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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9999-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Notice of Proposed Rulemaking - Rate Increase Disclosure and Review
Submitted via www.regulations.gov

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the notice of proposed rulemaking ("NPRM") relating to Rate Increase Disclosure and Review published in the *Federal Register* on December 23, 2010. The NPRM implements Section 2794 of the Public Health Service Act (PHSA), as enacted in the Patient Protection and Affordable Care Act (PPACA), which was signed into law March 23, 2010.

AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and have demonstrated a strong commitment to participation in public programs.

We appreciate the opportunity to comment on the rate increase disclosure and review requirements of the NPRM. From a process perspective, AHIP and our members are pleased that implementation of Section 2794 is proceeding with an NPRM rather than an interim final rule, as this process offers the opportunity for additional information sharing and consideration by consumers, health plans, and states as this important provision is implemented.

At the outset, we want to recognize that the NPRM addresses some of the important issues raised by AHIP in our comment letter responding to the Request for Information on the Rate Review Process. We strongly support the decision to retain the state-based tradition of rate review, with the primary focus of responsibility at the state level. We also support the scope of the new process as focused on the individual and small group markets (as defined by states) for all of the reasons set forth in the NPRM's preamble; this is the best use of state resources and recognizes the differences between regulation of small group and large group rates. As stated in the Preamble, purchasers in the large group market are sophisticated purchasers and states have

limited authority over this market. As a result, we recommend that the regulation maintain its scope of coverage to the individual and small group markets only.

Before addressing the issues raised by the NPRM, we want to stress that the implementation of Section 2794 does not address cost containment of the underlying drivers of health care costs. While stakeholders will have differing views over the specifics, there is no path to long-term fiscal responsibility that does not include a comprehensive approach to reducing health care cost growth. In addition to its impact on the federal budget, health care cost growth threatens our economic competitiveness, our public safety net, and the affordability of coverage for families and employers.

While our members are taking aggressive steps to address the cost crisis, a comprehensive discussion of rates needs to look at all components of expenditures. The annual national health expenditure data published by the Centers for Medicare & Medicaid Services (CMS) indicates that the costs associated with health insurance – including plan profits and administrative costs – account for only 4 percent of all national health expenditures. The other 96 percent of costs can be attributed to hospitals, physicians, pharmaceuticals, home health care, and other components of health care spending.

It is vitally important to recognize that implementation of Section 2794 through this NPRM cannot solve the problem of the rapid growth of the components of health care spending. Health plan solvency is threatened if these costs continue to grow unabated, but actuarially justified rate increases are not allowed to go into effect. Such suppression of rate increases would also significantly add to premium fluctuations, creating needless volatility for consumers and new burdensome and unnecessary administrative costs. We urge a reasoned approach to rate review that assures premiums are fair in proportion to the cost of the benefits covered.

Our comments and recommendations are categorized as follows:

- We offer several broad priorities for guiding the implementation of rate review in terms of providing consumers with information that provides them with understandable information about rate increases, including underlying cost drivers, actuarial soundness, financial solvency, and timeliness.

- We outline our recommendations on specific implementation issues.

I. Framing the Implementation of Rate Review in Terms of Understandable Information, Actuarial Soundness, Financial Solvency, and Timeliness

We begin by offering some overall framing thoughts before discussing general and specific comments regarding the NPRM proposal:

- ***Retrieving Useful and Understandable Information Should Be the Central Goal:*** AHIP and its members are committed to useful information transparency and believe consumers should have access to better information about the factors contributing to premium increases. This information will help consumers and regulators make informed

decisions and will have the additional benefit of emphasizing the overall cost drivers associated with rate calculation and identifying the impact of underlying medical costs on the cost of health insurance coverage.

- ***Examinations of Rate Increases Should Be Tied to the Twin Goals of Actuarial Soundness and Solvency:*** The true benchmark of an effective review program will be whether the review of the rate increase focuses on the goals of actuarial soundness and solvency. Politicizing the reviews, for example, threatens to undermine the financial health and continued viability of health plans. Rates must be adequate to cover the costs of medical care utilized by insured members, and administration of health insurance services. Additionally, rates must be adequate to assure that health plans remain solvent to meet the promises of paying claims and meeting customers' expectations by having adequate reserves on hand to meet those obligations. The rate review examinations should be viewed in light of the overall regulatory scheme in PPACA, including the Medical Loss Ratio provisions which require a retrospective review of premium dollars spent and rebating if the thresholds are not met.

