February 22, 2011

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attn: OCIIO-9999-P, Room 445-G
Docket No. HHS-OS-2010-0029
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

RE: Consumer Watchdog comments on Rate Increase Disclosure and Review proposed regulations under section 2794 of the Public Health Service Act

Dear Secretary Sebelius:

The federal health reform law will soon require every American to show proof of having health insurance or face a tax penalty, yet nothing in the law adequately restrains how much a health insurer can charge for coverage. Affordability is the number one barrier to consumer access to health care.

The Public Health Service Act's requirement for review and justification of unreasonable health insurance premiums can provide critical consumer protection because it is the law's only provision with the potential to rein in what health insurers charge. Without strong premium regulation to bar excessive increases before they go into effect, other provisions of the law could perversely encourage insurance companies to raise premiums at even greater rates. For example, the law requires that insurers spend 80 percent or 85 percent of the premiums they collect on health care services. Absent strict regulation, this requirement will encourage insurers to increase health care costs and raise rates so that their 15 or 20 percent cut of premiums is a larger dollar amount. However, this "medical loss ratio" rule, *in conjunction* with measures to encourage effective premium regulation in the states, can help prevent insurance companies from unnecessarily raising premiums in order to boost profits.

Ultimately, state insurance regulators will need full "prior approval" authority to reject or modify, and not just review, excessive or unreasonable rates if health reform is to succeed in expanding access and affordability of health care. This authority, along with a right of public intervention and backup federal review and regulation of rates, are the only certain way to control health insurance rates. However, in the absence of that authority, the proposed regulation ("Regulation") implementing section 2794 can take the crucial first step by exposing insurance rate hikes to close regulatory and public scrutiny.

The current draft is a good beginning, but must be strengthened to require public disclosure of all data submitted by health insurers so the public can evaluate rate increases, broaden the number

of rate increases subject to review to ensure potentially unreasonable hikes do not go unscrutinized, and, set minimum standards defining "unreasonable" rates and effective review to encourage states to strengthen oversight.

Consumer Watchdog has more than two decades of experience implementing, enforcing and defending effective rate regulation of the property casualty insurance market under California's Proposition 103, enacted by voters in 1988. The state's system of mandatory public hearings and regulations barring excessive rates has saved California drivers $62 billion since 1988. It is the nation's most effective system of insurance regulation according to a 2008 report by the Consumer Federation of America.[1]

§154.215 Submission of disclosure to HHS for rate increases subject to review.

All data provided in the rate justification must be publicly disclosed.
Section 2794 of the Public Health Service Act requires "health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. … The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers."

Nothing in this language suggests that the information disclosed to the states and HHS should differ, that the states or HHS should receive more information than the public, or that public disclosures should differ based solely upon whether a state or HHS conducts a review. However, the Regulation currently limits public disclosure of the preliminary justification to parts one and two, the rate summary and a narrative description of the increase. The Regulation leaves disclosure of part three – the rate filing documentation which will include the actuarial data necessary to allow outside experts to determine if a proposed increase is unreasonable – to the discretion of the states, which may choose to limit, or even prohibit, disclosure of detailed rate filing information.

The whole point of a public rate "justification" is to provide consumers, public advocates, and regulators with the information necessary to evaluate whether a rate is reasonable. The scope of the information provided will ultimately determine whether rate review requirements shine new light on health insurance rates, or become just another forum for the health insurance industry to obscure data and continue imposing unjustifiable rate hikes on consumers. In-depth information is critical for consumer experts to be able to meaningfully interpret insurance information, especially when it comes to rate increases based solely on calculations made by an insurance company's employees or contractors.

All three parts of the preliminary rate justification should be publicly disclosed, regardless of whether a State or HHS conducts the review. In fact, as the only part that will allow an independent analysis of a proposed increase, the third part is the most important piece of the puzzle. It must be made public in all cases.

The rate justification must contain comprehensive information about insurer spending.
The Regulation takes its cue from work conducted by the National Association of Insurance Commissioners (NAIC) to develop a three-part rate justification form. We generally applaud the

[1] J. Robert Hunter, Consumer Federation of America, "State Automobile Insurance: A National Quality Assessment and In-Depth Review of California's Uniquely Effective Regulatory System," 2008, *available for download at:* http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/state_auto_insurance_report.pdf

scope of information that insurers would disclose through the forms developed by the NAIC, and note specific areas below where reported information should be expanded to provide the most complete picture of the reasons for a rate increase.

We are concerned however that the scope of information the Regulation proposes to disclose is significantly narrower than that proposed by the NAIC. For example, the NAIC proposal would require disclosure of such basic information as: the proposed average rate increase; changes in medical utilization, price, and benefits; and, a breakdown of premiums into categories that are part of the medical loss ratio calculation, including clinical services, activities that improve health quality, and administrative costs. None of these elements is contained in the Regulation's current description of the preliminary rate justification.

