

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.

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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 considerations 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.

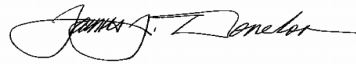
Sincerely,



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