- ***Timeliness of the Review Process is Critical:*** We want to emphasize that there is a strong public interest in timely resolution of review of rate increases. Reviews of rate increases targeted for review should not remain in limbo. Undue delay of rate increases determined to be reasonable through the review process will have the effect of causing higher future increases to address rate shortfalls, and potential exits from markets when companies face uncertain standards of fairness of review.

  Thus, we recommend that such reviews follow clearly delineated timeframes for resolution by states with effective review programs as well as those instances in which HHS conducts the reviews. Insurers should be given adequate timeframes to respond to questions, especially if the reviewer seeks large sets of data or historical information. The process for such reviews should outline clear timelines, with reviewers held to meeting those timelines. Such timeframes should be in the range of 30-45 days.

This approach offers the best opportunity for a workable and more transparent system that will allow for appropriate review of rate increases that provides a useful service to consumers while retaining the long-term solvency of health plans.

II. *Implementation Concerns and Comments*

A. Priority Concerns and Comments

1. An Inadequate Timeframe to Implement the Review Process Will Not Give States Enough Time to Meet Requirements and Threatens Disruption

The NPRM provides that a state must have in place four major factors for its examination process to be considered to be effective. *See* Proposed §154.301(a)(1)-(4). These factors have significant detail attached and include requirements that the review be timely and effective. The third factor setting out the requirements for the examination process sets out twelve specific elements. The Preamble states that "HHS expects a *significant majority of States* would

currently meet the standards for having an effective review process in one or both of the individual or small group markets…" (*emphasis provided).* But, the Preamble also notes that others would "likely establish an effective rate review process *as they obtain needed statutory authority or implement new or enhanced review procedures*." *(emphasis provided) See* 75 Fed. Reg. 81007.

There is inadequate time between now and July 1, 2011, for states to establish "effective review" programs if such programs are not already in place for both the individual and small group markets. The NPRM has not indicated how many states would meet the standards for one or both markets as currently proposed. Additionally, the window for establishing a program that meets the federal requirements for effectiveness will be even shorter if states defer action until final requirements are set forth in a final rule. Although the Preamble has projected that a "significant majority" would meet this standard in the individual or small group market (or both), it is unclear exactly how many states will need to modify their programs (and in what manner) to meet the standard. And, state legislatures may not have time to act to provide additional authority and/or issue new state regulations.

It would be disruptive and confusing to require disclosure to HHS and review by HHS of rate increases if states are delayed in setting up new systems in order to meet these stringent timeframes. Health plans also are challenged by the lack of clear knowledge of whether or when to file the additional rate disclosure to the state(s) only, or to the state(s) and HHS for review.

According to the Preamble, HHS would make its "effectiveness" determinations based on documentation and information received from the state through the grant process, through review of applicable state law, and through any other information otherwise available to HHS. It is not clear whether HHS will engage in additional detailed review and what the timing will be for making these determinations.

Recommendation:

In order to avoid disruption at the state level, we recommend that the best course of action would be to delay the effect of this regulation until there is sufficient time for states to build effective rate review programs in both the individual and small group markets. One approach could be to delay the effective date until July 1, 2012. This would give states an ample window to develop "effective" rate review programs by legislation or regulation (as necessary) in both the individual and small group markets. Another approach could be to delay the effective date of the regulation until the majority of states have effective rate review programs in both the individual and small group markets.

In conjunction with our comments above, we also would urge that HHS modify the discrepancy of treatment given to rate increases in the majority of states that have a filing requirement versus those states that do not. Rate increases for 2011 may already be scheduled to go into effect on a rolling basis throughout the year, typically based on policy renewal dates. The issue is that in states where there is no filing requirement, part of these increases would now retroactively be subject to the Proposed Rule which is likely to create confusion in local marketplaces.

To better align implementation across states, we suggest that in states where there is no filing requirement that HHS allow a reasonable roll forward period from July 1, in order to avoid retroactive application of the NPRM process to rates that already have been announced to the market and have formed the basis of decision making for a wide range of consumers.

Another related issue is the degree to which HHS will be establishing additional detailed federal standards or requirements surrounding the four major required factors for the review process and examining state processes according to national uniform standards. We are concerned that detailed federal standards here will be disruptive to differing state approaches based on specific state environments, resources, and markets. We suggest that these standards remain broad and allow for states to establish differing approaches to meeting the broad goals of developing an effective and timely program.

