

December 2, 2011

HHS Announces First Insurance Premium Rate Review Determinations: Implications for Insurance Carriers and Future Rate Reviews

RESOURCE LINKS

HHS Rate Review Lookup Tool (by State
and Insurance Carrier):

<http://companyprofiles.healthcare.gov/>

IMPORTANT DATES

June 1, 2012:

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

On November 21, 2011, the Center for Consumer Information & Insurance Oversight (“CCIIO”), in the Centers for Medicare & Medicaid Services (“CMS”),¹ announced its determination that a health insurance premium rate increase of 11.58 percent in the small group market in Pennsylvania represented an “unreasonable” rate increase, while an 11.10 percent increase in the individual market in Montana did not. These long-awaited determinations represent the first application of CMS’s rate review [regulations](#) under federal health reform.² This *Implementing Health and Insurance Reform alert* discusses these first federal rate review determinations, and their implications for insurance carriers and future insurance premium rate reviews.

Regulatory Background

Since September 1, 2011, health insurance issuers serving the individual and small group markets have been required to submit justifications for and information about insurance premium rate increases that meet or exceed a certain threshold (10 percent for 2011-2012) to CMS and the applicable state. The rate increases, underlying data, and justifications are subject to public disclosure.³ CMS and the states use the justifications and information to examine and determine whether the rate increases are “unreasonable.”

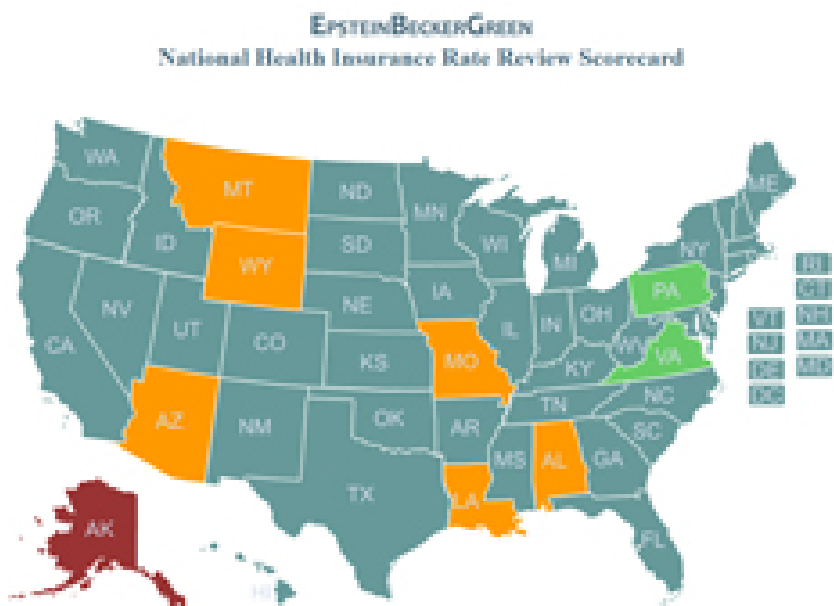
¹ CCIIO and CMS are agencies of the U.S. Department of Health and Human Services (“HHS”).

² CMS’s regulations are codified at 45 C.F.R. §§ 154.101-154.301. See also, Rate Increase Disclosure and Review Rule, 76 Fed. Reg. 29,964 (May 23, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf>, and Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market,” 76 Fed. Reg. 54,969 (Sept. 6, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf>. These regulations implemented Section 2794 of the Public Health Service Act, as added by Section 1003 of the Patient Protection and Affordable Care Act (“**Affordable Care Act**”), which required HHS to establish a process for the review of “unreasonable” health insurance premium rate increases in the individual and small group markets.

³ U.S. Department of Health and Human Services, *Your Insurance Company & Rate Increases*, available at <http://companyprofiles.healthcare.gov/> (last viewed Nov. 23, 2011).

