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REPORT



## HHS Premium Rate Review Proposed Regulations: Implications for Health Insurance Issuers, Providers, and the Health Care Marketplace



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On Dec. 21, 2010, the United States Department of Health and Human Services (HHS) released for public comment much anticipated proposed regulations implementing Section 2794 of the Public Health Service Act (PHSA) which requires HHS to establish a process for the review of ''unreasonable'' health insurance premium rate increases in the individual and small group markets. The proposed regulations, which would apply to rate increases in the individual and small group markets filed or effective on or after July 1, 2011, set an initial threshold for mandatory review of any rate increase at or above 10 percent. The proposed regulations were published in a Notice of Proposed Rulemaking (NPRM) on Dec. 23, 2010, in the *Federal Register*, and public comments are due by 11:59 PM on Feb. 22.[1]

[1] HHS Notice of Proposed Rulemaking (NPRM), 75 Fed. Reg. 81,004 (Dec. 23, 2010). As limits on increases to health insurance premiums can have a cascading effect on providers

 ISSN 2154-8986

The proposed regulations would require health insurance issuers with rate increases meeting or exceeding this threshold for the individual and small group markets to submit to both HHS and to the applicable state a ''preliminary justification'' for the rate increase. This ''preliminary justification'' also would be publicly disclosed on HHS's website. Actual review of the proposed rate increase and a determination of whether the increase is ''unreasonable'' remains with state regulators where HHS has determined that the state has an ''effective rate review program.'' If the state does not have an HHS-deemed ''effective rate review program,'' then HHS conducts the review.

In any event, rate increases, and the data underlying them, deemed ''unreasonable'' by HHS and/or a state would be subject to public disclosure, and if implemented by the health insurance issuer, required public justification. HHS has no authority under the proposed regulations to disapprove—or require a state to disapprove—a rate that HHS determines to be ''unreasonable.''

That the proposed regulations are likely to have a significant impact on the health insurance industry is obvious. Not so obvious is the likely cascading effect that this new requirement on certain rate increases will have on the rest of the health care industry, including health care providers—hospitals, physicians, pharmaceutical companies, and medical device manufacturers—and the small businesses and individuals who purchase these insurance plans.

This is because HHS made the policy decision to implement Section 2794 primarily by requiring health insurance issuers to publicly disclose, document, and justify rate increases in certain market segments that exceed a particular threshold regardless of underlying factors for the rate increase—or as HHS has alternately characterized it, ''shining a light on 'premium increases' or 'insurance companies.' ''

Some observe that using this ''sentinel effect'' is a tempered approach that is consistent with HHS's limited statutory authority in this area. The proposed regulations already have been criticized by consumer advocates as toothless and ineffective,[2] and by free market advocates as improperly ''impos[ing] price controls on private insurance premiums.''[3] To the health insurance industry, this approach fails to address the underlying forces driving premium increases, like provider costs, increased coverage mandates, and volatile individual and small employer insurance markets.[4] The proposed regulations—at least on their face—do little to rationalize the inconsistent application of rate reviews by different state regulators.

The proposed regulations also beg the question of whether such extensive and intrusive disclosure requirements are necessary in light of new federal medical loss ratio (MLR) requirements which already mandate premium rebates to consumers by health insurance issuers who fail to spend a minimum percentage of premium revenue on medical expenses and defined activities that improve health care quality.[5]

This article summarizes the proposed regulations, assesses the proposed regulations in light of lessons learned from recent state rate review proceedings, analyzes the likely impact of the proposed regulations on health insurance issuers and other market participants, and raises questions that might be appropriate for market participants—health insurance issuers, providers, and employers—to address to HHS during the 60-day formal comment period.

Furthermore, all relevant stakeholders should be monitoring state legislative and state regulatory activities on this subject as states seek to complement and take into account these new federal proposed regulations.

