T. McRaith
NAIC Secretary-Treasurer
Illinois Director of Insurance

Sandy Praeger
NAIC Health Insurance & Managed Care
Committee Chair
Kansas Insurance Commissioner

BlueCross BlueShield Association

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February 22, 2011

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services

Attention: OCIIO-9999-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Re: Comments on Rate Increase Disclosure and Review Proposed Rule

Dear Secretary Sebelius:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Department of Health and Human Services ("HHS") regarding the Notice of Proposed Rule Making ("NPRM") for "Rate Increase Disclosure and Review" issued in the Federal Register on December 23, 2010. 75 Fed. Reg. 81004.

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to nearly 98 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

While the NPRM seeks to provide deference to states in determining "unreasonable" health insurance rate increases, the proposed rule takes unprecedented steps to involve the federal government into what has long been a state process. Under the NPRM, the federal government:

- Defines the rate review process states must follow in order to be deemed "effective" and avoid the federal government becoming the default regulator;
- Adopts a one-size-fits-all threshold that triggers review of rate increases at the state and federal levels;
- Requires reporting to the federal government of all premiums exceeding the federal threshold -- even in states with "effective" review programs; and

- Establishes federal rate review for those states the federal government determines do not have an "effective" process.

Under the statute, HHS is to work "in conjunction" with the states – HHS is not required to supplant state rate review regulations – as the preamble to the NPRM recognizes. 75 Fed. Reg. at 81005. However, it is difficult to reconcile that statement with the regulation's mandates regarding the processes by which states must review rates. States have experience and expertise with issuers in their state; they understand the challenges in their insurance markets; they understand their unique regulatory environments; they have direct contact with the issuers, providers and consumers in their states and are best positioned to determine the processes for rate review in their state.

Furthermore, the NPRM does not take into account all the other major requirements in the ACA that regulate health insurance premiums. Most notably, the new federal medical loss ratio (MLR) rule sets strict standards for how premium dollars are spent so that consumers are assured that no more than 15 to 20 percent of premiums are allocated to administrative expenses, contributions to reserves and profits. To our knowledge, no other industry has such a federal standard. In addition, the new insurance rules requiring guarantee issue – including an exchange which facilitates shopping, and an annual open enrollment period - create a market place where a consumer can easily move if they feel their current issuer does not deliver the best value.

Finally, in 2014 the 10 percent threshold set out in the NPRM is likely to trigger reporting and review of most, if not all, premium increases as numerous new requirements go into place. This includes the new essential health benefits, the health insurance excise tax, new rating rules and the guarantee issue requirements, all of which will impact rates.

We offer the following major recommendations for your consideration.

1. Change the effective date for the NPRM to be July 1, 2012 so states have time to understand the requirements in the regulation once it is issued, implement the necessary regulatory and legislative changes to have an effective rate review process, and avoid the federal government becoming the default regulator;

2. Revise the NPRM so that states with an effective review process decide which rates are unreasonable and only report those unreasonable rates to HHS;

3. Amend the criteria for states to be deemed to have an effective rate review processes to provide flexibility for states to determine what is best for their residents;

4. Modify the federal one-size-fits-all threshold for rate review to reflect the interaction with the MLR provision, the current rate increases occurring in the marketplace and to reduce the excessive administrative burdens on regulators and issuers in states without an effective rate review program;

5. Ensure the form for reporting rate increases under the NPRM is meaningful to consumers and reflects the current reporting practices in the majority of the states; and

6. Maintain the decision in the NPRM to exempt the large group market from rate review.

BCBSA's detailed comments on these issues are set forth below.

I. Change the effective date for the NPRM to be July 1, 2012 so states have time to understand the requirements in the regulation once it is issued, implement the necessary regulatory and legislative changes to have an effective rate review process, and avoid the federal government becoming the default regulator.

Proposed Rule: The NPRM goes into effect for rate increases filed in a state on or after July 1, 2011, or effective on or after July 1, 2011 in a state that does not require rate increases to be filed. 45 C.F.R. §§154.200(a)(1) & 154.220.

Issue: As noted earlier, the vast majority of states do not require the level of detail outlined in the NPRM for an "effective rate review process." Once the NPRM is finalized, states will need adequate time to modify their processes. This includes changing any regulations and/or issuing insurance department bulletins with the new filing requirements and properly training regulatory personnel. Following that, issuers will need time to implement the new requirements in their rate filing processes.

This assumes that states can modify the new requirements without changes in state law. If states do need to modify their laws, many states will not be able to make changes until 2012 due to legislatures being out of session prior to issuance of the final regulation. States should be given a reasonable opportunity to meet HHS's standards.

We believe that only a few, if any states will be considered "effective" in both the individual and small group market on July 1, 2011. As a result, in a few short months, HHS will be required to review countless individual and small group product rate increases from across the entire country. Not only does this put an untenable burden on HHS, but it unfairly and unnecessarily undercuts states' regulatory authority and is at complete odds with HHS's announced intention to defer to state authority in this area.