Rate increases affecting states with effective rate review programs are reviewed by those states, while rate increases in states determined not to have an effective rate review program are reviewed by CMS.⁴ CCIIO has determined and published a list of those states that have effective rate review programs,⁵ which currently include 44 states, the District of Columbia, and three U.S. territories.⁶

The Epstein Becker Green interactive [National Health Insurance Rate Review Scorecard](#) provides more information and an easy-to-use, up-to-date, and comprehensive overview of the applicable rate thresholds, agencies responsible for rate review, and standards for determining an “unreasonable” rate increase for each state and U.S. territory. For a complete summary of the CMS regulations and the rate review requirements and process, see Epstein Becker Green’s *Implementing Health and Insurance Reform alert “HHS Publishes Health Insurance Premium Rate Review Final Rule, Amends Rule to Include Policies Sold Through Associations, and Lists States with Effective Rate Review Programs”* (Sept. 14, 2011).



Initial Filings and Determinations

On September 1, 2011, the first effective day of CMS’s rate review regulations, Everence Insurance Company (“Everence”) submitted information and justifications for an average increase of 11.58 percent impacting small group plans in Pennsylvania⁷ and an average increase of 11.10 percent impacting individual plans in Montana.⁸ The Pennsylvania increase went into effect on October 1, 2011, while the Montana increase is set to go into effect on January 1, 2012. Each increase impacts approximately 5,000 people.

⁴ 45 C.F.R. § 154.210(a)–(b).
⁵ Center for Consumer Information & Insurance Oversight, *List of Effective Rate Review Programs*, available at http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html (last viewed Nov. 23, 2011).
⁶ CCIIO has determined that Pennsylvania and Virginia have effective rate review programs for the individual market only. Therefore, rate reviews in these two states are split between the state regulators (individual market) and CMS (small group market).
⁷ U.S. Department of Health and Human Services, *Everence Insurance Company Rate Review*, available at http://companyprofiles.healthcare.gov/states/PA/companies/78080/products/78080PA001/rate_reviews/33?search_method=rate_reviews (last viewed Nov. 28, 2011).
⁸ U.S. Department of Health and Human Services, *Everence Association, Inc. Rate Review*, available at http://companyprofiles.healthcare.gov/states/MT/companies/64091/products/64091MT001/rate_reviews/32?search_method=rate_reviews (last viewed Nov. 28, 2011).

Everence's Preliminary Justifications – In its preliminary justification for its premium increase in Pennsylvania, Everence indicated that 81.80 percent of the total premium would be applied to the cost of providing medical services to policyholders – in other words the new premium rate was targeted to meet an 81.80 percent medical loss ratio (“MLR”). Everence indicated that 27.29 percent of the premium would be needed to cover administrative expenses. As a result, Everence projected that the new premium, even at an 11.58 percent increase, would result in a 9.10 percent underwriting loss to the company.⁹ Everence also explained that the Pennsylvania plan had experienced losses for the past three years. As such, Everence stated that the premium increase was needed “to keep up with medical trend and maintain the current financial experience level, without which larger losses would be incurred.”

In its preliminary justification for its Montana filing, Everence indicated that the new premium was targeted to meet an 87.39 percent MLR, that 20.70 percent of the premium would be needed to cover administrative expenses, and that, as a result, the new premium was projected to also result in an 8.09 percent underwriting loss to the company. Like the Pennsylvania plan, the Montana plan had experienced losses for the past 2½ years, and Everence indicated that the increase was needed to avoid even larger losses going forward.

CMS's Determinations – After reviewing the preliminary justifications and actuarial memoranda for both the Pennsylvania and Montana filings, CMS determined that the 11.58 percent increase in Pennsylvania was “unreasonable,” while the 11.10 percent increase in Montana was not. CMS based its determination that the Pennsylvania increase was unreasonable on two factors: (i) that the rate increase would result in a projected MLR below the applicable federal standard, and (ii) that Everence's choice of assumptions when calculating its rate increase was unreasonable.

