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Health care reform provision at-a-glance

Rate Review

The Affordable Care Act (ACA) or health care reform law requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish a process, in conjunction with the states, to review "unreasonable" premium increases.

On December 21, 2010, HHS issued a proposed rule for this provision. On May 19, 2011, the Centers for Medicare & Medicaid Services (CMS) released the Rate Increase Disclosure and Review Final Rule. CMS is a sub-agency of HHS. The final rule was issued with a comment period for certain provisions. This means the rule has the force of law, even though CMS is still requesting input on some parts of the rule.

Key points from the final rule

- No later than July 1, 2011, CMS will notify states about whether they have an "effective" rate review process in place to determine whether a rate increase is unreasonable.
- The effective date depends on whether the state currently requires filing of rate increases:
    - For states that already require filing – This regulation applies to rates filed on or after September 1, 2011.
    - For states that do not currently require filing – This regulation applies to rates effective on or after September 1, 2011.
- Applies to rates for nongrandfathered plans in the Individual and Small Group markets.
- Requires review of rate increases above a certain threshold.
    - 10% threshold in the final rule is transitional.
    - State-specific thresholds may apply starting September 1, 2012. CMS will work with states to develop state-specific thresholds. CMS will publish these thresholds by June 1 of each year beginning in 2012.
- Rate increases for "excepted benefits" are exempted from review under this regulation.

As required by the health care reform law, we will submit preliminary information about certain rate increases to the Centers for Medicare & Medicaid Services (CMS) and the applicable state. We must submit this information to CMS and the state if the rate increase for a nongrandfathered small group or individual plan exceeds a CMS-defined threshold. The rate review process does not require any action on the part of our customers.

The rate review process does not presume that an increase above this threshold is unreasonable, nor does it prevent issuers from increasing rates. The process only requires such increases be reviewed and that certain information be made public.

In addition, the rate review process doesn't override existing state processes. While the federal regulations only require a review for certain filings, state laws may require that additional rate filings be part of a review framework.

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Proposed rate review process

- Issuers must submit a Preliminary Justification Form for all effective annual rate increases at or above the threshold.
    - The Preliminary Justification will have three parts. See the "Questions and Answers" section for more details on these three parts.
    - All parts of the Preliminary Justification Form will be made public in accordance with the Freedom of Information Act (FOIA). The FOIA has exemptions for trade secrets and confidential commercial or financial information. Plans will be able to designate information they believe is protected by the FOIA exemption. When that occurs, CMS will determine whether the exemption applies.
    - CMS will post the Preliminary Justification Form on its website. CMS will place a disclaimer on its website to describe the purpose of the Preliminary Justification and to make clear that its posting is not a determination that the proposed rate increase is unreasonable.
- States are not required to hold public hearings, but must accept public comments.
- When a state conducts the review:
    - Within five business days following the state's final determination, the state must provide to CMS, on a form and in a manner prescribed by CMS, its final determination of whether a rate increase is unreasonable, which must include an explanation of how its analysis of the relevant factors caused it to arrive at that determination.
    - CMS will adopt the state's determination.
- When CMS reviews a rate increase, CMS will determine that the rate increase is unreasonable if the increase is:
    - Excessive – meaning the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided.
    - Unjustified – meaning the data or documentation the issuer provides to CMS in connection with the increase is incomplete, inadequate or otherwise doesn't provide a basis to determine whether an increase is reasonable.
    - Unfairly discriminatory – meaning the increase results in premium differences between insureds within similar risk categories that (1) are not permissible under applicable state law or (2) in the absence of an applicable state law, do not reasonably correspond to differences in expected costs.
- If an issuer implements a rate increase as allowable under state law, but it has been deemed unreasonable by CMS or the state, the issuer must post the following information on its website prominently. CMS will set rules for how this information is posted:
    - The Preliminary Justification information that was posted on the CMS website
    - CMS's or the state's final determination and brief explanation
    - The issuer's final justification for implementing an increase that has been determined to be unreasonable by CMS or the state

While the federal regulations only require a review for certain filings, state laws may require that additional rate filings be part of a review framework.

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Questions and answers

Q. What are the rules for determining whether a rate increase is subject to review?

A. Any rate increase over a 12-month period at the "product level" that meets or exceeds the threshold will be subject to review. Product is defined 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. 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." The final rule maintains the proposed rule's standard.