2. Identifying a Specific Numeric Threshold for Review Does Not Strike the Goal of Balance Articulated in the NPRM; Threshold for 2011 and Beyond Should Not Be Based on a Flat Numerical Benchmark

The NPRM established that a rate increase of 10% or more that is filed in a state on or after July 1, 2011 (or effective on or after July 1, 2011, for states that do not require rate filing) is subject to review to determine if the increase is unreasonable. HHS has solicited comments on whether 10% is a reasonable threshold. *See* 75 Fed. Reg. 81006.

We urge reconsideration of the approach of choosing a specific numerical benchmark, and would suggest that the 10% threshold is not a reasonable threshold. The Preamble, for example, suggests that nearly 50% or fully half of all increases in the entire individual market exceeded 10% each year for the past 3 years. It proffers that all such rates should be subject to further review because these yearly increases exceed some measures of medical cost inflation. Other surveys similarly suggest that a very high number of rate increases in some product lines will likely meet or exceed the 10 percent threshold for cost trends for 2011. According to a recent survey, for example, 63 percent of survey respondents projected open-access PPO trend rates for 2011 in the range of 10-14.9% and 4 percent in the range of 15-19.9%.[1]

The NPRM suggests that the 10% threshold is appropriate because it "balances" concerns that any threshold would be over-inclusive with the competing concern that it would subject too few rates to review. We are concerned, however, that a standard which would subject more than half of all rates to review in a particular market does not strike this balance. In this regard, it does not seem reasonable to assume that more than half of all rate increases proposed in a market are unreasonable – especially when, as discussed below, it is clear that a flat threshold approach cannot take into account the wide range of factors impacting rates, and when the NPRM recognizes that virtually all states have the ability and legal tools necessary to address any concerns over rates.

[1] The Segal Health Plan Cost Trend Survey for 2011 is a survey of over sixty health plans, TPAs, and PBMs. Accessible at http://www.segalco.com/publications-and-resources/surveys-studies/?id=1519

Our concern that the threshold approach outlined in the NPRM does not strike the right balance is supported by language in the Preamble acknowledging that the 10% threshold was selected because the National Health Expenditures Data do not reflect all of the various components of health care rates.

In particular, the 10% threshold is flawed on many levels as it does not capture: (1) geographical variation; (2) the multiplicity of factors that historically go into calculating rates including consideration of factors related to risk and adverse selection; (3) increases in premium due to the decreased value of cost sharing when medical inflation increases and cost sharing remains constant; or (4) the calculation of PPACA compliance costs.[2]

There is a strong public interest in ensuring that implementation of Section 2794 achieves the goal of balance described in the NPRM. In this regard, the intent of Section 2794 is to provide for review and disclosure of unreasonable rates – it is not intended to subject the majority of reasonable and justifiable rates to a new review process. Harm to consumers comes equally from the risk of delay and the unnecessary administrative cost and burden that would result from an implementation that is significantly over inclusive, as it does from the risk of an "unreasonable rate." In this regard, the 10% threshold will have the likely result of burdening states, HHS, and health plans with a tremendous volume of fully justifiable and reasonable rates now being subject to a new and unnecessary, additional review process.

A further concern is that this 10 percent threshold will have the effect of establishing a *de facto* presumption or otherwise influencing what should be an actuarially-based and solvency-based decision-making process during examinations of rate increases by states. The implementation of Section 2794 should not overshadow the duties of state regulators to exercise their continuing authority as recognized by the NPRM to regulate health plans and safeguard consumers by requiring rates to be actuarially sound.

Recommendation:

We are concerned that the 10% threshold and benchmark-type approaches in general do not strike the balance sought for in the NPRM, and urge the consideration of alternative approaches.

As discussed above, any threshold standard that governs the review of rate increases should be based on actuarial justification and principles of solvency. We recommend the development of an alternative approach for the first year, followed by a proposed rulemaking procedure for the second and subsequent years to determine a more state-specific, factor-based approach aimed at identifying outliers based on an analysis of the component trends behind the rates.

For rates filed on and after July 1, 2011 (although we strongly recommend that HHS delay implementation altogether as explained above), we recommend instead of a flat 10% threshold

[2] *Id.* Seventy-eight percent of respondents to the Segal Health Plan Cost Trend Survey for 2011 projected the impact of PPACA compliance costs on overall cost trend would be an additional increase of 1.1 percent or more. AHIP has cited this publicly available figure to illustrate what we believe to be the lower end of a range. The Segal projection appears to be an average and there may be significant differences of compliance costs – with heavier burdens to be borne by individual and small group coverage.

that states be permitted to determine their own interim approach that could include development of an outlier approach.[3] This would move the system closer in the direction of developing a state-specific approach that takes into account both underlying health care costs on a local basis as well as other factors that may justify a rate increase.