Recommendation: Make the rate review program effective for rates filed on or after July 1, 2012. This will give states time to make the necessary changes to their rate filing processes and provide adequate notice to issuers.

In states that cannot implement the new requirements without changes in law, HHS should consider deeming existing filing requirements as "effective" states for the first two years after the regulation becomes effective. This will allow states time to make the necessary changes in law so that their insurance department can be considered to have an effective rate review process.

II. Revise the NPRM so that states with an effective review process decide which rates are unreasonable and only report those unreasonable rates to HHS.

Proposed Rule: Under the proposed regulation, a state with an effective review program will review rate increases of 10 percent or greater. The NPRM requires issuers to submit a preliminary justification for all proposed rate increases subject to review to an applicable state and to HHS. The format of the justification will be provided in forthcoming guidance. 45 C.F.R. §§154.200, 154.215, and 154.220.

Issue: While the NPRM generally defers to states on determination of whether a rate increase is unreasonable, BCBSA is concerned that the NPRM requires substantial federal involvement even in states that have effective review processes. By requiring a federal threshold that could make the majority of rate increases in the individual market subject to additional review, the NPRM adopts an approach that is inconsistent with the deference granted to states elsewhere in the ACA, ignores the local market conditions that drive rate increases, and will place an unnecessary and costly burden on issuers, states and the federal government.

State insurance departments have unparalleled experience in regulating health insurance within their jurisdictions and understand the unique concerns of their residents. According to HHS, 43 states currently have rate review processes in either the individual or small group markets, or both. 75 Fed. Reg. at 81011, 81012. In addition, the ACA provided $250 million to support states' efforts to enhance their premium rate review process and 45 states and the District of Columbia have received grants of $1 million each for that purpose.

State regulators have experience with the state's providers and understand the challenges and market dynamics faced by the physicians, hospitals and other healthcare professionals in that state. Knowledge of the provider marketplace and the state specific regulatory environment help inform a state regulator's judgment as to which rate increases should be subject to additional review.

State rate review makes sense because insurance markets and premiums are local. Premiums are based on local provider costs and utilization patterns. State-specific insurance market rules (e.g., guaranteed issue, community rating, and mandated benefits) also impact premium rates. It is unlikely that the federal government could stay abreast of these factors in all 50 states.

In addition, the need for states to be able to design their own thresholds for review is exemplified by states that do not allow rating factors like age that HHS agreed in the regulation preamble should not count towards the threshold. Reasonable thresholds need to vary by state to account for variations in the rating practices in those states. For example, community rated states include the aging impacts in the overall rate increase because the rating structure does not allow member-level differentiation by age. As such, as the population ages the average rate increases in such situations would be appropriately higher on average than states that allow age as a rating factor.

Recommendation: We recommend that States with an effective rate review process determine which rate increases are subject to review under the requirements of the NPRM. We also recommend that the information required to be reported under the NPRM would be submitted to HHS only in instances where a state determines that a rate increase is unreasonable.

III. Amend the criteria for states to be deemed to have an effective rate review process to allow flexibility for states to determine what is best for their residents.

Proposed Rule: HHS proposes to evaluate a state's review process in several general categories, including whether the state receives sufficient data and documentation to review an issuer's rates and whether the state conducts a timely and effective review. 45 C.F.R. § 154.301(a)(1) & (2). The regulation also requires that the state examine:

1) the reasonableness of the assumption used to develop the rate increase;
2) the data related to past and actual experience;

3) an analysis of the impact of medical trend changes by major service categories;
4) an analysis of the impact of utilization trend changes by major service categories;
5) an analysis of the impact of cost-sharing changes by major service categories;
6) an analysis of the impact of benefit changes;
7) an analysis of any overestimate or underestimate of medical trend for prior year period related to the rate increase;
8) an analysis of the impact of changes in reserve needs;
9) an analysis of the impact of changes in administrative costs related to programs that improve health quality;
10) an analysis of the impact of changes in other administrative costs;
11) an analysis of the impact of changes in applicable taxes, licensing or regulatory fees;
12) an analysis of medical loss ratios; and
13) an analysis of risk-based capital status relative to national standards.

45 C.F.R. § 154.301(a)(3) & (4). And the state's rate review determination must also be made pursuant to a State regulation or statute. 45 C.F.R. § 154.301(a)(5).

Issue: While BCBSA supports HHS's decision to rely on state rate review processes, the extensive list of information that a state must review effectively requires states to adopt federal review standards and processes. This approach is too prescriptive and does not give states the needed flexibility to implement the ACA in a manner that best serves their residents.