Q. What specific items will the Preliminary Justification include?

A. The Preliminary Justification must consist of three parts:

- Part 1 is the rate increase summary. It must include all of the following:
  - Historical and projected claims experience
  - Trend projections related to utilization, and service or unit cost
  - Any claims assumptions related to benefit changes
  - Allocation of the overall rate increase to claims and nonclaims costs
  - Per enrollee per month allocation of current and projected premiums
  - Three-year history of rate increases for the product associated with the rate increase

- Part 2 is the written description that describes and justifies the rate increase. This part must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase, including all of the following:
  - Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and nonclaims expense increases reported in the rate increase summary
  - Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios

The above two parts are submitted for all rate increases subject to further review. The following is only submitted in the event CMS reviews the rate increase:

- Part 3 is the rate filing documentation supporting the information required in Parts 1 and 2 of the Preliminary Justification. It must be sufficient for CMS to conduct an examination to determine if the rate increase is unreasonable. If the issuer submits rate filings to the state, CMS will accept a copy of the filing provided it includes all of the information required for Part 3. Instructions concerning the requirements for Part 3 will be provided in further guidance issued by CMS. It must include the following:
  - Description of the type of policy, benefits, renewability, general marketing method and issue age limits
  - Scope and reason for the rate increase
  - Average annual premium per policy, before and after the rate increase
  - Past experience, and any other alternative or additional data used
  - A description of how the rate increase was determined, including the general description and source of each assumption used
  - The cumulative loss ratio and a description of how it was calculated (for Individual business only)
  - The projected future loss ratio (a one-year projection from the effective date of the rate increase) and a description of how it was calculated

- The projected lifetime loss ratio that combines cumulative and future experience, and a description of how it was calculated (for Individual business only)
- Federal medical loss ratio standard in the applicable market to which the rate increase applies, accounting for any adjustments allowable under federal law
- If the projected future loss ratio is less than the federal medical loss ratio standard, a justification for the outcome

Q. What happens if HHS or a state determines a rate increase is unreasonable?

A. Options include:

- Choose not to implement the rate increase and provide notification to CMS.
- Implement a lower increase than it had proposed and provide notification to CMS. If the lower increase is still above the review threshold, the issuer would need to submit a new Preliminary Justification and the entire process would begin again.
- If state law allows, implement the rate increase even though it's been deemed unreasonable. The issuer would be required to post its Preliminary Justification, the state's or CMS's determination and its final justification on its website.

Q. How will HHS determine whether a state has an "effective" rate review program?

A. A state's rate review process will be considered "effective" if it has adopted something similar to the National Association of Insurance Commissioners (NAIC) model law on rate review. States may comply with the requirements through statute or regulation.

In evaluating whether a state has an effective rate review program for the individual and small group markets, CMS will apply the following criteria:

- The state receives data and documentation in connection with rate increases from issuers that are sufficient to conduct the examination.
- The state conducts an effective and timely review of the data and documentation submitted by an issuer in support of a proposed rate increase.
- The state's rate review process includes an examination of:
  - The reasonableness of the assumptions used by the issuer to develop the proposed rate increase.
  - The validity of the historical data underlying the assumptions.
  - The issuer's data related to past projections and actual experience.

- The examination must include an analysis of all of the following, to the extent applicable to the filing under review:
  - The impact of medical trend changes by major service categories
  - The impact of utilization changes by major service categories
  - The impact of cost-sharing changes by major service categories
  - The impact of benefit changes
  - The impact of changes in the enrollee risk profile
  - The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase
  - The impact of changes in reserve needs
  - The impact of changes in administrative costs related to programs that improve health care quality
  - The impact of changes in other administrative costs

- The impact of changes in applicable taxes, licensing or regulatory fees
- Medical loss ratio
- An issuer's capital and surplus

- The state's determination of whether a rate increase is unreasonable is based on a standard set forth in state statute or regulation.
- In addition to satisfying the above provisions, a state must provide access from its website to Parts 1 and 2 of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

Q. What qualifies as a small group plan for the rate review provision?

A. In the notice of proposed rulemaking, CMS indicated it will defer to the definitions used under applicable state rate filing laws. The final rule continues to defer to state rate filing law definitions for individual market and small group market. Where state rate filings laws do not contain definitions of small and large group markets, CMS will use the definitions in the Public Health Service Act, with the caveat that the number used for a cut-off between small and large groups would remain at 50 employees prior to 2016, and a 100 employee cut-off would be used after that date.