Moving sooner to a more flexible state-based approach would also build on the NPRM's recognition that: 1) a significant majority of states are expected to meet the standards for having an effective rate review program; 2) others are seeking additional legislative authority to enhance existing processes; and 3) even in those states where there is not an explicit statutory standard for addressing the reasonableness of rates, that these states may use other legal tools available to regulate rates.

The public's interest in having a system that strikes a more reasonable balance and is not unnecessarily burdensome further supports our proposal to delay overall implementation of Section 2794. It is also important in this regard that information about state-specific metrics be published on July 1st of each year, and not the September 15 timeframe contemplated in the NPRM.

3. State Flexibility is Needed in Evaluating Whether a Program is "Effective" and List of Elements Requires Modification

Under the NPRM, in order for a rate review program to be effective, it is required to meet a list of very specific factors set forth in Proposed § 154.301(a)(1) and (2). While these factors are very specific, there are also some undefined qualifications that make it unclear how and whether states will be able to satisfy the requirements. These factors include a determination of: (1) whether the "data and documentation are sufficient to conduct the examination"; and (2) whether the "State conducts an effective and timely review." These subjective criteria present the hazard that state processes will be scrutinized according to some unspecified standards, resulting in the failure of states to meet the "effectiveness" standards.

We also note that the specific factors set forth in § 154.301(a)(3) include, among other elements, the medical loss ratio and the health insurance issuer's risk-based capital status relative to national standards. It is unclear whether the reference to the medical loss ratio is the actuarially projected loss ratio for that specific product, a particular state's medical loss ratio according to state requirements, or a reference to information regarding the most recently reported prior year federal medical loss ratio calculation (which is an aggregate, and adjusted retrospective review of a market segment). If the latter, we would suggest that this information is not determinant of the reasonableness of a given product rate, just as is reflected in the Preamble of the NPRM.

[3] Possible State-based approaches could include the development of metrics for an outlier approach based on recent rate filings (e.g., above the 85th or 90th percentile of increases). The comparison would be to recent rate filings in the same market segment (individual, small group) and for the same delivery system type (e.g., HDHP, PPOs, HMOs). In cases where HHS conducts review, HHS could receive the state-specific outlier information and metrics from states that collect such information.

We also note significant concern that regulators are being asked to review a company's risk-based capital in the context of a rate filing. Development of an actuarially supportable rate is based on the analysis for a particular book of business and is not linked to a company's evaluation of its risk-based capital (RBC). RBC is not linked to rate making, but instead is a measure of the level of risk, and solvency concerns, that a company faces at the enterprise level. RBCs are not managed on a rate by rate basis, but rather by how well a company manages its finances and business model.

Recommendation

AHIP recommends that the subjective standards included in section § 154.301(a)(1) and (2) be deleted. States are well situated to establish procedures that are best suited to their markets, resource levels, and consumers and should not be second-guessed under subjective standards or by a Federal regulator.

With regard to the specific factors, AHIP recommends that the medical loss ratio reference be clarified to refer to the state's medical loss ratio statute (if any) or to the anticipated loss ratio of that specific rate filing – consistent with the standard of actuarial review in the NAIC Guideline for Rate Review – Model 134. Also, this would be the most appropriate reference because the state would normally collect this information.

We also recommend that the comparison of the organization's RBC to national standards be deleted, since RBC has no relevance to the rate filing. Additionally, there are no "national standards" that have been established for comparing companies' RBCs.

4. HHS Should Base Review on Actuarial Memo Guidelines When Conducting a Review and Should Not Consider Factors that Will Lead to Inaccurate Comparisons

Under HHS review of rate increases (but not state review), a rate increase is unreasonable if the increase is "excessive, "unjustified" or "unfairly discriminatory." *See* Proposed § 154.205. This decision is based on data submitted to HHS based on actuarial memorandum guidelines. HHS is asking for comment on other factors impacting the reasonableness of a rate such as the structure and competitiveness of the market. We are concerned that this represents an attempt at policymaking through insurance rate review, which is inappropriate as a decision element in rate review, and not related to the actuarial soundness of a given rate.