With respect to the first factor, CMS stated that, in calculating its projected MLR of 81.80 percent in Pennsylvania, Everence used claims data for policyholders in all of the states it does business in, as opposed to just those policyholders in Pennsylvania. According to CMS, using only Pennsylvania claims experience would result in a projected MLR “significantly lower than the 80 percent medical loss ratio that is required” under current federal standards and, as such, “makes the increase unreasonable.”¹⁰ Similarly, with respect to the second factor, CMS found that Pennsylvania-only claims data was reliable and should have been considered; therefore, Everence's choice of assumptions – basing its Pennsylvania rates on its nationwide data – was not reasonable.¹¹ In announcing that the Everence rate filing was “unreasonable,” Steve Larson, the director of the CCIIO, stated that “we have called on this insurer to immediately rescind the rate, issue refunds to consumers or publicly explain their refusal to do so.”¹²

⁹ The components making up a premium rate (medical claims, administrative expenses, and profit or loss) should equal 100 percent (e.g., 81.80 percent + 27.29 percent - 9.10 percent = 99.99 percent).

¹⁰ Under the Affordable Care Act, individual and small-group market insurers must meet the federal MLR of 80 percent unless the state has received an adjustment from HHS or the state imposes a higher MLR. 45 C.F.R. pt. 158. Neither Pennsylvania nor Montana has received an adjustment for the MLR applied to individual and small group plans in the state.

¹¹ In determining that the 11.10 percent increase in Montana was reasonable, CMS found that Everence had used reasonable assumptions and that the projected MLR was estimated to meet or exceed the 80 percent federal requirement.

¹² Press Release, U.S. Department of Health and Human Services, Health Insurer Charging Unreasonable Rate Increases (Nov. 21, 2011).

Everence's Response – Under CMS's rate review regulations, once Everence received notice that CMS had determined that its Pennsylvania increase was "unreasonable," Everence could either decline to implement the increase, implement a lower increase, or implement the "unreasonable" increase.¹³ On November 21, 2011 (the same day as CMS's determination), Everence released a statement indicating that the company did not intend to change the 11.58 percent increase that had already gone into effect in Pennsylvania. As required under CMS's rate review regulations, Everence posted its "final justification" for the increase on its website.¹⁴ Everence explained that, even using Pennsylvania-only claims data, its two-year claims experience resulted in a MLR of 81.6 percent, approximately equivalent to the national experience and above the 80 percent federal standard. Everence defended its use of two years of experience, as opposed to the one-year basis relied upon by CMS, stating that "a longer experience period reduces premium volatility, which works better for group clients." Everence also "welcome[d] the opportunity to have a conversation with HHS officials about how we determine our rates."¹⁵

Implications, Issues, and Questions After the Initial Determinations

CMS's focus on the Everence rate filings as its initial rate reviews and, more significantly, its first determination that a rate increase is "unreasonable" seems odd. Everence is a relatively small insurance carrier affiliated with a faith-based organization (the Mennonite Church) and appears to serve primarily other faith-based employers. There are less than 5,000 individuals impacted by the Pennsylvania filing, and the specific insurance product under review was only introduced in 2010. Perhaps, most significantly, CMS did not refute the company's contention that it has lost money on its health insurance premiums over the past three years or that the rate, as filed and reviewed by CMS, would result in underwriting losses to the organization going forward. When HHS first announced its proposed health insurance rate review regulations one year ago, it specifically highlighted soaring insurance company profits as justification for this new heightened scrutiny.¹⁶ Yet, it seems a stretch to hold the Everence rate filings as indicative of any alleged insurance industry excesses.

Nevertheless, these initial CMS determinations do offer insights that health insurance issuers can analyze to better determine what information CMS will focus on in future rate reviews.

