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

February 22, 2011

Dear Secretary Sebelius:

On behalf of millions of health care consumers, we are writing to comment on the notice of proposed rulemaking **OCIIO-9999-P, Rate Increase Disclosure and Review.** The Affordable Care Act (ACA) created several critical provisions to stop unjustified health insurance premium increases, improve the rate review capacity in states, and make the rate review process more transparent. These provisions are essential to protect consumers from record, and often unjustifiable, premium increases.

Section 2794 of the PHSA (added by 1003 of the ACA) requires the HHS Secretary, in conjunction with the states, to develop a process for reviewing "unreasonable" premium increases for all fully-insured health plans. In this process, a health insurer is required to submit to the Secretary and the relevant state a justification for an unreasonable premium increase prior to its implementation. The Secretary and insurers will disclose this information on their respective websites. Unfortunately, the statute does not give the Secretary the ability to deny or modify unreasonable rate increases.

This rule will give consumers and regulators needed information about proposed rate hikes and will force insurers to justify rates in a public process. We urge HHS to strengthen these provisions in some key areas outlined below. These areas include tightening the standards for review at the federal and state levels, expanding review to include the large group market, and ensuring that information about rates is made public and not shielded from public scrutiny.

Lower the national threshold for review in future years; consider trends in health expenditures to establish thresholds

In general, we support the definition of "product" and the requirement in 154.215 that health insurers submit a preliminary justification for each product affected by an increase. We request clarification that increases will be examined for each product in sections 154.103 and 154.200 as well. Section 154.103(a) says that the requirements apply to "issuers," which could create some ambiguity.

Section 154.200(a)(1) requires rate increases to be reviewed if they are 10 percent or more in 2011. Section 154.200(a)(2) requires that in 2012 and future years, rates will be reviewed if the increase exceeds state-specific thresholds "based on the cost of health care and health insurance coverage in the state" *or* exceed 10 percent if a state-specific threshold has not been established.

We have two concerns about this standard for future years. First, we believe that the national threshold should be lowered in future years to encourage plans to bend the cost curve. While many consumers experienced premium increases this year of 10 percent or more, there have been many periods in which average premium increases were much lower. For example, the CMS Office of the Actuary reports that in 2009, per enrollee private health insurance premiums increased 4.7 percent and per enrollee private health insurance spending on benefits increased 6.8 percent[1]; in 2007, per enrollee premium increases were even lower (3.9 percent).[2] Thus, there may be years that 10 percent increases are excessive in relation to national premium trends. An alternative standard would be for CMS to calculate national average growth in privately-insured medical costs (or, beginning in 2014, in privately-insured medical costs for essential benefits). Rate increases more than two standard deviations above projected national average growth in these privately insured medical costs could trigger review. Growth in FEHBP medical costs could similarly provide a national benchmark.

Second, while the use of state-specific thresholds may be helpful to account for differences in health care costs and utilization among states, we are concerned that a threshold based only on the cost of private health insurance coverage in a state could be circular and may *never* permit regulators to review rates in many states. This is particularly true in states with weak competition where one or two insurers dominate the market. Similarly, a threshold based on state-specific costs may be circular if you only examine private insurance costs: such a threshold would not encourage plans to negotiate more favorable provider rates nor to establish cost-containment measures. In these cases, it may be more appropriate to rely on a federal threshold. 154.200(a)(2) provides the Secretary with some discretion about whether to establish state-specific thresholds for each state, and we urge you to rely on a national threshold in states where neither competition nor regulation constrains price increases.

Review rate increases that would cause any individual enrollee's premium to rise beyond a maximum

Section 154.200(b) provides that whether an insurer meets or exceeds the review threshold is calculated based on the weighted average increase for all enrollees. We are concerned that this will mask very large increases that certain enrollees may experience if, for example, they have moved to a new age band at the same time that their insurer has received a general rate increase; or if the insurer alters its rate structure in addition to increasing its overall rates; or if the insurer does not use bands but instead calculates a weighted increase for a block of business and then uses rating factors to distribute the increase across enrollees. Large increases for particular segments of the enrolled population or for individuals subject to a new rate band can cause certain groups of enrollees to drop coverage and should thus be examined. We urge you to adopt some thresholds that apply to premium increases for each individual enrollee so that consumers will be able to easily understand when their rate increases will be reviewed and when rate increases are unjustified. For example, in addition to reviewing weighted average increases of 10 percent, you could review increases that cause any individual enrollee's premiums to

[1] Anne Martin, et al., Recession Contributes to Slowest Annual Rate of Increase in Health Spending In Five Decades, *Health Affairs*, January 2011, vol. 30 no. 1, pp 11-22.
[2] National Health Expenditures Historical Tables, Table 13, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

rise more than 15 percent. (Urban Institute's Health Insurance Premium Simulation Model may be useful in gauging at what point price increases would cause many people to drop coverage.)

