BNA, INC.

HEALTH INSURANCE REPORT

BNA Employee-Owned Since 1947

VOL. 0, NO. 0 SEPTEMBER 14, 2011

HHS Final Rule on Premium Rate Review Amended to Include Policies Sold Through Associations, Lists States with Effective Rate Review Programs

BY LYNN SHAPIRO SNYDER AND JESSE M. CAPLAN

The authors are affiliated with Epstein Becker & Green PC. Snyder is Senior Member of the firm in the Health Care and Life Sciences and Litigation practices. She may be contacted at lsnyder@ebglaw.com. Caplan is a Member of the law firm, where he practices in the Health Care and Life Sciences Practice. He may be contacted at jcaplan@ebglaw.com. Brandon C. Ge, a Summer Associate (not admitted to the practice of law) in Epstein Becker & Green's Washington office, contributed significantly to the preparation of this article.

On May 23, the Center for Consumer Information & Insurance Oversight (CCIIO), in the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services (HHS), published its Final Rule implementing Section 2794 of the Public Health Service Act (PHSA). This section requires HHS to establish a process for the review of ''unreasonable'' health insurance premium rate increases in the individual and small group markets. The Final Rule[1] remains largely unchanged from the Proposed Rule, with important exceptions.[2]

[1] Rate Increase Disclosure and Review Rule, 76 Fed. Reg. 29964 (May 23, 2011).

[2] For a summary of the December 2010 proposed regulations and their implications, *see HHS Publishes Health Insurance Premium Rate Review Proposed Regulations—*

 ISSN 2154-8986

On Sept. 6, HHS published an Amendment to the Final Rule that revises the definitions of ''Individual Market'' and ''Small Group Market'' to include insurance policies sold to individuals and small groups through *associations*, whether or not the applicable state includes association coverage in its own definitions of the individual and small group markets.[3]

In addition, CCIIO released its list of states with effective rate review programs.[4] Rate increases affecting states with effective rate review programs will be reviewed by those states, while those increases in states determined not to have effective rate review programs will be reviewed by CMS. Now that this list has been published, health insurance issuers can better determine which government agencies will be responsible for reviewing their rate increases, what standards will be applied when determining whether such increases are ''unreasonable,'' and whether the rate increases are subject to disapproval.

This article also introduces Epstein Becker & Green's new interactive *National Health Insurance Rate Review Scorecard*. The Scorecard offers insurance carriers, lawyers, and other stakeholders an up-to-date resource on federal and state health insurance rate review programs, standards, and initiatives.

Summary of the Final Rule

Overview – The Final Rule requires health insurance issuers serving the individual and small group markets with rate increases meeting or exceeding certain thresholds (10 percent for 2011-2012) to submit justification for, and information about, those rate increases to both CMS and the applicable state for an examination and determination as to whether those rate increases are ''unreasonable.''

Effective Sept. 1, 2011, rates impacting 44 states (as well as the District of Columbia and one U.S. territory) now will be reviewed by the regulators in those states, while rates impacting the remaining states will be reviewed by CMS. Rate increases subject to review, and data underlying them, will be publicly disclosed and require public justification by the issuer. Although CMS has no authority under the Final Rule to disapprove a rate it determines to be ''unreasonable,'' such rate increases may nevertheless face disapproval by state regulators. Furthermore, CMS's determinations may affect the actions of state regulators, as well as public opinion.

Applicability and Effective Date – The Final Rule applies to non-grandfathered plans in the individual and small group markets.[5] In response to some recommendations that the large group market also be subject to the rule, CMS will monitor rate increases in that market to assess whether future amendments may be warranted.[6] Consequently, all health insurance issuers should be monitoring this government initiative.

The Final Rule pushed back the effective date of the program from July 1 to Sept. 1, 2011. Therefore, the Final Rule applies to health insurance premium rate increases that are filed on or after Sept. 1, or, in states that do not require filing of rate increases, rate increases that are effective on or after Sept.1.[7]

''Individual'' and ''Small Group'' Market Definitions – The Final Rule defers to state definitions of the individual and small group markets. Where a state rate filing law does not define such markets, CMS will use the relevant definition in the PHSA. However, in the case of small group markets, groups referred to as ''small employers'' are capped at 50 employees instead of 100. CMS also clarified that, if a state excludes short-term limited duration coverage from its definition of individual market, the state's definition is still decisive.[8] The Final Rule does not apply to ''excepted'' benefit plans, such as separately issued dental or vision policies, even if offered in the individual or small group markets.[9]