In addition, the NPRM lists as a factor in considering whether a rate increase is excessive whether the rate increase results in a projected future loss ratio below the Federal MLR standard for the applicable market to which the rate applies. Although this factor is not to be determinative, HHS has stated that this standard serves as a benchmark against which the reasonableness of rates are measured in the industry. *See* 75 Fed. Reg. 81012. We suggest that this comparison is misleading and flawed because of the differing standards and aggregation levels for the calculation of the projected future loss ratio in accordance with typical actuarial practice and the Federal MLR standards. Such a comparison is "apples" to "oranges" and is inaccurate. We contrast the comparison proposed in the NPRM – which we believe is highly

problematic for the reasons explained above – to traditional consideration of loss ratios calculated as part of the process of developing actuarially sound rates.

Recommendation

AHIP suggests that HHS should not consider factors outside of the actuarial memorandum guidelines when engaging in review. The review should be limited to the question of whether the rate is justified actuarially and is supportable by the underlying documentation. In order to engage in this review, HHS should ensure appropriate staffing by certified actuaries.

We urge the deletion of the following provisions requiring the reporting of the Federal MLR standard in Proposed § 154.215(g)(ix) and the comparison of the projected loss ratio to the Federal MLR standard for that market as required in Proposed § 154.215(x). This comparison is misleading and does not provide relevant information. More importantly, HHS should not consider this comparison in any manner when determining whether a rate is excessive.

And with regard to the request for comment on other factors impacting the reasonableness of a rate, such as the structure and competitiveness of the market, we note that additional, external qualitative factors, such as number of competitors, are not relevant or appropriate in determining the actuarial soundness of a given rate filing.

5. Clarify that Rate Increase is Not the Same as Premium Increase in the Regulatory Text

The NPRM explains that a "rate increase" (which HHS states is the subject of the rule) '"alters the underlying rate structure of a policy form, while a 'premium increase' can occur even without any increase (or change) to the underlying rate structure." 75 Fed. Reg. 81009. Premium changes correlated with age bands that do not change the underlying rate structure are cited as an example of the type of premium change that is not a "rate increase."

Recommendation

We recommend that this language be incorporated into the regulatory text in addition to the Preamble because this is a critically important point. Other examples that are illustrative of the point, in addition to age bands, are factors such as any changes due to mandated changes in benefits or changes due to geography or a change in family status. New benefits required by Federal or state law, for example, should not be included in the calculation of a rate increase for these purposes.

6. Preliminary Justification Should be Tailored to Particular Circumstances of State Law; Disclosure Should be More Consumer-Friendly

Any plan with an increase above the threshold is required to submit to HHS and the state a preliminary justification at the same time the plan submits the filing to the state or prior to implementation of the increase. *See* Proposed § 154.220.

This preliminary justification requirement is not required in Section 2794 and runs the risk of being confusing to consumers because the requirement to file (unless modified per the suggestion above) will be triggered automatically by a rate increase reaching the threshold.

As currently drafted, the preliminary justification is to be posted on the HHS website with the following disclaimer: "The preliminary justification is the initial summary information regarding the rate increase subject to review and does not represent a determination that the rate increase subject to review is an unreasonable rate increase."

Recommendation

We recommend that the preliminary justification requirement be optional so as to allow health plans with identified rate increases the flexibility to determine whether or not, commensurate with state law, they opt to implement a rate increase prior to the posting of an examination and final justification. This approach is consistent with the statute which provides that "health insurance issuers … submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase." *See* § 2794(a)(2), PHSA. This would minimize paperwork burden and potential consumer confusion as the preliminary justification would be on view and identified only for those rate increases that have been implemented and are in effect. Similarly, this would help further protect against, as the NPRM states, the "anomaly of 'pre-determining' the reasonableness of a rate before it has been reviewed."

In any event, the preliminary justification should be very clear that the posting of the justification on the website does not represent any judgment about the reasonableness of rates.

We suggest that the following language be used: "The preliminary justification is intended to provide transparency of rate information to consumers while this rate is undergoing review for reasonableness by [State X or HHS]. This rate increase was selected for review because it met a regulatory threshold and not because [State X or HHS] has made a judgment about the reasonableness of the rate increase. [If applicable: "You may purchase this product in your state while the review is pending."]

B. Additional Concerns and Comments

1. Collection of Confidential Information in Preliminary Justification Should Be Minimized and Advance Notice Should Be Given as To What Will Be Protected Under FOIA

The NPRM provides that rate filing documentation must be submitted to HHS as Part III of the preliminary justification if HHS is conducting the review of the rate increase. The information in Part III is posted on its website if it is not designated as "confidential" under HHS' FOIA regulations. HHS will be required to make a determination as to whether this information is "confidential" under HHS' FOIA regulations, but this takes place after the information is

submitted. *See* Proposed § 154.215(i). This process does not allow for submitters to know whether the information will be deemed confidential at the time it is submitted.