We can only hope that the limited content of the preliminary rate justification as proposed in the Regulation is merely because greater detail will be provided in guidance. If this is not the case, the proposed level of disclosure is completely inadequate and will make public rate justifications meaningless.

We recommend the Regulation require disclosure of all of the information proposed by the NAIC. Taking the NAIC proposal as the baseline, we suggest additional disclosures that will give regulators and the public better information to identify any unnecessary or wasteful spending behind premium increases. (The NAIC proposal we base our comments on is here: http://www.naic.org/documents/committees_exec_plenary_101216_rate_filing_form.pdf)

Administrative expenses.
The preliminary rate justification should include a detailed allocation of administrative and overhead costs, to ensure public disclosure of the elements insurers use to determine the medical loss ratio. The disclosure should be expanded to include: lobbying expenditures, campaign contributions, utilization and benefit management expenses, advertising, travel, association fees and insurance. These costs are in large part already reported elsewhere, or otherwise required under the Affordable Care Act, and should not place a significant additional reporting burden on insurers.

Affiliate and parent company transfers.
The preliminary rate justification should also detail insurers' monetary transfers from state subsidiaries to both out-of-state affiliates and parent companies. Management agreement and service contract transactions with affiliates merit closer scrutiny, including the amount spent on each medical or administrative service provided, to ensure administrative costs are being appropriately accounted for under Section 2718 (the medical loss ratio requirement) of the health reform law. If not itemized, bulk payments to out-of-state affiliates could be used to camouflage excessive administrative costs or profit within the guise of purported payments for services.

The financial incentive when administrative costs are limited, as they are by the reform law's medical loss ratio requirements, is for the out-of-state affiliates to overcharge for medical services, and for the state entity to willingly overpay, in order to transfer profit amounts off the balance sheet that would otherwise exceed the limit. The public and regulators need enough information to determine whether affiliate transfers are legitimate payments for services rendered or if insurers are playing a shell game with premiums.

(Find Consumer Watchdog's analysis of multi-billion-dollar dividend distributions and affiliate transfers by Blue Cross of California here: http://www.consumerwatchdog.org/newsrelease/blue-crosswellpoint-profit-transfers-california-should-spur-national-investigation-congr)

Sample rate calculations.
Finally, the preliminary rate justification should also include standard examples of rate calculations that are the same across rate filings for all insurance companies, to demonstrate the impact of a rate change on policyholders in different circumstances and allow for comparisons across companies.

Such rating examples for health insurance filings would require an insurer to illustrate the premium impact on, for instance, a single younger applicant, a couple with no children, ages 50-55, and a family with two children. Each example would have different coverage levels and deductibles. The rating example would be generated for both the current rate and the proposed rate to illustrate changes. It would itemize the impact of each rating factor, and each coverage and deductible characteristic, on the sample policyholder's premium.

The guidance issued in February by California's Insurance Commissioner outlining the factors he will use to determine if a rate is "unreasonable" requires such an example of rate calculations to be included in the actuarial certification of a rate. (View that guidance here: http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/upload/Draft1163-2.pdf.)

§154.200 Rate increases subject to review

When should a rate be "subject to review" to determine if it is "unreasonable"?
It is important to note that, after years of unjustified health insurance rate hikes, even small rate increases, or no rate change at all, may result in consumers paying unreasonably high premiums. This is even more likely during these first few years of reform, when consumers have seen an avalanche of double-digit rate hikes that insurance companies seem to be rushing to enact before stronger regulation takes hold.

This probability makes it crucial for the Regulation to broadly define the conditions that will trigger review in order to capture all potentially unreasonable rates.

Any rate increase of 10 percent or greater.
Consumer Watchdog agrees that any increase of 10 percent or higher in a given year should trigger review. (Download Consumer Watchdog's prior comments supporting this threshold here: http://www.consumerwatchdog.org/resources/RateReview.Comments.pdf

However, subjecting rates to review only if they meet or exceed a 10 percent threshold would lock in a 9.9% increase as the *de facto* "reasonable" rate. In such a circumstance, the insurance company that raises rates 9.9% every year will never get reviewed. The Regulation must provide at least one other trigger for review to ensure whole categories of unreasonable rates don't slip through the cracks.

Any rate increase that exceeds the rate of increase of medical spending.
As Consumer Watchdog wrote in our initial comments, we believe a rate increase that exceeds the rate of increase of medical spending should be a second trigger.

The draft regulation cites several national measures of changes in medical costs, spending and utilization, each of which is currently increasing at a rate well below 10% per year. As calculated by the Bureau of Labor Statistics in the Consumer Price Index (CPI), "medical care" inflation, including prescription drugs, medical equipment and supplies, and medical care and other services, increased 2.9 percent in 2010. A broader measure, the Standard & Poor's Healthcare Economic Commercial Index which considers both medical costs and changes in utilization, reported an average 6.06 percent increase in the per capita cost of healthcare services during 2010.