Many states have reviewed rate increases for decades and understand the unique concerns of their residents. For example, the challenges of a rural state in regulating individual health insurance are likely to be profoundly different than the challenges of regulating individual health insurance in a densely populated state. These reviews are performed by experienced state regulators, who are held accountable to their governors, commissioners and communities at the local level and work diligently on behalf of consumer interests. Adding any additional requirements to the rate review process is not necessary in light of the new medical loss ratio requirements and well established state practices for reviewing rates.

Given the proposed effective date for the NPRM, many states will likely not be able to modify their rate review processes to meet these exhaustive criteria. This could result in the federal government becoming the primary rate reviewer and supplanting a traditional state role which is not the stated intention in the NPRM's preamble or the law.

HHS's requirement to examine risk-based capital (RBC) status is especially problematic for the following reasons:

- A "national standard" does not exist and would be inappropriate for evaluating every issuer. A for-profit issuer can hold lower surplus levels than non-investor owned companies as they can issue additional stock to raise capital. Non-investor owned companies need to maintain additional reserves because they do not have access to the capital markets and cannot raise funds on an as-needed basis for such things as information systems and to reinvest in their businesses. Historical risk margins are likely to be compressed by the rebate formula which could limit the ability of non-investor owned companies to maintain safe capital levels. In addition, since non-investor owned plans typically operate in a single state or only a few states, they may need to hold proportionately more capital than a national or multi-state issuer due to less diversification of risk. The end result is to add uncertainty and increase margin of error in management of capital levels for non-investor owned companies.

- RBC is a measure used by regulators solely to determine if an issuer is solvent or in a weak condition. The 2010 RBC instructions published by the NAIC says that "Risk-based capital standards will be used by regulators to set in motion appropriate regulatory actions relating to issuers that show indications of weak or deteriorating conditions. It also provides an additional standard for minimum capital requirements that companies should meet to avoid being placed in rehabilitation or liquidation."

- The NAIC Risk-Based Capital (RBC) for Health Organizations Model Act specifically states in Section 8(F) that risk-based capital reports "shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance". In addition, the RBC formula is a retrospective formula based on industry-wide assumptions, not forward looking. By design, it does not incorporate such factors as the issuers company-specific business risks, future strategies, growth plans, or investment needs.

Recommendation: Rather than the extensive federal criteria for what a state must examine, HHS should rely on more general criteria when evaluating whether a state has an effective rate review program. We recommend that HHS eliminate the extensive criteria in 45 C.F.R. §154.310(4)(i) through §154.301(4)(xii). States have years of rate review experience and a detailed federal standard is overly prescriptive. We recommend that HHS use the remaining criteria in the NPRM and add an additional condition related to actuarial principles as follows:

1. The state receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination;

2. The state conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase;

3. The state's rate review process includes an examination of the reasonableness of the assumptions and the validity of the data used by the issuer to develop the proposed rate increase;

4. The state's determination is based on sound actuarial principles and rate increases that are actuarially justified, are found reasonable, and the determination is made in a timely manner; and

5. The state's determination of whether a rate increase is unreasonable is made under a standard that is set forth in state statute or regulation.

These criteria will protect consumers while allowing states to determine the best approach for their unique market. In addition, states can use the $250 million in federal funds that the health reform law makes available to states to ensure their processes meet these criteria in a manner that best serves their residents.

Instead of HHS reviewing every state's rate review processes, states should be able to self-certify that they meet the above criteria.

If HHS does not adopt our recommendations, we recommend that the RBC requirement be eliminated because it is not an appropriate measure and disadvantages not-for-profit issuers compared to for-profit competitors.

IV. Modify the federal one-size-fits-all threshold for rate review to reflect the interaction with the MLR provision, the current rate increases occurring in the marketplace and to reduce the excessive administrative burdens on regulators and issuers in states without an effective rate review program.

Proposed Rule: Under the proposed regulation, HHS will review rate increases over 10 percent. In establishing the 10 percent threshold, the NPRM preamble states that HHS "has balanced the need to set a standard that would effectively capture unreasonable increases, while avoiding unnecessary filing burdens for health insurance issuers with regard to increases that are likely to be reasonable." 75 Fed. Reg. at 81010 and 45 C.F.R. §154.200.

Issue: Under the proposed regulation, rate increases that are 10 percent or greater are subject to the additional filing, review and reporting requirements of the NPRM. We believe this threshold is too low because it presumes, without substantiation, that the majority of health plans offering coverage in the individual and small group markets institute rate increases that are unreasonable.[1] In addition, in 2014 the 10 percent threshold set out in the NPRM is likely to trigger reporting and review of most, if not all, premium increases as numerous new requirements go into place. This includes the new essential health benefits, the health insurance excise tax and the guarantee issue requirements, all of which will impact rates.

It is important to create a threshold that recognizes that the ACA also has a transparent medical loss ratio (MLR) formula to ensure "that consumers receive value for their premium payments". In addition, this threshold should be market-based, as opposed to an arbitrary, fixed threshold that would subject most rate increases in a state to review for being "unreasonable." A market based threshold will ensure proper oversight of rate increases while minimizing administrative costs to both the reviewing entities and issuers.