Recommendation

Release of confidential and competitive information into the marketplace jeopardizes competition and innovation. Such information should be safeguarded in order to prevent marketplace harm and we ask that any data collection confine the collection of such information to the minimum amount necessary to achieve the purpose of the review. Additionally, AHIP recommends that HHS determine, prior to submission, determine which elements required in Part III of the justification are confidential under the HHS FOIA regulations. Such information should not enter into the marketplace without submitters first having the opportunity to have input into the process. These confidential elements could be designated when HHS develops the form and instructions for this submission.

2. Integration of Disclosure Form With NPRM's Requirements

The NPRM does not reference in the regulatory text the disclosure form developed by the NAIC. It is unclear how this will be integrated into the final regulation, or if HHS intends to develop a separate form for use. We recognize that the rule anticipates an electronic filing based on the disclosure format of the rule.

Recommendation

AHIP previously has recommended changes to the NAIC form referenced in the NPRM. We recommend that the NAIC form not be used in conjunction with the NPRM. Regardless, however, of whether HHS utilizes the NAIC form, or an amended version of it, or proposes an alternative approach, we recommend that the proposed approach be published for notice and comment in a form that is sufficiently detailed to allow for adequate and meaningful public comment.

From a technical standpoint, any form adopted by HHS should allow for relevant information to be required. The original NAIC form was unnecessarily burdensome in that it requested duplicate sets of data, whether relevant or needed for the details of a given rate filing.

3. Aggregation Following Typical Actuarial Practice If Pool is Insufficient

The Preamble provides as follows:

> The perspectives represented by the comments on aggregation, the proposed regulation requires the consideration of rate increases at the ''product'' level when determining whether the increase is subject to review. Product would be defined under this proposed regulation 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. 75 Fed. Reg. 81001.

The definition of "product" is included in the regulatory text at Proposed § 154.102. It states: "Product means 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."

Recommendation

We recommend clarifying, in cases where there is not a sufficient pool for credibility at the product level to engage in ratemaking, that the standard actuarial practice of combining similar pools' experience be permitted.

We also recommend that the definition of "product" in § 154.102 be revised to incorporate the following clarifying language from the Preamble: "While each filed 'product' may include variable options (such as different cost-sharing or deductible requirements), this definition, consistent with State law, does not consider each variable option as a separate '''product'.'' 75 FR 81010-81011.

We also recommend that the measurement of a threshold trigger, and the resulting review of rates, should occur at the rate filing level. This would help to ensure that rates are reviewed on the same basis as they were developed. The issue here is related to the NPRM's definition of "product."

In particular, depending on the state and its filing standards, plans have been permitted to submit rate filings aggregated at the legal entity or market serviced level (*e.g.*, the insurer's individual HMO business is aggregated in one filing; individual PPO business is aggregated in a separate filing, etc.). And, in some states, once a rate has been filed in this way (on a legal entity basis, for example), the insurer is not permitted to disaggregate the products for other purposes. Thus, it would be unnecessary and costly to require insurers to disaggregate products for purposes of HHS's review, and if applied at the state level, would interfere with the principles of state-led review outlined in the NPRM.

The NPRM product definition only allows a consolidated review if all of the rate increases are uniform. Yet in aggregated filings actual premium rate increases may be different for the different benefit packages within a state, due to several factors. Those include claim leveraging based on different types of cost sharing, as we noted earlier with deductible leveraging, and also due to different networks used by the products resulting in different costs or benefit utilization.

Thus, we recommend that HHS should not require rate increases to be identical before products may be aggregated. We recommend current state practices with regard to aggregation of rate filings continue, and the provision that "all rate increases be uniform in order for the rate filing to be reviewed in aggregate" be amended to recognize and accept a state's standard of review.

Conclusion

Thank you for your consideration of our comments on these important issues. While our recommendations would help to minimize disruption and confusion for consumers and employers, we want to emphasize, as we noted at the outset, that strong steps *outside of the rate review process* are needed to address the underlying factors that are driving

medical costs. The rate review process cannot serve as a substitute for meaningful health care cost containment.

Feel free to contact us with any questions you may have about our comments and recommendations. We stand ready to work with HHS to help improve the rate increase disclosure and review requirements of the NPRM.

Sincerely,

Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs