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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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**Comments of Consumers Union of U.S., Inc., on
Rate Increase Disclosure and Review Reporting Requirements
(45 CFR Part 154); CMS-10379**

Introduction

Consumers Union, the independent, nonprofit publisher of *Consumer Reports*,¹ is pleased to provide the following comments to the U.S. Department of Health and Human Services (HHS). These comments address the proposed Rate Increase Disclosure and Review Reporting Requirements under Section 1003 of the Patient Protection and Affordable Care Act (ACA) (Section 2794 of the Public Health Service Act). Under this section, the Secretary, in conjunction with the States, is required to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage. The Secretary is required to provide a means for “the public disclosure of information on such increases and justifications” (underlined added).

Our comments address the proposed preliminary justification templates, plain-language disclosure forms, and reporting requirements that are intended to meet the ACA’s requirement that consumers have a public justification of the increases that are subject to review.

¹ Consumers Union is a nonprofit organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union publications have approximately 8.3 million combined paid circulation and carry no advertising and receive no commercial support. Consumers Union income is solely derived from the sale of Consumer Reports and ConsumerReports.org, its other publications and from noncommercial contributions, grants and fees. In addition product testing, Consumer Reports and ConsumerReports.org regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare.

Background:

The ACA requires health insurance issuers to provide HHS and states with a preliminary justification for rate increases that are above a defined threshold. In December, HHS published a proposed regulation establishing the rate review process and associated issuer reporting and disclosure requirements for these increases. (See Rate Increase Disclosure and Review; Proposed Rule, 75 FR 81004, hereinafter “the Proposed Rule”). HHS proposes the following reporting requirements:

Review Step	Required Reporting		When?	Purpose	How Accessed?
Preliminary Justification	Part I	Rate Increase Summary	All rate increases that exceed the reporting threshold and therefore are subject to review	Provide consumers a thorough narrative description and quantitative analysis of all rate increases that are subject to review	Posted on an HHS website
	Part II	Written Explanation of the Rate Increase			
	Part III	Rate Filing Documentation	When HHS is conducting the review (because HHS has determined that the state lacks an “effective” rate review process)	Provide HHS with material needed to conduct an actuarial review	HHS will post any information contained in Part III of the preliminary justification that is not designated as “confidential” ²
Final Determination	<i>There is no specific form or set of instructions associated with the Review Final Determination. A short text narrative will be used.</i>		After final determination is made		Posted on an HHS website in the same location as the Preliminary Justification. If found unreasonable, must be posted on the carrier’s website.
Final Justification	<i>There is no form or instructions associated with this statement apart from the requirements provided in the proposed regulation. A short text narrative will be used.</i>		Rate is found to be unreasonable in final determination <u>and</u> the carrier proceeds with the rate increase.		Posted on an HHS website in the same location as the Preliminary Justification and Final Determination. Must also be posted on the carrier’s website.

The proposal asks carriers to enter into the electronic system the information required by Parts I and II of the preliminary justification. This information will be publicly available on an HHS website.

² “Confidential” is defined in HHS’ Freedom of Information Act regulations, 45 CFR § 5.65, per the document 508_CMS-10379.

In addition, this information will directly populate a **new consumer disclosure document**, to be posted on the healthcare.gov website.

A final determination on the rate increase will be made in one of two ways. HHS will adopt a state's determination if the state has an effective rate review program as set forth in the Notice of Proposed Rulemaking (NPRM). HHS will conduct reviews of rates that exceed the threshold in the remaining states. HHS does not have the authority to reject rate increases, even those that it determines to be unreasonable. Therefore, carriers may implement rate increases found to be unreasonable, but in these cases, carriers must post a final justification for the unreasonable increase on their websites, and HHS will post the final justification on its website, as described in the chart above.

Additional Review and New Reporting Requirements Will Help Consumers

Consumers Union generally supports the Proposed Rule and the proposed reporting and disclosure requirements stemming from the Rule. By ensuring that the more burdensome rate increases are subject to a review process, consumers will have greater protection from excessive increases. In addition, public disclosure of justifications for rate increases holds carriers more accountable for how they spend consumers' healthcare dollars and encourages them to be careful in how they calculate rate increases. Public justifications also can help educate consumers about their rates and the major cost drivers behind rising premiums.

Below, we propose specific ideas for strengthening the reporting and disclosure requirements so that the information provided will be more effective in helping consumers, small businesses, lawmakers, and outside experts understand these rate increases.