In contrast, the NPRM over inclusively categorizes plans as "subject to review". This will (1) increase costs for consumers, as even plans with actuarially sound rates will be forced to participate in the intrusive and expensive review process; (2) confuse consumers by labeling the rate increases for the majority of available plans as potentially unreasonable; and (3) burden both state and federal agencies with an excessive, costly review requirement.

Importantly, the arbitrary threshold in the NPRM is not required by the statute. The statute only requires a process for reporting unreasonable rate increases. Thus, HHS has authority to require an alternative that would better balance the objectives of reviewing unreasonable rates and minimizing the burden of review on health plans, states and the federal government.

Recommendation: As noted earlier, states that have an effective review process should determine which rate filings to review and then report to HHS only if found unreasonable. In states without an effective rate review program, a review threshold should be based on two conditions:

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[1] HHS acknowledges that "the majority of increases in the individual market exceeded 10 percent each year for the past 3 years."

1. The issuer failed to meet market segment medical loss ratio (MLR) for all products combined in the state in the prior year; AND
2. The issuers average rate increase for a given market segment is 50% above the member weighted average in the state in the prior year (e.g., if the average rate increase was 7%, this threshold would be 10.5%).

Rates that exceed this review threshold should be reviewed by a health actuary that is a member of the American Academy of Actuaries to determine whether the rates are unreasonable and that they are actuarially sound.

V. Ensure the form for reporting rate increases under the NPRM is meaningful to consumers and reflects the current reporting practices in the majority of the states.

Proposed Rule: Requires issuers to submit a preliminary justification for all proposed rate increases subject to review to an applicable state and to HHS. (The format of the justification will be provided in forthcoming guidance.) The preliminary justification will consist of three parts: (1) Rate Increase Summary; (2) Written Description; and (3) Rate Filing Documentation – which would only be required in cases where a state does not have an effective review program. 45 C.F.R. §154.215.

Issue: The form for reporting rate increases that was developed by the NAIC is currently under consideration at HHS. BCBSA is concerned that the form submitted by the NAIC would not provide meaningful information for consumers, is administratively challenging to produce, and exceeds what is needed for rate review. This is especially true because the NAIC form requires information to be broken out in several new categories for medical trend and on a monthly basis.

Our analysis indicates that only two states require information to be broken out into categories beyond the four that are typically used by issuers for analysis: inpatient, outpatient facility, professional and outpatient pharmacy. And the vast majority of states historically have not required any breakout of claims and trend information by place of treatment. In addition, most states have required claims information to be presented by twelve month periods to improve the credibility and remove the effect of seasonality.

Making issuers present the data at too granular of a level will not produce useful information related to the rate review while requiring health plans to spend administrative dollars that would be better spent elsewhere.

Recommendation: We recommend limiting trend reporting for place/type of treatment to the five categories that states are required to report as part of the rate review grants: inpatient, outpatient facility, professional, outpatient pharmacy and ancillary (imaging, laboratory, DME, etc.). Claims should be aggregated for 12-month periods instead of monthly to improve credibility and reduce the effect of seasonality. To provide additional information on cost drivers, the health plan could provide a brief explanation of major drivers of increased cost the plan is observing across its broader block of business in each category, where material (i.e. imaging in the professional setting).

Once the final guidance and forms are released, we recommend that sufficient time is given to clarify all terms, and that there is an understanding that there will be a learning period as issuers, HHS, and state insurance departments learn how to implement all of these new

requirements. This will also allow time for issuers to modify data warehouses to sort the data in the manner required to complete the preliminary justification.

VI. Maintain the decision in the NPRM to exempt the large group market from rate review.

Proposed Rule: Requirements apply to the individual market and small group market. 45 C.F.R. §154.103.

Issue: The NPRM seeks comments on whether the rate review process should be different for the large group market. As drafted, the NPRM does not apply rate review to large groups in recognition of their more sophisticated purchasing capabilities and greater leverage with insurers. The vast majority of states recognize this by not imposing rate review requirements on large group policies.

Recommendation: Maintain the decision in the proposed regulation to not review rates for the large group market. If HHS contemplates including the large group market in this process at some point in the future, HHS should consult with all stakeholders in a transparent process, including large employers and their benefit consultants, to determine if rate review is needed and what process would best suit this market.

VII. Additional recommendations

In additional to the above issues, BCBSA recommends the following changes, clarifications and technical changes to the NPRM.

Definitions of Individual Market and Small Group Market 45 C.F.R. §154.102

Proposed Rule: The regulation proposes to adopt state rate filing definitions of the individual and small group markets. In cases where a state rate filing law does not define the individual market, the individual market would be defined in accordance with the PHSA. In cases where a state rate filing law does not define the small group market, the small group market would be defined in accordance with section 2791(e)(4) of the PHSA; however, for the purpose of this definition, "50" employees is substituted for "100" employees in the definition of a small employer.