Policies Sold Through Associations – In the preamble to the Final Rule, CMS notes that it requested comments and additional data on whether to include individual and small group policies sold through associations within the scope of the rate review rule.[10] After analyzing those comments, on Sept. 6 it published an Amendment to the Final Rule to clarify that ''individual and small employer policies sold through associations will be included in the rate review process, even if a State otherwise excludes such coverage from its definitions of individual and small group coverage.''[11]

CMS effectuated this change by revising the definitions of ''individual market'' and ''small group market'' in section 154.102 of the regulation. In making this change, CMS stated that excluding such coverage sold through associations from the rate review process ''creates an unlevel playing field between issuers that sell coverage through associations and those that do not,'' and ''raises the risk of creating incentives that could lead to adverse selection,'' potentially concentrating poorer risk in non-association coverage in certain states.[12]

CMS did, however, delay the effective date of this Amendment until Nov. 1, 2011, which means that rate increase submissions required under the Final Rule that would not otherwise include association coverage under state law, will not have to include association sold policies until that date.

Rate Increases Subject to Review – The initial threshold for rate increases subject to review during the first year continues to be 10 percent or higher. However, CMS reiterated that this threshold is intended to be ''transitional'' and that the Secretary of HHS anticipates setting state-specific thresholds effective Sept. 1, 2012. The Secretary will publish by June 1 of each year the state-specific thresholds that will apply to the 12-month period that begins on September 1 of that year.[13] This postpones HHS's original plans to publish its first state-specific thresholds by September 15, 2011, and that were to take effect as early as January 2012.

Implications for Health Insurance Issuers, Providers, and the Health Care Marketplace, Epstein Becker Green Client Alert, Dec. 30, 2010.

[3] Rate Increase Disclosure and Review: Definitions of ''Individual Market'' and ''Small Group Market,'' 76 Fed. Reg. 54969 (Sept. 6, 2011).

[4] Center for Consumer Information & Insurance Oversight, *Rate Review Fact Sheet* (last viewed July 11, 2011).

[5] 45 C.F.R. § 154.103.

[6] 76 Fed. Reg. 29966.

[7] 45 C.F.R. § 154.200(a).

[8] *Id.*

[9] 45 C.F.R. § 154.103(b).

[10] 76 Fed. Reg. 29965-66.

[11] 76 Fed. Reg. 54,969.

[12] *Id.*at 54,970.

[13] *Id.* at § 154.200(b).

  HIR ISSN 2154-8986

Important Dates

Sept. 1, 2011:
Effective date of CMS Rate Review Regulations

Nov. 1, 2011:
Rate Reviews include all individual and small group coverage sold through associations

By June 1, 2012:
Publication of state specific rate review thresholds effective September 1, 2012

A rate increase is defined as any increase of the rates for a specific product offered in the individual or small group market. The Final Rule continues to define ''product'' 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.''[14] Some commentators were concerned that such a definition is not consistent with state definitions and that the difference in classification would be administratively onerous. CMS responded that its definition of ''product'' is flexible enough to accommodate state definitions and that health insurance issuers will not have to reclassify products in complying with the rate review process.[15]

The rate increase for a product will be subject to review if the ''average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold.''[16] CMS amended this definition to clarify that the method for calculating a rate increase is ''arithmetically identical to calculating the rate increase as the overall average percentage increase between the old premium and the new premium,'' and should be the same as the percentage change between the old revenue and the new projected revenue.[17] The Final Rule continues to require health insurance issuers to aggregate all of a product's rate increases for the 12-month period preceding the effective date of the rate increase.[18]

State vs. CMS Review – The Final Rule provides that, if CMS determines that a state has an effective rate review program, the state will be responsible for reviewing its rate increases. CMS will adopt such a state's determination of whether a rate increase is unreasonable if the state provides CMS with an explanation of its determination within five business days following its final decision. If a state does not have an effective rate review program, then CMS will conduct the review.[19]

As of Aug. 22, 44 states, the District of Columbia, and one U.S. territory have been deemed to have effective rate review programs in at least one insurance market. In the two states with effective rate review programs in only one of the two applicable insurance markets (individual or small group), CMS will share rate review responsibilities with the state.[20]