## Summary of Proposed Regulations

**Applicability and Effective Date.** The proposed regulations would apply to non-grandfathered plans in the individual and small group markets, as those markets are defined by each specific state. Where such markets are not defined by a state, they are defined consistent with the PHSA, except that those groups referred to as ''small employers'' are capped at 50 employees. The proposed regulations will not apply to ''excepted'' benefit plans, such as separately issued dental or vision policies even if offered in the individual and small group market. The proposed regulations apply to health insurance premium rate increases filed or effective on

and manufacturers of covered benefits, as well as with vendors to health insurance issuers, all potential stakeholders should review these proposed regulations and consider filing comments.

[2] *See* Dec. 21, 2010, statement of Carmen Balber, director of Consumer Watchdog's Washington, D.C., office, *available at* http://www.consumerwatchdog.org/newsrelease/regulation-issued-hhs-today-should-require-insurers-justify-every-double-digit-health-in (''The new rules rely on public disclosure to shame insurance companies into charging consumers fairer prices, and this symbolic stoning may work to hold down increases in some cases. However, regulators must ultimately have the power to modify and deny premium increases in order to prevent insurers from imposing unreasonable premium increases on consumers'').

[3] *See Wall Street Journal* Editorial of Kathleen Sebelius, ''Price Controls,'' Dec. 22, 2010.

[4] *See* Dec. 21, 2010, statement of Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), *available at* http://www.ahip.org/content/pressrelease.aspx?docid=32380;

[5] PHSA § 2718 requires health insurance issuers in the individual and small group markets to spend 80 percent and large-group health insurance issuers to spend 85 percent of premium revenue on reimbursement for clinical services and activities that improve health care quality. Health insurance issuers that fail to meet the applicable percentage must provide a rebate to enrollees.

  HIR ISSN 2154-8986

or after July 1, 2011.[6] Consequently, it is likely that HHS intends to issue these proposed regulations as final regulations on or before this date.

**The proposed regulations—at least on their face—do little to rationalize the inconsistent application of rate reviews by different state regulators.**

**Rate Increases Subject to Review.** Rate increases of 10 percent or more are subject to either state or HHS review under the proposed regulations. However, beginning in 2012, HHS may set state-specific thresholds based on ''the cost of health care and health insurance coverage'' in that particular state. HHS must publish any new state-specific threshold no later than September 15th of the preceding year. If no state-specific threshold is set by HHS, then the 10 percent threshold applies.[7]

In determining whether a rate increase meets the 10 percent or state-specific threshold, and is therefore a ''rate increase subject to review,'' the proposed regulations look at ''an increase of the rates for a specific *product* offered in the individual or small group market.'' ''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.'' The rate increase for that product is determined by applying the ''weighted average increase for all enrollees subject to the increase.'' Further, the proposed regulation looks at the cumulative impact of increases by requiring the health insurance issuer to aggregate all such increases for that product for the past 12 months.[8]

**State vs. HHS Review.** Under the proposed regulations, HHS defers to state review—and will adopt that state's determination of whether a rate increase is ''unreasonable''—if the state has an ''effective rate review program'' and provides HHS with timely notice of, and a sufficient explanation supporting the state's determination.[9]

HHS will deem a state to have an ''effective rate review program'' by applying various criteria, including (i) whether the state receives sufficient documentation from the health insurance issuer to conduct a rate review examination, and conducts a timely and effective review; (ii) whether the review process includes an examination of specific factors; and (iii) whether the state's determination of whether the rate increase is ''unreasonable'' is made under a state statutory or regulatory standard.[10] Significantly, HHS does not define what constitutes an ''unreasonable'' rate increase under state review. Instead, each state's determination of what constitutes an ''unreasonable'' rate increase is controlling. The proposed regulations provide that HHS is required to publicly post a list of the states that have an ''effective rate review process,''[11] so presumably each health insurance issuer will know in advance whether its rate filing will be subject to state or HHS review. In the NPRM, HHS observes that it believes that a majority of states currently have effective rate review programs, and that it ''fully expect[s] that the vast majority of states will be able to conduct effective reviews in the future, should they choose to.''[12]

In those states without an ''effective rate review program,'' as determined by HHS, a rate increase will be deemed ''unreasonable'' by HHS, if it is ''excessive,'' ''unjustified,'' or ''unfairly discriminatory.'' These defined terms, discussed further below, appear to allow HHS wide discretion in making a determination that a rate increase is ''unreasonable.''

The proposed regulations do appear to permit a situation where a health insurance issuer may be subject to concurrent review of its rate increases by both the state (under a state's traditional filing or review requirements) and HHS for purposes of Section 2794 under circumstances where HHS has not deemed the state's program as ''effective.'' Under these circumstances, the health insurance issuer could be subject to duplicative reviews of the same rate increase, reviews that could require different documentation requirements, apply different analyses, and result in conflicting determinations as to whether a rate increase is ''unreasonable.''

**Health Insurance Issuers' Preliminary Justification of Rate Increases.** Every health insurance issuer that proposes a rate increase that meets or exceeds the 10 percent or state-specific threshold must submit to HHS, and to the applicable state if the state accepts such submissions, a ''preliminary justification'' for each product affected by the increase, *whether the rate increase is subject to HHS review or state review*.

The health insurance issuer's ''preliminary justification'' must include, at a minimum, a ''rate increase summary'' (Part I), and a ''written description justifying the rate increase'' (Part II). If the rate increase is subject to HHS review (as opposed to state review), the ''preliminary justification'' also must include specific ''rate filing documentation'' (Part III). HHS will promptly post on its website Parts I and II of the health insurance issuer's ''preliminary justification,'' and those portions of Part III other than information that the health insurance issuer designates—and HHS confirms—are confidential.[13]

Parts I and II of the ''preliminary justification'' must include specific and comprehensive information describing the factors underlying the rate increase including, but not limited to, descriptions of the rating methodology and the most significant factors causing the increase. Further, the health insurance issuer must submit its ''[e]mployee and executive compensation data from the insurer's annual financial statements.''[14] Significantly, in the NPRM, HHS states that the primary purpose of requiring submission and public posting of Parts I and II of the ''preliminary justification'' is to

[6] 45 C.F.R. §§ 154.102 (Definitions); 154.103 (Applicability); 154.200(a) (Rate increases subject to review).
[7] *Id*. at § 154.200(a).
[8] *Id*. at §§ 154.200(b)-(c); 154.102.
[9] *Id*. at § 154.210(a)-(b).
[10] *Id*. at § 154.301(a).
[11] *Id*. at § 154.210(c).
[12] 75 Fed. Reg. 81,011.
[13] 45 C.F.R. § 154.215(a)-(d) and (i).
[14] *Id*. at § 154.215(e)-(f).

alert *consumers* to the rate increase and to provide *consumers* with the information they need to interpret the rate increase, including the factors the health insurance issuer asserts are causing the increase.[15]

Part III of the ''preliminary justification'' only applies if the rate increase is subject to HHS review. Part III requires the health insurance issuer to submit specific detailed documentation (as well as any additional information HHS deems necessary) ''sufficient to permit HHS to conduct a review to determine whether the rate increase is an unreasonable rate increase.'' This documentation includes extensive information relating to the MLR, whether the projected MLR will be less than the new federal MLR requirements, and if so, the health insurance issuer's justification for this outcome.[16] As noted above, a health insurance issuer may be subject to concurrent review of its rate increases by both the state and HHS under circumstances where HHS has not deemed the state's program as ''effective.'' Under these circumstances, the health insurance issuer would be subject to duplicative reviews that require different documentation requirements. Indeed, the proposed regulations contemplate such circumstances by permitting the health insurance issuer to submit to HHS its state rate filing so long as that state filing includes all of the documentation required by Part III.[17]

**HHS Review and Determination of ''Unreasonable'' Rate Increases.** Those rate increases meeting or exceeding the 10 percent or state-specific threshold that are not subject to review by a state with an ''effective rate review program'' as designated by HHS, will be subject to HHS review for HHS to determine whether the rate increase is ''unreasonable.''[18] A rate increase subject to HHS review is ''unreasonable'' if it is ''excessive,'' ''unjustified,'' or ''unfairly discriminatory.'' The proposed regulations define these key terms as follows:

- *Excessive Rate Increase*: An increase that causes the premium to be unreasonably high in relation to the benefits provided under the coverage. Indications of an excessive rate increase include a projected medical loss ratio that is less than the federal standard, assumptions that are not supported by substantial evidence, and unreasonable assumptions on which the rate increase is based.[19]
- *Unjustified Rate Increase*: An increase for which the documentation provided to HHS in connection with the increase is incomplete, inadequate, or otherwise does not provide a basis upon which to assess the reasonableness of the increase.[20]
- *Unfairly Discriminatory Rate Increase*: An increase that results in premium differences between insured individuals within similar risk categories that are not permitted under applicable state law or do not reasonably correspond to differences in expected costs.[21]

The proposed regulations do not require HHS to complete its review within any time frame. However, HHS will post that determination and provide a brief explanation of HHS's analysis within five business days of HHS making its final determination. If HHS determines that the rate increase is ''unreasonable,'' then that determination and the explanation also will be provided to the health insurance issuer.[22]

**Health Insurance Issuer Submission of Final Justification.** If a health insurance issuer receives HHS notification that HHS or a state has determined that a rate increase is ''unreasonable,'' the proposed regulations contemplate that the health insurance issuer may either decline to implement the rate increase, implement a lower increase (which may or may not be lower than the mandatory review threshold), or implement the ''unreasonable'' rate increase. The health insurance issuer must timely notify HHS of its decision. If the decision is to implement a lower rate increase that nevertheless meets or exceeds the threshold for mandatory review, the health insurance issuer must file a new preliminary justification to the state and to HHS under the proposed regulations. If the health insurance issuer's decision is to implement the ''unreasonable'' rate increase, then the health insurance issuer must, within the later of 10 days after the health insurance issuer's implementation of the ''unreasonable'' rate increase or receipt of HHS's final determination, (i) submit to HHS a ''final justification'' for the rate increase containing only information consistent with the ''preliminary justification,'' *and* (ii) prominently post on the health insurance issuer's website for at least three years the public portions of the preliminary justification, the HHS or state final determination and explanation, and the health insurance issuer's final justification for the ''unreasonable'' rate increase. This information also will remain available to the public for three years on the HHS website.[23]

**Health Insurance Issuer's Implementation of ''Unreasonable'' Rates.** Once a health insurance issuer submits its preliminary justification of a rate increase that meets or exceeds the threshold for mandatory review, there is nothing in the proposed regulations that prohibits the health insurance issuer from implementing that rate increase, including implementation prior to a state or HHS determination regarding whether the rate increase is ''unreasonable.'' In addition, the proposed regulations do not prohibit a health insurance issuer from implementing—or continuing to offer the product at—the rate increase even after the rate is deemed ''unreasonable'' by HHS. The ability of a health insurance issuer to implement an ''unreasonable'' rate increase will be subject exclusively to applicable state law. This is consistent with the statutory authority provided to HHS on this particular topic under the federal health reform legislation.

## Observations and Potential Areas for Comment

**Setting Mandatory Rate Review Thresholds.** HHS sets an initial threshold of a 10 percent rate increase to trigger mandatory review. HHS also states that HHS will be designating state-specific thresholds based on the cost of health care and health insurance coverage in that state. HHS's basis for choosing 10 percent was a bal-

[15] 75 Fed. Reg. 81,008.
[16] 45 C.F.R. § 154.215(g)-(h).
[17] *Id.* at § 154.215(g)(2).
[18] *Id.* at § 154.205(a).
[19] *Id.* at § 154.205(b).
[20] *Id.* at § 154.205(c).
[21] *Id.* at § 154.205(d).
[22] *Id.* at § 154.225(1)-(2).
[23] *Id.* at § 154.230.

  HIR ISSN 2154-8986

ancing act at best. In its NPRM, HHS concedes that the 10 percent threshold was based on limited data that, in any event, provided that increases in the individual market already have exceeded 10 percent in each of the past three years. With new federal (and possible state) mandates, one might expect even greater than historical claims expenses in the individual and small group markets in many states, that could drive even greater rate increases. HHS estimates that, in 2011 alone, anywhere from 371 to 1,396 rate filings will meet or exceed the 10 percent threshold for mandatory review.

- HHS specifically invites comments on whether the 10 percent threshold is reasonable. While increasing the threshold might reduce the ''sentinel effect'' from public disclosure and scrutiny, a higher threshold might more effectively and efficiently use HHS and state regulatory resources to address those rate increases that are truly ''unreasonable'' and are not otherwise subject to pricing discipline by either the new federal MLR standards (as discussed below), or competitive forces. An additional, related, subject for comment is whether there is a rational basis for having the same threshold in both the individual and small group markets.

**Clarifying How to Determine When Mandatory Rate Review Thresholds Are Reached.** Perhaps the most important determination a health insurance issuer must make under the proposed regulations is whether a specific rate increase meets or exceeds the 10 percent (or state-specific) threshold for mandatory review. If the threshold is not met, then no preliminary justification or HHS review—and potentially no state review—is required. Yet the standard for determining whether the threshold is met—which focuses on the cumulative weighted average increase for all enrollees in a particular ''product''—lends itself to potential confusion and inconsistent treatment, particularly to the extent that different states define insurance ''products'' differently, or not at all.

- An area for possible comment is asking HHS for greater clarity on how to determine whether a rate increase meets the threshold for mandatory review, possibly taking into account good faith reliance on specific state law definitions and practices in defining insurance products.

**Clarification of the Standards for Determining an ''Unreasonable'' Rate Increase** HHS chose not to specifically define or quantify what constitutes an ''unreasonable'' rate increase, instead deferring to state regulators when an increase is subject to state review, and a collection of factors when subject to HHS review that, according to HHS, are based on the National Association of Insurance Commissioners' (NAIC's) adopted guidelines thus indicating that HHS will be performing a comprehensive actuarial review of the rate increase.

Significantly, HHS chose not to advocate comparing percentage rate increases with percentage rate increases in specific indices, like the medical consumer price index—an approach that was first used, and then rejected, by the Massachusetts Division of Insurance in much publicized rate proceedings earlier in 2010. *See* EpsteinBeckerGreen Client Alert, *Massachusetts Division of Insurance Rate Disapprovals Show Mixed Results; Implications for National Health Reform* (October 2010).[24] As HHS observed in its NPRM, ''[h]ealth insurance rates are affected, not only by the prices charged by the providers of health care services, but also by changes in the rate at which those services are accessed and the characteristics of the group covered by the insurance,'' which are factors not accounted for in most indices.[25]

However, two related factors that are statutorily required in many if not most state rate laws, and of principal concern to actuaries developing rates and officials regulating health insurance issuers—that the rates have been certified as *actuarially sound* and *adequate*—are conspicuously absent from the proposed regulations, although as noted previously, HHS has indicated that HHS will be performing a comprehensive actuarial review of the rate increase. As recent rate proceedings in both Massachusetts and Maine demonstrated, in order to protect policyholders, rates should and arguably must be certified as actuarially sound, which requires that they be adequate to cover anticipated claims costs, administrative expenses, and in some cases a reasonable contribution to insurance reserves. The consequences to policyholders could be disastrous if the proposed regulations result in a financially weakened health insurance issuer with inadequate rate increases.

- An area for possible comment, and HHS clarification, is whether and how HHS and the states should address the important concepts of actuarial soundness and rate adequacy in conducting their rate reviews and in determining whether a rate increase should be subject to public scrutiny or considered ''unreasonable.''