Issue: We strongly support HHS's deference to state definitions in this area. However, the definition as written is ambiguous as to who will regulate certain product filings in the individual and/or small group markets.

In the individual market, several issuers offer their coverage through "out-of-state" associations or group trust in many states. In this situation, a "group" policy is issued in one state and then certificates are issued to consumers that live in other states. Since many state laws that govern rate review in the individual market only apply to health insurance policies issued in the state, some state's rate review laws may not apply to these types of coverage.

Another situation that impacts both the individual and small group market is states that review rates for some issuers and not others. Some states' rate review laws only apply to Blue Cross Blue Shield plans and/or HMOs. Because of this, other plans selling in these states are not subject to rate review.

Recommendation: Regardless of state definitions, all products in the individual and small group markets (as defined by the PHSA) whose proposed rate increases meet the threshold for review should be reviewed by either the state or HHS. We recommend that HHS clarify the language in the NPRM so that it is clear that HHS will review any individual or small group rate increase that meets the criteria for review that is not subject to review by a state, including in states that review rates for some issuers and not others.

We also recommend that HHS add language to make it clear that the rate disclosure and review requirements are uniformly enforced in compliance with Section 1252 of the ACA. Section 1252 requires Title I reforms to be applied uniformly to all health insurance issuers and group health plans within a state. Section 1252 applies to standards or requirements adopted by states pursuant to the ACA and any state standards or requirements that may be different than the ACA as long as there is a relationship between the different standards or requirements. For example, if state standards are more comprehensive than the ACA standards, all carriers in such states would be subject to those standards as required by Section 1252. This will ensure that all health insurance issuers are regulated equally, all consumers are protected equally regardless of which issuer they purchase coverage from, and will promote competition and affordable coverage.

Public Disclosure of Confidential and Proprietary Information 45 C.F.R. §154.215

Proposed Rule: The NPRM requires a health insurance issuer to submit a preliminary justification for each rate increase that meets the threshold for review. 45 C.F.R. § 154.215(a). The preliminary justification must include a rate increase summary and a written description justifying the rate increase. 45 C.F.R. § 154.215(b). Both the rate increase summary and the written justification must contain detailed information including historical and projected claims experience; historical and projected expenses and loss ratios, utilization trends and service or unit costs; and employee and executive compensation data from the health insurance issuer's annual financial statements. 45 C.F.R. § 154.215(e) & (f). HHS proposes to publicly disclose all of this information. 45 C.F.R. § 154.215(i).

In addition, issuers must file detailed documentation if HHS is determining whether a rate increase is reasonable. HHS intends to disclose "any information contained in the rate filing documentation of the preliminary justification that is not designated as 'confidential' as defined in HHS's Freedom of Information Act [FOIA] regulations." 45 C.F.R. § 215(i)(2)(i). Further, for any information that is designated confidential, HHS intends to review the information to determine if it is in fact confidential under FOIA.

Issue: BCBSA is concerned that the proposed requirement to produce the volume of sensitive, proprietary and confidential data is beyond the scope of the statute which does not contain a sweeping new federal disclosure requirement. We are also concerned about the usefulness of this data to consumers.

Even the most sophisticated consumers are unlikely to find information like "the projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated" meaningful in their search for health insurance coverage. 45 C.F.R. § 215(g)(viii). Even if they did, they would be unlikely to have the knowledge to be able to assess the reasonableness of the assumptions that were made that underlie the projections and trends. Only competitors and providers will find this information valuable, because it could reveal confidential and proprietary information. Forced disclosure of trade secrets and proprietary

company information will only help competitors selectively target markets to their advantage and will actually reduce competition.

Recommendation: BCBSA strongly urges HHS to reconsider publicly disclosing the information required under the proposed regulation, particularly the information required under the rate filing documentation. Disclosure will not assist consumers in purchasing decisions but has the very real potential of reducing competition between insurers and providers which runs counter to the goals of the ACA and consumer interests.

Unreasonable Rate Increases When HHS Reviews a Rate Increase 45 C.F.R. §154.205

Proposed Rule: Where HHS conducts the review, the standard for unreasonable would be whether the rate increase is "excessive," "unjustified," or "unfairly discriminatory."

Issue: Generally, many state rate review statutes include principles that prohibit rate increases that are excessive, unjustified, unfairly discriminatory or inadequate. In the regulation, HHS does not recognize the principle of inadequate rates and that an appropriate premium must be charged in order for an issuer to pay expected medical claims for the future.

Inadequate rates can also be discriminatory if the product is not self-supporting with the rate increase and requires significant cross subsidization from other products or markets. This forces consumers enrolled in one product or market segment to subsidize the cost of coverage from another product or market segment.

Recommendation: HHS should recognize the principle that rates must be adequate in order to pay for expected medical claims. HHS should revise the NPRM to clarify that forced cross subsidization across products or market segments could be discriminatory. In addition, these requirements should also be applied to rate increases that are subject to state rate review.

Definition of Product 45 C.F.R. §§154.102 & 154.215(d)

Proposed Rule: The NPRM proposes to allow issuers to file rate review increases based on "products." 45 C.F.R. § 154.215(a). "Product" is defined as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a state." 45 C.F.R. § 154.102. The issuer can combine the claims experience for multiple products as long as the rate increase is the same across all products. 45 C.F.R. § 154.215(d).

Issue: This definition would require issuers to submit rate review filings for rate increases subject to the NPRM differently than issuers submit rate review filings with the various states. Having two different levels of aggregation in rate review filings is confusing and inefficient. In some instances, HHS's requirements may conflict with state law.

Examples of requirements in state laws include:

- Some states require all products to be filed together in a common filing, but allow the issuer to vary the rate increases by product;
- Some states require that open and closed blocks of business be bundled for rate filing purposes, but allow the rate increases to vary by product. Under the proposed regulation, grandfathered plans are not subject to rate review; as a result, under the

regulation, closed grandfathered business would not be reviewed under federal standards, but would be required to be filed as a single rate in a state; and

- Some states allow issuers to combine products in rate filings, but once combined they must be filed this way in the future.

Differing requirements imposes unnecessary costs on issuers and could create confusion for consumers. These issues can be avoided by deferring to state aggregation/filing rules and allowing rate increases to vary in the same product filing.

In addition, the experience for various products differs and issuers should be allowed to vary rate increases based on this experience without having to do a separate filing for rate increases subject to review under the NPRM. A common example is that products with higher deductibles will have a higher trend due to deductible leveraging.

Finally, the NPRM appears to allow rate increases for the same "product" to vary for different cost sharing options; however, the language does not expressly state this.

Recommendation: We recommend that in states with an effective rate review program, HHS allow issuers to file rates in the manner required by state law. Issuers would not have to adjust their state rate filing which will help to avoid confusion for consumers and minimize administrative costs. We recommend that for states without an effective review program, HHS clarify that issuers may report "products" with a discrete set of benefits and underlying rating structure.

We also recommend that HHS allow issuers to implement different increases within a "product" by policy/plan if the experience or the actuarial value of the benefit differences dictates different increases are appropriate. Issuers would then average the increases in those product options to determine whether the increase meets the threshold for review. To avoid gaming, HHS could prohibit an issuer from disaggregating product options from a filing once they have been combined, as is done in many states today.

If HHS does not adopt our recommendation to allow aggregation as permitted or required under state law, it should clarify the definition of "product" and the rules under which issuers may aggregate "products", including allowing rate increases to vary by product and cost sharing level.

Definition of Rate Increase 45 C.F.R. §154.102

Proposed Rule: The NPRM preamble states that while section 2794 of the PHSA refers to premiums, HHS has interpreted this as referring to a "rate increase" that alters the underlying rate structure for a policy. HHS notes that this is more consistent with how these terms are commonly used by state regulators and the insurance industry. 75 Fed. Reg. at 81009. For example, according to the preamble, rate increases do not include premium changes that are attributable to age, in policies that are age rated, because those changes do not change the underlying rate structure. *Id.*

Issue: The NPRM preamble clearly outlines that a "premium" is "the final amount charged to a specific insured," but it is the underlying rate and actuarial methods used that are subject to review by states that have review programs in place. Rates are established by projecting future claims costs and the premium needed to pay future claims and non-claims expenses for a particular insurance product. BCBSA agrees that a meaningful review should focus on changes

in the underlying rate structure and the actuarial methods used to arrive at the rate. Changes in premiums due to generally accepted rating practices should not be subjected to review.

In addition, several factors that could lead to a change in the rate are out of the control of issuers such as mandated benefits or new taxes.

Recommendation: BCBSA recommends that the "rate increase" definition in the NPRM more specifically reflect the distinction acknowledged in the preamble. A "rate increase" should only reflect changes in the underlying rate structure. Changes in premiums due to generally accepted rating variables in the issuer's rate table/manual should not be subjected to review. In addition, amounts imposed outside of an issuer's control, such as changes in federal and state taxes, assessments or fees, the cost of mandates or government imposed changes in rating structure should not be considered part of the rate increase for the purpose of rate review.

HHS Consideration of Projected MLR When Determining Excessive Rate Increases 45 C.F.R. §154.205(b)(1)

Proposed Rule: HHS will determine that a rate increase is "excessive" if the premium charged for the coverage is unreasonably high in relation to the benefits provided. The NPRM says HHS would consider projected medical loss ratio (MLR) as one measure to consider when making this determination (i.e., whether the proposed rate increase would result in a projected future loss ratio below the 80% MLR standard for the individual and small group markets). However, the NPRM notes that if the projected MLR for an individual market product were below 80%, the proposed increase would not necessarily be considered excessive, so long as the aggregate MLR for all products in the market were at or above the 80% standard.