Focus on MLR – CMS's rate review regulations state that, in determining whether a rate increase is "unreasonable," CMS will consider, among other things, whether the rate increase will result in a projected MLR below the federal MLR standard "in the applicable market in which the rate increase applies."¹⁷ In both the Pennsylvania and Montana reviews, CMS placed great emphasis on the information used to calculate the projected MLR, and whether that projected MLR met or exceeded the new federal MLR standards. In the Pennsylvania filing, CMS seemed to require that the MLR be projected based on state-specific, as opposed to national, claims experience. As such, insurance issuers should pay special attention to (i) the specific MLR standards that apply in each state in which a filing is being made, and (ii) whether the MLR projection in the rate filing is based on state-specific

¹³ 45 C.F.R. § 154.230.

¹⁴ Everence, *Everence Responds on Rate Increase in Pennsylvania*, Nov. 21, 2011, available at <http://www.everence.com/showitem.aspx?id=13044>.

¹⁵ *Id.*

¹⁶ Rate Increase Disclosure and Review, 75 Fed. Reg. 81,004 (Dec. 23, 2010).

¹⁷ 45 C.F.R. § 154.205(b)(1).

or national claims experience. Issuers should note that two states currently impose minimum MLR standards that are above the 80 percent federal standard, while six states have received approval from CCIIO for a minimum MLR below the 80 percent federal standard in at least one, if not both, of the individual and small group markets. In addition, seven states have submitted applications to CCIIO and are currently awaiting determination for MLR adjustments that would lower the MLR standards in those states.¹⁸

In any event, one could reasonably question whether CMS's seemingly hard and fast rule that a rate increase must meet or exceed projected MLR requirements is an appropriate standard to apply in all cases. This is because the MLR projection in any given rate filing is simply that – a *projection* – and actual claims experience over the plan year may very well demonstrate a higher or lower MLR. Even if the actual MLR ends up being below the federal standard, consumers are protected in that the carrier will be required to rebate the difference under federal MLR regulations. However, if the actual MLR proves higher than federal standards and results in losses to the insurance issuer, there is no recourse to retroactively increase those premium charges.

Rate “Adequacy” Ignored – Similarly, CMS's focus on the MLR does not address the important concept of “rate adequacy” – whether the filed rate is adequate to cover the anticipated costs of medical claims and administrative expenses. Many states require that rates meet adequacy standards. In its final rule, CMS acknowledged that “inadequate rate increases can be problematic” but ultimately decided not to include adequacy as a factor in determining the reasonableness of an increase.¹⁹ In both the Pennsylvania and Montana filings, Everence indicated that the plans have historically experienced losses and that the rate increases would not adequately cover anticipated medical claims and administrative expenses and, as a result, would result in additional losses. Although CMS has acknowledged that inadequate rate increases can lead to larger increases in future years and negatively affect an issuer's financial condition, in the Everence reviews, CMS did not appear to consider these factors at all.

CMS does not currently have the authority to actually disapprove a rate increase or to force an insurance issuer to revoke or adjust a filed increase. As such, CMS's apparent disregard for rate adequacy does not pose the same risks that the actual disapproval of an inadequate rate increase might have. However, issuers should bear in mind that certain states do have the authority to disapprove a rate filing, and that some of those states do include adequacy as a consideration in determining the reasonableness of an increase. As such, it may behoove issuers, in the appropriate circumstances, to include a robust discussion of adequacy in their rate increase filings.

Focusing on Rate “Increases” Can Be a Flawed Methodology – CMS's determination does not indicate how the Everence rates compare to similar products in the same market. One deficiency in reviewing an individual rate increase is that it does not tell consumers whether the rate is competitive with the rates for similar products sold by other carriers. In this case, Everence claims to have lost money in previous years. This suggests that while the Everence rate *increase* may be relatively high, it does not mean that the *actual rate* for the Everence product is higher than for other similar products in the market. For example, an 11 percent increase on a relatively lower premium can actually cost consumers less than a 9 percent increase on a relatively higher premium. In 2010, a Massachusetts

¹⁸ Center for Consumer Information & Insurance Oversight, *Medical Loss Ratio*, available at <http://cciio.cms.gov/programs/marketreforms/mlr/index.html> (last viewed Nov. 28, 2011).

¹⁹ Rate Increase Disclosure and Review Rule, 76 Fed. Reg. 29,968 (May 23, 2011).

panel of hearing officers found that looking at a percentage rate increase rather than the actual rate is a flawed methodology.²⁰ In the appropriate circumstances, issuers may want to provide information in their rate filings on how their filed rates compare to the rates of similar products in the market.

Increases Above 10 Percent Can Be Reasonable – As demonstrated by CMS’s determination that the Everence Montana rate increase of 11.10 percent was reasonable, it is clear that CMS acknowledges that rate increases above 10 percent may be reasonable in certain circumstances. In this instance, it appears that where the rate increase is calculated using a projected MLR that meets or exceeds the federal minimum MLR standard, and where the insurance issuer is not otherwise projecting a profit, the increase may be justified.

Timeliness of CMS Reviews – Finally, health insurance issuers should also consider the length of time it took for CMS to make these first rate review determinations. CMS’s rate review regulations state that “CMS will make a timely determination whether the rate increase is an unreasonable rate increase.”²¹ Everence filed its preliminary justifications on September 1, 2011 – the first day CMS’s rate review regulations became effective. It took more than two months for CMS to review and respond to the filings. However, the 11.58 percent increase impacting the small group plans in Pennsylvania went into effect on October 1, 2011. As such, it would have been administratively difficult for Everence to have retroactively modified the increase based on CMS’s unreasonableness determination. Certainly, a CMS determination that a rate increase is “unreasonable” would be more useful to both consumers purchasing health insurance and to those insurance issuers that might consider modifying their rate increases if CMS made the determination before the increase went into effect. Issuers should bear in mind that, while CMS does not have the authority to disprove any rate increases, some state regulators do possess the authority to deny rate increases. As such, issuers should be mindful of rate increase effective dates and may want to develop plans for rate modification based on rate review determinations.

Conclusion

In its first rate review determinations, CMS has shown that it will focus on whether a filed rate increase will meet federal minimum MLR requirements and whether the assumptions used to calculate the rate increase – and, specifically, those assumptions underlying the MLR projections – are appropriate. CMS has indicated that it may disregard whether a filed rate is adequate to meet projected medical claims and administrative expenses. Additionally, CMS has demonstrated that no insurance issuer, even a small faith-based carrier, is immune from a determination that its rate increase is “unreasonable.” On the other hand, CMS has also shown that simply filing a rate increase of 10 percent or more does not automatically mean that the increase will be deemed unreasonable.

There are numerous additional filings currently awaiting CMS or state review. Those determinations will no doubt help further clarify the standards that CMS and state regulators intend to apply. Nevertheless, these first rate review determinations provide insights into CMS’s review process (and, potentially, state review processes) that insurance carriers should consider as they prepare rate filings going forward.

²⁰ For more information about the Massachusetts Division of Insurance case, see the Epstein Becker Green Client Alert “Massachusetts Division of Insurance Rate Disapprovals Show Mixed Results; Implications for National Health Reform” (October 2010), available at <http://www.ebglaw.com/showclientalert.aspx?Show=13553>.

²¹ 45 C.F.R. § 154.225(a).

For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

Jesse M. Caplan

Member
Epstein Becker Green
Washington, DC
508/368-9571
jcaplan@ebglaw.com

Serra J. Schlanger

Law Clerk - Admission Pending
Epstein Becker Green
Washington, DC
202/861-1859
sschlanger@ebglaw.com

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Kristi Swanson
Practice Development Manager
National Health Care & Life Sciences Practice
Epstein Becker & Green, P.C.
1227 25th St., NW, Suite 700
Washington, D.C. 20037
phone 202/861-4186 -- fax 202/861-3086
kswanson@ebglaw.com

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