Health Insurance Issuers' Preliminary Justification of Rate Increases – When proposing rate increases that meet or exceed the applicable threshold for review, health insurance issuers must submit to CMS and the applicable state, if the state accepts such submissions, a ''Preliminary Justification'' for each product affected by the increase, regardless of whether the rate increase is subject to CMS review or state review. The Preliminary Justification consists of three parts: a ''rate increase summary'' (Part I); a ''written description justifying the rate increase'' (Part II); and, if the rate increase is subject to CMS review, specific ''rate filing documentation'' (Part III).[21] In the Final Rule, CMS has somewhat relaxed the requirements for Preliminary Justifications:

- *Rate Increase Summary (Part I)*: The Final Rule requires six pieces of information in the rate increase summary: (1) historical and projected claims experience; (2) trend projections related to utilization, and service or unit cost; (3) any claims assumptions related to benefit changes; (4) allocation of the overall rate increase to claims and nonclaims costs; (5) per enrollee per month allocation of current and projected premium; and (6) three-year history of rate increases for the product associated with the rate increase.[22] The Final Rule no longer requires inclusion of medical loss ratios or executive and employee compensation data.[23]
- *Written Description Justifying the Rate Increase (Part II)*: The Final Rule requires, in addition to a ''simple and brief narrative describing the data and assumptions that were used to develop the rate increase,'' two items: (1) explanation of the most significant factors causing the rate increase; and (2) a brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.[24] CMS has removed the requirement that this component include an explanation of the health insurance issuer's rating methodology.
- *Rate Filing Documentation (Part III)*: This filing requirement only applies if the rate increase is subject to CMS review. Nevertheless, CMS has made the Part III rate filing documentation requirements the same as those required by any state with an ''effective rate review program.'' These requirements include documentation sufficient to permit examination of: (1) the reasonableness of the assumptions used by the issuer to develop the rate increase and the validity of the historical data underlying the assumptions; and (2) the issuer's data related to past projections and actual experience. CMS will provide additional in-

[14] *Id*. at § 154.102.
[15] 76 Fed. Reg. 29966.
[16] 45 C.F.R. § 154.200(c).
[17] 76 Fed. Reg. 29968.
[18] 45 C.F.R. § 154.200(d).
[19] *Id*. at § 154.210(a)-(b).
[20] Center for Consumer Information & Insurance Oversight, *supra*.
[21] 45 C.F.R. § 154.215.
[22] *Id.* at § 154.215(e).
[23] CMS indicated that the medical loss ratio data could be computed from the remaining Part I elements and was therefore redundant, and executive and employee compensation data, which represents a very small proportion of premium rates, ''would not be helpful to consumers in showing the primary rate increase drivers.'' 76 Fed. Reg. 29970.
[24] 45 C.F.R. § 154.215(f).

structions regarding rate filing documentation in future guidance.[25]

Standards for Determining ''Unreasonable'' Rate Increases – A rate increase subject to CMS review will be deemed ''unreasonable'' if it is ''excessive,'' ''unjustified,'' or ''unfairly discriminatory.''[26] The Final Rule maintains the proposed definitions of ''excessive,'' ''unjustified,'' and ''unfairly discriminatory'' as follows:

- *Excessive Rate Increase*: An increase that causes the premium to be unreasonably high in relation to the benefits provided under the coverage. Factors in determining excessiveness include: whether the rate increase results in a projected medical loss ratio below the federal standard; whether the rate increase is based on unsubstantiated assumptions; and whether the rate increase is based on an unreasonable choice or combination of assumptions.[27]

- *Unjustified Rate Increase*: An increase based on data or documentation that is incomplete, inadequate, or otherwise does not provide a reasonable basis for the increase.[28]

- *Unfairly Discriminatory Rate Increase*: An increase that results in premium differences between insured individuals within similar risk categories that are not permissible under applicable state law or do not reasonably correspond to differences in expected costs.[29]

CMS will defer to a state's determination of whether a rate increase is unreasonable if that state has an ''effective rate review program.'' In such cases, the state's process and standards for determining whether a rate increase is ''unreasonable'' will govern. However, in order to be deemed an ''effective rate review program,'' the state's rate review process must include a robust examination of substantial data.[30]

Although most state standards for determining reasonableness include factors similar to those adopted by CMS (that the rate increase is not ''excessive,'' ''unjustified,'' or ''unfairly discriminatory''), many states also examine the ''adequacy'' of the rate. Significantly, CMS acknowledged that ''inadequate rate increases can be problematic'' in that they can lead to larger increases in future years and negatively affect an issuer's financial condition. Despite these concerns, CMS decided not to include adequacy as a prong for determining reasonableness in conducting its own rate reviews.[31]

Determinations of ''Unreasonable'' Rate Increases – CMS will make ''a timely determination'' of whether the rate increase is ''unreasonable,'' and within five business days of its determination will post the determination and analysis on its website. CMS will also post a state's final determination where applicable. If CMS (or, in some cases, the state) determines that a rate increase is in fact ''unreasonable,'' CMS will so notify the issuer.[32]

Health Insurance Issuer Submission of Final Justification – If a health insurance issuer receives notice that CMS or a state has determined that its rate increase is ''unreasonable,'' the Final Rule, like the proposed rule, provides that the issuer may either decline to implement the rate increase, implement a lower increase (which may or may not be lower than the applicable review threshold), or implement the ''unreasonable'' rate increase. If the health insurance issuer implements a lower increase that meets or exceeds the applicable threshold, the issuer must file a new preliminary justification.

If the issuer implements an ''unreasonable'' rate increase, then within the later of 10 business days after implementation of the increase or receipt of CMS's final determination of unreasonableness, the health insurance issuer must: (1) submit to CMS a ''Final Justification'' that is consistent with the Preliminary Justification; and (2) on its website, prominently post and make available for at least three years, information related to the rate increase, including (i) the public portions of the Preliminary Justification, (ii) the CMS or state final determination and explanation, and (iii) the health insurance issuer's Final Justification for implementing the ''unreasonable'' rate increase. CMS will also post all Final Justifications on its own website.[33]

Authority to Disapprove Rates – CMS reiterated that Section 2794 of the PHSA only provides it with authority to require justification and disclosure of rate increases, and does not give it authority to disapprove proposed rate increases. However, if a health insurance issuer does not comply with the requirements of the Final Rule, CMS can seek a court order to enforce compliance.[34] Additionally, if a health insurance issuer's state has an effective rate review program and is responsible for reviewing rates, the issuer should be mindful that some states have the authority to deny rate increases.

Increased Public Participation – In the Final Rule, CMS has added requirements that bolster the level of public disclosure and opportunity to comment in the rate review process. The Final Rule requires that CMS make available for public comment the proposed rate increases that it reviews. Additionally, a state with an effective rate review program must provide public access to Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews, and a mechanism for public comment on the proposed increases.[35]

Epstein Becker & Green's Rate Review Scorecard

With implementation of the Final Rule, health insurance issuers now face varying (and changing) rate review thresholds, different regulatory agencies potentially responsible for reviewing rate increases, different

[25] *Id.* at §§ 154.215(g); 154.301(a)(3)-(4).
[26] *Id.* at §§ 154.102; 154.205(a).
[27] *Id.* at § 154.205(b).
[28] *Id.* at § 154.205(c).
[29] *Id.* at § 154.205(d).
[30] *Id.* at §§ 154.210(b); 154.225(b); 154.301(a)(3)-(5).
[31] 76 Fed. Reg. 29968-29969.
[32] 45 C.F.R. § 154.225. Where a state has determined that a rate increase is ''unreasonable,'' CMS will only notify the issuer if that issuer is otherwise legally permitted to implement the rate increase under applicable state law. *Id.* at § 154.225(c). Where a state has the authority to disapprove a rate increase, CMS notification to the issuer, and any ''Final Justification,'' are unnecessary.
[33] *Id.* at § 154.230.
[34] 76 Fed. Reg. 29965.
[35] 45 C.F.R. §§ 154.215(j); 154.301(b).

  HIR ISSN 2154-8986

standards for determining what rate increases are ''unreasonable,'' and varying authority on whether an ''unreasonable'' rate increase can be disapproved.

To help insurance issuers, their counsel and other stakeholders stay informed of current federal and state rate review regulatory information, Epstein Becker & Green has created its interactive National Health Insurance Rate Review Scorecard. The Scorecard provides easy-to-use and up-to-date information on the applicable rate thresholds, agencies responsible for rate review, standards for determining an ''unreasonable'' rate increase, authority to disapprove rates, and required minimum medical loss ratios under federal law and for each state and territory.

In this one Scorecard, health insurance issuers have a useful resource when preparing rate filings in a post-health reform environment.

RESOURCE LINKS:

Rate Review Final Rule

(http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf)

Amendment to Final Rule

(http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf)

CMS Rate Review Webpage

(http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html)

EBG National Health Insurance Rate Review Scorecard

(http://www.ebglaw.com/scorecard.aspx)