Overarching Concerns

As an initial matter, we reiterate a concern made in our prior comments on the Proposed Rule. **The Proposed Rule should require that entire rate filings for rate increases subject to review be made public, including the supporting documentation that would be included in Part III of the preliminary justification.** Instead, HHS's proposed framework for disclosure would require it to "promptly" post Parts I and II of the preliminary justification on its website prior to implementation of the rate increase; however, Part III will be posted at some other point after its receipt, and only those parts that are not designated as confidential will be posted. Moreover, carriers would not be required to submit Part III if the rate increases will be reviewed by the state. Many states do not make these filings public.

We strongly believe that entire rate filings for all rate increases subject to review should be open to public scrutiny. Public disclosure of the documentation supporting these rate increases will help keep carriers more honest in their projections, pressure them to lower costs instead of just passing them on to consumers, and will allow for public evaluation of healthcare cost drivers and trends. States that have transparent rate filings and a more

open rate review process, such as Oregon and Maine, are demonstrating strong results for consumers in lowering proposed rate increases.

Having said that, our recommendations are designed to improve the disclosures made within the proposed framework. **We have identified certain additional information that should be included in the automatically-disclosed Parts I and II of the preliminary justification so that these disclosures are sufficient to assess the rate justification.**

While many policyholders may only be interested in the limited information included in the “consumer disclosure,” for the law to function as intended, “the **public** disclosure of information on such increases and justifications”³ must be sufficient to allow any interested party to make a fair assessment of the asserted need for the rate increase.

For a majority of rate increases, consumers, businesses, advocates, outside experts, lawmakers, or any other interested parties will be relying primarily on Parts I and Parts II to evaluate the rate increase. Part III of the preliminary justification may be redacted if it contains information determined to be confidential and it would not be required at all in states that have a rate review process that has been deemed “effective.” We have concerns that some states may be deemed effective, even if they keep rate filings confidential.⁴ Therefore, for many increases, Parts I and II may be the only information that these parties will have access to. For these reasons, it is critical that the disclosures in Parts I and II provide a greater breadth of data and information.

Below we describe the additional information that we recommend including in Parts I and II. Much of the additional data elements that we recommend below are included in some format in one of the three sections included on a Disclosure Form developed by an NAIC Committee, with input from consumer representatives.⁵ It is our understanding that the NAIC made no recommendation that these data elements be kept confidential. Indeed, we fail to see how rate filing documentation, which typically includes data such as claims history or numeric values of rating factors, constitutes confidential information.⁶

³ See ACA, section 1003 (section 2794 of the Public Health Service Act), 42 U.S.C. 300gg-94.

⁴ For example, Maryland and North Carolina are prior approval states that are likely to qualify as “effective.” But Maryland has refused to release any part of a rate filing or justification. North Carolina provides online access to rate filings, but some are so heavily redacted that they do not provide sufficient justification. Other states, such as Oregon and Maine, require disclosure of all materials supporting an increase, so those consumers would receive more information than what is proposed in Parts I and II.

⁵ http://www.naic.org/documents/committees_b_rate_filing_disclosure_form.pdf

⁶ Carriers usually point to potential competitive harm when arguing that rate filings should be confidential. Among the definitions of confidential information exempt from disclosure under 45 CFR Section 5.65 is information for which “[d]isclosure would substantially harm the competitive position of the person who submitted the information.” The type of claims data and other information used to develop rate increases are typical among carriers and we have not seen any evidence in states with full disclosure suggesting that that competitors could use such information to substantially harm the filer.

Comments on the “consumer disclosure” form follow the comments on the preliminary justification forms.

Preliminary Justification Reporting – Part I

Part I, the Rate Increase Summary as proposed in the Rate Summary Worksheet and the Instructions for Completing Part I of the Preliminary Justification, has some significant omissions and needs some clarification.

1. Premium Revenue

The most glaring problem with the proposed Part I is that it appears to lack clear data about premium revenue for the product or products subject to review. Carriers calculate rate increases by estimating how much revenue will be earned at current rates during a future time period. They then compare that projected revenue to an estimate of future claims, expenses and profits for the same time period. If projected revenue at current rates is expected to fall short of covering projected claims, expenses and profits, a rate increase will be needed to make up the difference.

In other words, rate increases are based on a simple equation: projected costs - projected revenues = increase needed. Part I, as proposed, gives us only half the equation. Section C seems to be an attempt to bring the revenue projection into the equation, but it is not clear what the exact projection is for revenue at current rates for the rating period and how that compares to projected claims, expenses and profits.

The form should be expanded to include fields in which the carrier will report **total** premium revenue **and per member per month** (PMPM) base period premium revenue (Section A), premium revenue for the adjusted period that begins 12 months before the effective date of the proposed increase (Section B1) and projected revenue at current rates for the future rating period (Section B2). In addition, fields should be created in Section D. that will provide the projected total and PMPM revenue for the rating period if the rate increase is approved. Rate filings in some states already include such information.