Issue: A specific product may have a higher or lower MLR due to several factors that are reasonable. For example, high deductible health plans would naturally have a lower MLR given that administrative costs are a greater percent of the premium. Other factors such as demographics of the enrollees and risk mix could also lead to a reasonable MLR that is below the applicable 80% or 85% standard. The MLR Interim Final Regulation only requires that the aggregate medical loss ratio for all products in a market segment meet the applicable standard.

Also, it is unclear how HHS defines "projected future loss ratio" and if it applies to the upcoming calendar year, rating period or lifetime of the product.

Recommendation: A product's rate increase should not be deemed as excessive solely on the condition that it does not target the MLR standard for the reasons discussed above. In addition, if the product filing targets and meets the MLR standard, then the product should be given a safe-harbor and be deemed as reasonable as long as the assumptions in the rate filing are actuarially justified.

BCBSA also recommends that HHS clarify the definition of "projected future loss ratio."

States to Inform HHS of Determination within Five Days 45 C.F.R. §154.210

Proposed Rule: The proposed regulation would require states to inform HHS within 5 days of its determination of whether a rate is unreasonable.

Issue: The regulation implies that if a state fails to inform HHS within 5 days of a decision, HHS will review that rate. 45 C.F.R. § 154.210 (a) & (b)(2). HHS should attempt, wherever possible, to support a state's rate review process, rather than supplanting a state's review process.

In addition, the NPRM makes no reference to the state notifying the issuer of this determination. Issuers may be waiting until a final determination is made as to a rate increase being reasonable before implementing an increase. And the issuer may want to adjust the rate increase if the proposed increase is going to be labeled as unreasonable. To facilitate timely implementation, a state should be allowed and required to notify the issuer of their determination on or before notifying HHS.

Recommendation: We expect that states will inform HHS of unreasonable rates in a timely manner. In states with an effective review program, we recommend that HHS shall assume the rate is reasonable until a state informs HHS that it is unreasonable.

In addition, states should be required to notify the issuer of the determination on or before notifying HHS.

Timelines for Rate Review By HHS 45 C.F.R. §§154.210 & 154.225

Proposed Rule: The regulation proposes that states with an effective review program will review rates. In states without an effective review program, HHS will review rates.

Issue: The regulation fails to propose any timeframe by which HHS will make a decision when it is reviewing the rate increase. As a result, the regulation does not provide an issuer with an expected timeframe under which they could expect a determination. Absent an expected timeframe, issuers cannot plan when to file a rate increase if they would like a determination of reasonableness prior to implementation. Implementing a rate increase is a complex process that requires notifying consumers and brokers of the new rates as well as programming the billing, sales and customer service systems.

Another issue is if a state does not have an "effective" rate review process under the regulation, HHS will review rates in that state. However, despite HHS's determination that the state's process is not "effective," state laws, regulations and processes will continue. As a result, it is possible that HHS will be reviewing rate increases that *have already been reviewed* in that state. If HHS determines that a rate is unreasonable after state review and the rate goes into effect, HHS's "unreasonable" label will undermine the very state laws that exist to protect consumers and prevent unreasonable rate increases. A process that could label a rate increase as "unreasonable," even when that rate is permissible under state law will frustrate states, consumers and issuers.

Recommendation: In cases where a state does not have an effective review program, we recommend a review process that relies on an independent actuary under contract with HHS and includes a timeframe by which HHS will make a determination so that issuers can plan their filings accordingly. We recommend that HHS review and make a determination on the rate no later than 30 days after the receipt of the rate review filing, but in no case less than 60 days before the rate will be effective assuming the rate increase is received 90 days in advance of the effective date.

Areas of Communication Ambiguity Between HHS, States and Issuers 45 C.F.R. §154.225

Proposed Rule: If a state determines that the rate increase is unreasonable and the issuer is legally permitted to implement the unreasonable rate increase, HHS will provide the state's final determination and brief explanation to the issuer within 5 business days following HHS's receipt of such determination. Where HHS makes a determination, it must prepare a final determination and a brief explanation of its analysis and post this information on the HHS website within 5 business days of making its final determination. If HHS determines that the increase is unreasonable, it also must provide its final determination and brief explanation to the issuer within 5 business days of making its final determination.

Issue: The NPRM has several areas of communication ambiguity which creates uncertainty for issuers. First, there is no timeline for when HHS must communicate determinations that rates are "reasonable." Second, the communication from the state appears to go through HHS prior to being communicated to the issuer by HHS. This process puts HHS in the middle of communication between state regulators and issuers which is inconsistent with the state-level regulatory framework. These communication gaps create inefficiencies and additional administrative burdens that can be easily avoided.