By both measures, a 10% rate increase would have well exceeded increases in medical spending last year.

In fact, a recent study by Weiss Ratings finds a *decrease* in overall medical costs for health insurers in 2010, for the first time in ten years.[2] With medical costs falling for some insurers for the first time in a decade, insurance companies cannot credibly continue to insist double-digit rate hikes are due to increasing medical costs.

The Regulation should include a second trigger to subject rate increases to review: Any rate increase that exceeds 150% of the CPI's rate of medical inflation, or any increase that is greater than the S&P Healthcare Index. Just as with the 10 percent trigger, these thresholds do not indicate an increase is necessarily unreasonable, but does raise enough concern to merit further review.

Any rate increase by an insurer that failed to meet the medical loss ratio requirement in the prior year.
Any proposed rate increase, regardless of the percentage, that is proposed by an insurer that failed to meet the medical loss ratio requirements of section 2718 for any policy form in the year prior to the proposed increase should be subject to review. The assumption is that the insurer failed to meet the medical loss ratio requirement because the insurer's overhead and administrative expenses were too high in relation to the amount of the premium spent on medical care.

Even though insurers must refund overcharges to consumers if their medical loss ratios fall below the levels required by the federal law, those refunds do not address the fact that future premium increases will also be unreasonable if tiered off the prior year's premium increase.

The Regulation should apply to all rate increases proposed or implemented since the federal reform law was enacted.
Section 2794 very clearly states that its provisions apply "beginning with the 2010 plan year." The Regulation would take effect July 1, 2011. Although it was appropriate for HHS to solicit input from state regulators, the industry and the public prior to issuing rules, consumers should not pay the price of this delay. All rate increases proposed or implemented since the federal health reform law was approved should be subject to review to determine if they are unreasonable per the Regulation's standards. As the Regulation requires only review and disclosure, not modification of rates, it can easily be applied to rates that have already taken effect without any disruption in the market.

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[2] Weiss Ratings, "No Rise in Health Insurer Medical Costs for First Time in 10 Years," Feb. 14, 2011. http://www.weissratings.com/News/Ins_General/20110214general.html

§154.210 Review of rate increases subject to review by HHS or by a State

HHS should set minimum standards for the definition of an "unreasonable" rate.
HHS should not leave the definition of an unreasonable rate to those states that conduct reviews. A complete lack of a national standard could lead to *pro forma* or arbitrary determinations of whether rates are "unreasonable." The Regulation should set minimum standards that apply in all states to determine whether a rate is unreasonable, and states should be able to go above and beyond that definition. The national baseline should be the definition of "unreasonable" in §154.205 of the Regulation.

No doubt some states already go beyond this definition, by prohibiting rates that are unreasonable in relation to the benefits provided. However, simply requiring that there be a standard set forth in regulation or law, no matter what that standard entails, is not enough.

§154.301 HHS's determinations of effective rate review programs.

The Regulation should support the traditional role of the states as front line regulators. State-based regulators have expertise in the local laws, insurance market and consumer concerns that a federal regulator does not. However, the federal law requires review and the Regulation must also set minimum guidelines to ensure basic standards for review are met. In addition to the factors laid out in the Regulation, several other standards should be used to determine if a state has an "effective" rate review program.

The public's ability to comment during the review process is necessary for effective rate review.
Consumer participation, with full transparency in the rate review process and a formal public comment system, should be a minimum factor for HHS to determine a state has an effective rate review program. That measure must include full access by the public to the data submitted by insurers to HHS and the state. In those states with prior approval authority, or those that hold formal hearings on rate increases, consumers must have the right to official standing in the rate review process.

In fact, funded public intervention is the only way to make consumer participation steadily effective. Funded intervention ensures that consumers' representatives can hire their own actuaries and experts to examine the claims made by insurance companies. A public intervenor serves as a counterbalance on state regulators to help ensure review occurs, no matter what the political climate or fiscal condition of the Department of Insurance. HHS should use the remaining rate review grants to encourage states to create funded intervention systems, as Maine did by allocating $200,000 of its grant funds for the participation of consumer experts in rate hearings.

In California, the intervenor system established under Proposition 103 has allowed Consumer Watchdog to save auto, homeowners and medical malpractice policyholders $2 billion since 2003 by challenging excessive rates.

Prior review is necessary for effective rate review.
The Regulation should also require that insurance companies file rates with state regulators before they take effect in order to determine whether a state has an effective rate review program.

Ultimately, consumers will not be protected from unjustified rate hikes until regulators have full authority to modify, and not just review, unreasonable rates before they take effect. However, if transparency and review is strengthened, this Regulation can move the rate review process forward in the states and provide some desperately needed sunshine, if not relief, for consumers facing unaffordable premium increases. Thank you for considering our views.

Sincerely,

Carmen Balber