Clear reporting of premium revenue is needed because PMPM revenue can change for the future rating period even if rates do not change. Carriers should report the total projected revenue, with a break down of the types of anticipated changes to PMPM revenue at current rates. The form should include fields for these anticipated changes, such as “premium trend,” which are changes in PMPM revenue that are due to demographic changes rather than rate increases. For example, if the average age of members covered in a product is expected to increase, the carrier will realize higher average revenues even without an increase because members pay higher premiums as they enter higher age brackets. Projected revenues also must reflect assumptions such as anticipated changes in enrollment, that might result in higher or lower PMPM premiums earned (and might also result in changes to projected PMPM claims – see changes to enrollment below). The claim projection PMPM will take into account these shifts, so

therefore the premium projection PMPM should also take this into account.⁷ Estimated investment income earned on the product should also be included in total revenue projections, and reported in a separate field. (See underwriting gain/loss below).

By including the historical premium PMPM data in Section A and then showing the adjustments made in Sections B1 and B2, it will allow consumers to see how the insurance company premium revenue has changed from the historical experience period to the projected rate period.

Only by comparing projected PMPM premium at current rates with projected PMPM claims, administrative costs and underwriting gains/losses, can we determine how much current rates need to rise to cover projected costs. Part I, as proposed, does not allow issuers to report and users to easily identify any adjustment to revenue at current rates that could, potentially, be used to cover any projected increase in claims (or result in a steeper shortfall).

2. *Enrollment figures*

We recommend adding a field to Sections A, B1 and B2 that will report the number of actual and projected enrolled members for each time period. This would allow verification of PMPM calculations and enable tracking of losses or gains in enrollment.

3. *Claims History*

Historical claims data, preferably for at least three years, must be disclosed in Part I of the preliminary justification. Because actuarial assumptions are largely based on historical claims data, this information is essential to determining whether a rate appears reasonable. A year-over-year PMPM claims history for a product allows us to see how much average medical claims have actually risen over the past few years, and whether the medical trends used to project claims appear reasonable. Future trends can differ from those in the past, but allowing for disclosure of a history would prompt a carrier to explain any significant anticipated deviation from prior years that is contributing to the rate increase. **Carriers should not be permitted to keep this information confidential because they consistently and publicly point to “rising medical costs” as the reasons for these double-digit rate increases.** A claims history provides further verification for carriers’ most-often used justification.

4. *Trend Total and Further Breakdown of Trends*

The form should include fields for reporting the total medical trend factor used, along with the breakdown by service categories. In addition to disclosing medical trends according to service categories, carriers should report trends according to how much is attributed to unit cost increases and how much to utilization. In addition, some carriers

⁷ “The costs that will be incurred and the revenue that will be received are not known at the time the rate is established (indeed, the number of people that will be covered by the product is not known...)” 45 FR 81005.

use factors such as deductible leveraging and “deterioration” in their pricing.⁸ These also need to be identified and reported separately. This can be done with respect to each service category, or with respect to the total trend. Reporting these items is critical for evaluating why medical costs continue to rise and can flag abnormally high unit cost increases or utilization for a particular product. It is also necessary for determining which assumptions carriers are using and whether they are reasonable.

5. *Breakdown of Administrative Costs*

Consumers and businesses should get detailed information about where their premium dollars will go when carriers are seeking to impose double-digit rate increases. The Part I Rate Summary Worksheet includes just one field for reporting administrative costs in Section C.2., and does not provide a breakdown of costs. Carriers should report in Section C.2. the PMPM amounts projected to go to major administrative categories, including marketing, broker commissions and other forms of producer compensation, executive compensation, claims processing and cost control programs (those categories are identified on carrier financial statements).⁹ Historical administrative cost information should be submitted in total as well as split into various components.

6. *Whether the Increase Applies to an Open or Closed Block*

A carrier should report in Part I whether the block of business subject to the proposed increase is open or closed. Closed blocks are often hit with high increases, which may not be justified if they can be avoided by blending the experience of a closed block with a similar open block. (This also highlights the need for a carrier to report enrollment, as low enrollment in a particular policy or block may indicate a need for broader pooling). Disclosing the open or closed status is important for carrier accountability. The public should see which carriers are operating closed blocks and whether policyholders in those blocks are being hard hit by rate hikes.

7. *Rating Factors*

In some rate filings, carriers report which rating factors are applied in determining premiums for various categories of enrollees, as well as plan benefit factors, and the

⁸ The trend factors, as disclosed in Part I, could allow a carrier to “hide” assumptions commonly used in individual market pricing that are not based on unit cost or utilization trends, but on so-called “insurance” trends. These assumptions, such as deductible leveraging factors, anti-selection factors, and duration factors, result in higher cost projections. We believe that using such assumptions is suspect and should be carefully scrutinized, and in a perfect world the service category factors alone would be used to calculate rates. But because we have seen several carriers using these factors, we are concerned that not requiring disclosure or data in support of these factors will lead carriers to simply build them into service category trends. We ask that either the Part I summary or Part II narrative instructions require carriers to disclose whether they are applying any of these factors when developing their overall medical trends and the numeric value of these factors.

⁹ The Proposed Rule specifies that “employee and executive compensation data” should be reported, but there is no field for this on the Summary Worksheet. 45 FR 81027, Section 154.215(e)(8). It is not clear where this information would be disclosed, if at all.

numeric value of these factors. We believe these rating factors should be disclosed in the preliminary justification. This would allow scrutiny of how a carrier is distributing an overall increase across its members, whether the carrier is complying with state rating laws, and to evaluate whether certain categories of members are being unreasonably targeted for higher rates.

8. *Reserves*

Any contract reserves being held for a policy should be reported. These reserves are built with premium dollars and presumably held to mitigate future rate increases as costs rise for members in a policy or block. These reserves should be disclosed so that the public has a realistic accounting of the necessity for the increase.

9. *Underwriting Gain/Loss*

With respect to the underwriting gain / loss, information should also be provided regarding investment income as well as the return on surplus expected from the rates. Taking into account investment income and financial leverage, the return on surplus can be much bigger than the underwriting profit. The 4.35% underwriting profit shown in the rate summary worksheet can easily be equivalent to a return on surplus of more than 15%. Consumers should have this information to evaluate whether the profit included in the rate is reasonable.

10. *Financial Information*

As noted in the NAIC Disclosure Form, a rate filing “cannot be understood without a wider understanding of the company.” At a minimum, the five-year historical data exhibit from a company’s most recent annual financial statement should be included in the publicly disclosed filing.

In addition to these overarching recommendations for additions to Part I, we recommend the following clarifications:

Instructions

- The instructions should specify that the base period data should include data for the most recent period for which actual experience is available, including incurred claims. This will limit a carrier’s ability to selectively choose a base period that reflects higher costs and will make Section B1 and B2 projections more accurate.

A. *Base Period Data*

- According to the Instructions For Completing The Preliminary Justification (Page 2), “The base period data may include data from other products or sources if the experience for the product is not fully credible (e.g., national level data).” Hence, it appears that insurers do not have to rely on just the actual experience for the product

being priced. In order for HHS and consumers to understand what experience is being shown, Part A should be expanded to show both the *actual* experience as well as any adjustments that are made to arrive at the base period data.

- The net claims will consist of both payments and reserves. The values for net claims should be shown separately for payments and reserves. Furthermore, different types of reserves (claims, contract, etc.) should be shown separately.
- Member's Cost Sharing PMPM is shown as a dollar amount. In Sections B and C, the Member's Cost Sharing is shown as a fraction. These columns should be made consistent, as otherwise it could be confusing. As the very least, it should be made clear that the Section B and C values are fractions. Perhaps showing these as percentages would be helpful.

B1, B2 Adjustment to the Current Rate and Claims Projection for Future Rate

- The overall medical trend presumably would be calculated as an annual trend extended over the time period to adjust to the current rate and future rate. The annual trend should be shown as well as the overall medical trend. Showing the annual trend will allow for a comparison between the overall medical trends in Sections B1 and B2. In the example provided by HHS, the implicit annual trend rate is much larger in B2 than in B1. If a company uses different annual trend rates in the two periods, then an explanation should be required for the difference.
- The member cost sharing column is a fractional value as opposed to a dollar value as shown in Section A. The formats should be made consistent, or at least clearer that there is a difference.

C. Components of Current and Future Rates

- For clarity, the cell in Section C "prior estimates of current rate" should specify the effective date and period of time of the rate filing in which the current rates were estimated. The carrier instructions should be amended to reflect this.

F. Range and Scope of Proposed Increase

- In addition to having the maximum % increase, it would be useful to obtain information on the maximum dollar (\$) increase.
- Descriptions should be given of the type of policyholder getting the minimum and maximum rate increases.