**Rate Increases That Meet the New Federal MLR Standard Should be Presumptively Reasonable.** In determining whether a rate increase is ''unreasonable,'' HHS's first factor involves comparing the projected MLR against the new federal MLR standards.[26] Arguably, a rate increase that can be accurately projected to meet the federal MLR standards (80 percent for plans in the individual and small group markets), should be presumptively deemed reasonable. It can be argued that meeting the federal MLR standard should mitigate the risk of truly ''unreasonable'' increases in that, to the extent the rate increase proves more than sufficient to cover actual medical costs and health care quality programs at the 80 percent MLR level, consumers will be guaranteed a proportionate premium rebate.

- An area for possible comment is the proposal that a rate increase that would result in an accurately projected MLR that meets new federal standards should be presumptively reasonable.

**Should the Regulations Be Extended to Apply to Large Groups?** Although Section 2794 of the PHSA does not differentiate between insurance markets, HHS specifically chose not to apply these new rate review obligations in the proposed regulations to large groups at this time, finding that ''[p]urchasers in the large group market are viewed as more sophisticated purchasers, who have greater leverage and therefore better ability to avoid the imposition of unreasonable rate increases.''

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[24] *Available at* http://www.ebglaw.com/showclientalert.aspx?Show=13553.

[25] 75 Fed. Reg. 81,010.

[26] 45 C.F.R. § 154.205(b)(a).

HHS also found that, at this time, ''few states could satisfy the standards for an effective review process in the large group market.''[27] However, HHS stated that HHS could revise the proposed regulations to include rate increases covering large group plans because large employers and consumer groups may take a different view. A further consideration is whether HHS and/or state reviews of large group rate increases that occur concurrently with negotiations between health insurance issuers and these same large groups could result in unintended uncertainty that actually reduces large employer leverage to strike a better deal.

- HHS is specifically soliciting comments on whether, if rate increases in the large group market were subject to a review process, that process should be different than the one provided in the proposed regulations. To that end, participants may want to comment on whether any rate review process for the large group market is necessary or even appropriate.

**Required Public Disclosure of Proposed Rate Increases and the Information Underlying Those Increases Poses Potential Competitive Concerns.** The proposed regulations focus on transparency, and, therefore, require advance public disclosure of certain rate increases and the data underlying those increases. However, where the required disclosures involve *proposed* rates (which are subject to change by the health insurance issuer) and the underlying data involves proprietary information that could be *competitively sensitive*, then the disclosure requirements in the proposed regulations could pose potential competitive concerns.

- An area for possible comment is how the public disclosure requirements under the proposed regulations will protect the competitive marketplace by protecting competitively sensitive information.

Additionally, HHS specifically requested comments from states regarding the potential burden states will endure in reviewing rate increases to determine if the increase is ''unreasonable.'' HHS also specifically requested comments regarding the potential impact that the rate review requirements will have on premiums in order to assess whether the economic impact of the proposed regulations exceeds $100 million and, therefore, the proposed regulations should be deemed a ''significant regulatory action'' under Section 3(f) of Executive Order 12866.[28]

## Conclusion

HHS's proposed regulations on health insurance issuer rate reviews will likely have significant ramifications for the insured health care financing market. The proposed regulations raise a number of questions and expressly request additional clarification. Consequently, it is important for all relevant stakeholders to review and submit comments to these proposed regulations by 11:59 PM on Feb. 22.

Furthermore, all relevant stakeholders should be monitoring state legislative and state regulatory activities on this subject as states seek to complement and take into account these new federal proposed regulations. All federal and state policymakers need to consider and then adopt rational proposals that fairly balance the interests of all health care marketplace participants affected by health insurance premium increases.

[27] 75 Fed. Reg. 81,009.

[28] 58 Fed. Reg. 51,735.

  HIR ISSN 2154-8986