Recommendation: Once HHS determines that a rate increase is reasonable through an independent actuary, it should notify the issuer within five days. Correspondingly, if a state determines that a rate increase is reasonable or unreasonable, it should notify the issuer at the same time or prior to notifying HHS. If the rate review process has a predictable schedule, it will be more efficient and more responsive to consumers.

States Required to Provide Explanation of Determination to HHS 45 C.F.R. §154.210

Proposed Rule: The NPRM requires states with an effective review program to provide an explanation of how its analysis of a rate increase caused it to arrive at its determination of reasonableness.

Issue: The statute requires only that issuers justify unreasonable rate increases. It does not require states to justify their determination to HHS that a rate increase is reasonable or unreasonable. We do not believe that HHS has the resources or the specific state-level expertise to oversee the decisions of states' Departments of Insurance.

Recommendation: The state's decisions should not be subject to further review by HHS. While we recommend that states self-certify that they have an effective process, unless this change is adopted HHS will have already reviewed a state's review process when making its determination that a state's review is effective. Accordingly, we recommend that the regulation be revised to omit these requirements on states. States should only be required to report information about rate increases that have been determined to be unreasonable.

Disclaimer Language 45 C.F.R. §154.215

HHS Request for Comments: HHS solicited comments on the wording of the disclaimer.

Issue: HHS recognizes that under the NPRM a "range of proposed rate increases [will be reviewed], some of which ultimately would be determined to be unreasonable, *while others would not*." 75 Fed. Reg. at 81010 (emphasis added). The regulation, through its preliminary justification requirement, requires issuers to justify increases that are not yet—and may never be—considered unreasonable.

We believe that this "preliminary justification" requirement will increase issuer costs without providing additional value to consumers. This will also confuse consumers because products with rate increases that are not unreasonable are required to be posted on the HHS web site. Notwithstanding HHS's proposed disclaimer, the effect of posting the preliminary justification will be to signal to consumers that this rate is presumptively unreasonable.

Recommendation: We recommend that preliminary justification not be posted to the HHS website. If this ultimately is required we suggest that HHS revise the disclaimer as follows: "The preliminary justification is the initial summary information regarding the rate increase subject to review. Requiring this information in no way indicates that this rate increase is considered 'unreasonable'. Information regarding the claims utilization in relation to the premium that is being proposed is being reviewed to determine the appropriateness of this increase."

Additional Requirements to Effective Rate Review Programs 45 C.F.R. §154.301

HHS Request for Comments: HHS solicited public comment on whether the public's ability to comment on unreasonable rate increases during the review process should be considered as a criterion for an effective rate review program.

Issue: Any additional requirements should carefully weigh the additional administrative costs against the protections already in place to protect consumer interests. For example, a rate review process that provides for a 90 day notice period and public hearings could take five to six months to complete. Such a process would be a significant undertaking by state regulators who already review these rate increases.

Finally, insurance companies need rate approvals with adequate time before they take effect in order to notify consumers and brokers as well as to program their billing, sales and customer service systems. While some may believe there are short term benefits for consumers, this regulatory approach often proves counter-productive over the long-term as delays in rate increases result in larger rate increases later on.

Finally, given the MLR requirements that are also a component of ACA, rate increases are not a function of an insurer charging excessive rates. Rather, they are a reflection of increases in the underlying medical prices, changes in utilization and changes in technology. Rate hearings only focus on issuers without highlighting the role of other stakeholders (e.g., medical device companies, pharmaceutical manufacturers, physicians and hospitals) and the increasing prevalence of chronic disease (e.g., obesity rates). This will only frustrate and mislead consumers without fully addressing the underlying cost drivers of rate increases.

Recommendation: We urge HHS to allow states to make their own decisions about which rate review policies are in the best interests of their residents. State regulators are most

knowledgeable of their local communities and circumstances and states are in the best position to weigh important trade-offs between various rate review policies.

Structure and Competitiveness of a Market 75 Fed. Reg. at 81009

HHS Request for Comment: HHS specifically solicited public comment regarding other factors that should be considered in determining whether a rate increase is unreasonable, noting that factors other than those addressed in the NPRM may impact the reasonableness of a rate, such as the structure and competitiveness of a market.

Issue: Issuers do not control the regulatory structure of the market. Issuers remaining in a regulated market that has led to fewer issuers should not have necessary rate increases denied because of the regulatory structure. Such an approach could have the unintended consequences of the particular market having even less competition as issuers exit due to insufficient rates.

Recommendation: HHS should not consider structure and competitiveness of the market when determining whether a rate increase is unreasonable. States are in the best position to determine the health of their state market and HHS should not attempt to displace state regulatory expertise and authority in that area. Instead, the final regulation should continue to rely on state law standards and not impose a federal standard regarding the structure and/or competitiveness of the market.

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We appreciate your consideration of our comments on the NPRM. We look forward to continuing to work with HHS on implementation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com .

Sincerely,

Justine Handelman

Justine Handelman
Vice President
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