Part II – Written Explanation of the Rate Increase

Part II of the proposed form requires a non-technical narrative description of why the carrier is requesting the proposed increase. In addition to the items proposed in the Instructions for Completing Part II of the Preliminary Justification, we recommend augmenting the information to be included with the following:

- An explanation for all assumptions used in calculating the rate increase. For example, assumptions about changes in utilization rates, changes in enrollment, changes in benefits or cost-sharing, changes in demographics of the members or any others impacting the rate increase should be described.
- Any changes in members' cost sharing reported from Section B1 to Section B2 should be explained.
- The carrier should describe how past rate increases are impacting policyholders, including increased switching to higher deductible plans or plans with less rich benefits.
- The carrier should describe the rating factors used, such as a brief sentence describing geographic factors, if used, or age factors (see discussion above).

We recommend that HHS consider Sections II and III of the NAIC Disclosure Form as a template for Part II.

Part III – Rate Filing Documentation

We generally agree with the Part III rate filing requirements. We note that HHS would require reporting of anticipated lifetime loss ratios for the product. We would hope that HHS will not rely on lifetime loss ratio exhibits in evaluating the rate increase. In our experience, lifetime loss ratios, which rely on projections far into the future, are easily manipulated and unreliable.

Consumer Disclosure About Proposed Health Insurance Rate Increase

The statute requires HHS to disclose certain information to consumers “prior to the implementation of unreasonable rates.”

In general, we find the proposed disclosure clear and consumer friendly. We believe these recommendations below would strengthen it further.

Lack of notification process

Fulfilling the requirements of the ACA to publicly post rate increases and justifications will do little good if consumers aren't aware of increases that affect them. The reporting requirements and the Proposed Rule have no provision for notifying consumers that information about an increase that affects them has been posted on HHS website. Hence, there needs to be a way for consumers to readily determine whether there is a rate increase that meets the 10% threshold and affects them.

- We recommend adopting some sort of notification requirement whereby carriers notify affected policyholders and direct them to the two types of information available to them: The consumer disclosure and the more detailed information found in the Preliminary Justification.

In addition, the disclosure doesn't indicate when the review will be complete, leaving consumers with the only option of checking back from time to time.

- We recommend that an e-alert be offered on healthcare.gov site that will notify the consumer when the final determination has been posted and again when the final determination has been posted.

Consumer uncertainty about whether they are affected

Nothing in the disclosure form allows a consumer to confirm whether the proposed rate increase affects them. Providing the state, company and product name may be insufficient for a consumer to confirm whether or not the information is relevant to them. We recommend including a tool or link that allows them to confirm whether or not they are currently enrolled in the plan.

If the proposed notification (described above) is included, then the first page could say: if this rate increase affects you, you will have received a letter from your carrier. But some sort of additional method of confirmation will be needed.

Increasing the clarity of the disclosure

- On page 1: The sequence of events would be clearer to readers if the order of the final four sentences were changed to read:

This posting does not mean that the proposed rate increase is too high or unreasonable. That can be determined only after the rates have been reviewed.

The Indiana Department of Insurance will review this proposed rate increase.

When the review is completed, you can see the result by checking this website.

Consider: most of the document treats the "rate" as singular. In the sentence above, consider replacing "rates have" with "rate has."

- On page 2, where rate factors are explained, we recommend linking to the part I and II discussion of rate factors.

- On page 3, add the word “monthly” and “premium” as indicated:
The Proposed 11.8% Increase Adds \$24.82 to the **Monthly Average Premium**

In the table on page 2, add a row at the bottom for “total” and place the \$24.82 figure there, along with the total percentage “100%” for additional clarity about the calculations.

On page 4, eliminate the sentence “The insurance company believes that **80%** of the **11.8%** total proposed rate increase will be the result of higher medical service costs next year.” The main point of the paragraph is still clear, and the math in the sentence is pretty complicated for many consumers.

On page 6, the caveat “These increases were approved before this review process was in place” will soon be true for some rate increases, but not others. You may want to alter the form (or use an asterisk) to allow for this situation.

Provide a better indication of what the consumer is to do

It isn’t clear from the disclosure what action, if any, the consumer is supposed to take. Until you get to the last page, there is also no resource for more information if they have questions. We recommend:

- On the first page, state: **there is nothing that policyholders need to do at this time.** If you’d like to be notified when the rate review is complete, please use this form to sign up for an email alert. (The sign up form should, of course, reassure the consumer that their email will not be used for any other purpose or shared with other organizations.)
- On the first page, include the sentence: If you have questions about this proposed rate increase, or any other questions about this plan, you should contact your state insurance regulator. Information at the end of this form will help you.
- On the last page, include a link to contact information for each state regulator. This contact information must be the actual person/office the consumer is to talk to, not a general number that requires extensive navigation on the part of the consumer to get their questions answered. If this type of resource doesn’t exist, this instruction should be replaced with a source of help that is really exists.