Extend premium-rate review protections to the large-group market

HHS chose to limit the applicability of the rate review regulation to the individual and small-group markets. This is contrary to Section 2794 of the ACA, which applies to fully-insured plans of any size. Consumers in large-group plans should have access to the same premium-review protections as those in the small-group and individual markets. While large employers tend to have more stable premiums and lower annual increases, this authority would be an effective back-stop against unjustified increases and would offer large employers important peace of mind. This authority may be particularly necessary in markets with one dominant insurer, where even large employers have little room for negotiation.

Given that only 18 states conduct rate review in the large-group market, HHS should fill this gap in review in the short-term. In the longer-term, HHS should encourage states through enhanced rate-review grants to expand their legal authority and rate-review capacity to include plans in the large-group market.

If the rule is not expanded to include the large-group market in the initial years, HHS should closely monitor increases in this market (possibly through use of existing private market surveys) and survey regulators in the 18 states with large-group review to find out more about their existing authority, how often it is applied, and to what effect.

HHS proposes deferring to states' definitions of the small-group market used under current rate filing laws. According to the preamble of the rule, this could result in employers as small as 26 being considered "large" and therefore not protected by the federal rate review law. Groups of 26 employees, or even 51, as would be the standard used in most states, are not sufficiently large to have bargaining power against insurers. At a minimum, we urge HHS to use the Public Health Service Act definition of small-group market, as amended by the ACA, to include any health insurance market in which employers with 100 or fewer employees obtain health insurance coverage.

We are concerned that association health plans will not be covered by the rate review regulation in states where they are regulated as large groups. Association health plans normally market their products to individuals and small groups. As such, their rates should be subject to reasonableness review, just like the rates of any other insurer that markets to small groups and individuals.

Strengthen the criteria for effective state review

Section 154.210 provides that HHS will review a rate increase subject to review or it will adopt a state's determination of whether the increase is unreasonable if the state:
(1) Has "an effective rate review program"; and
(2) Provides to HHS its final determination as to the reasonableness of a rate increase, including an explanation of how its analysis of the issuer's actuarial assumptions and validity of underlying data, as well as the issuer's data related to past projections and actual experience, factored into its determination. See Sections 154.210(a),(b) and 154.301(a)(3).

Section 154.301 sets forth five criteria that HHS will use to determine whether a particular state has an effective rate review program for small group and individual market rates and for different types of products within those markets. HHS expects that a "vast majority of States will be able to conduct effective reviews in the future, should they choose to." (p. 81001).

We have concerns that the criteria for determining whether a state has an effective rate review program set the bar too low, missing an opportunity for HHS to ensure that consumers in *every state* are afforded a minimum level of rate review that will effectively help constrain the growth in premium rates. Working in tandem with the ACA rate review grants, this regulation should strive to improve the standards and processes under which rates are evaluated so that all consumers are better protected from excessive rates.

A Kaiser Family Foundation survey, cited by HHS in the proposed regulation preamble, notes that "having approval authority over rates does not necessarily protect consumers from large rate increases, and that the rigor and thoroughness that states bring to rate review can vary widely, depending on motivation, resources, and staff capacity."[3] In determining whether a state's rate review is effective, HHS must carefully study each state's rate review process.

The five criteria for effective rate review in Section 154.301 provide a good start for a determination of effectiveness. However, to truly prompt states to improve rate oversight, the regulations should elaborate on some of these criteria and identify additional criteria that will be evaluated. Specifically, in addition to criteria 1-5, HHS should require the following for each state:

1. A scope of review that covers all products and carriers in a particular market segment. Because rate review standards and processes may vary within states by product or carrier-type, HHS must evaluate the effectiveness for review with respect to specific products, such as HMOs, PPOs, or for products sold by life/accident/health insurers, managed care organizations, or nonprofits. States should be required to review all products in the relevant market segments from all carriers in order to have a rate review process that is considered "effective." HHS also should consider whether the state has loopholes allowing carriers to avoid or expedite review for certain products, such as those issued with a guaranteed medical loss ratio. Rate review should be deemed ineffective with respect to those products that are authorized to evade review.

2. Authority to deny the proposed increases before they go into effect, or at a minimum, the ability to negotiate for lower rates. Prior-approval authority to reject a rate increase before it goes into effect is an important tool in restraining premium increases. Yet, several states, including California, Texas, and Illinois, currently lack prior-approval authority. HHS must carefully consider whether states lacking prior-approval authority have sufficient means to review increases and negotiate for lower rates. States with file-and-use procedures often require only a certification that rates meet state standards, and they may not review data underlying rates at all unless policyholders complain. Retroactive review of increases, even when rates are found to be unjustified, provides little relief to consumers who have dropped coverage or reduced benefits to avoid the increase or businesses that were forced to drop

[3] "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," Kaiser Family Foundation and Georgetown University Health Policy Institute, Dec. 2010, available at www.kff.org.

or change policies. Still, even states with prior-approval authority may fall short of effective rate review, as noted, due to insufficient review standards, data collection, or resources. Therefore, prior approval should be one – but not the deciding – factor in a determination of effectiveness.

3. Sufficient filing requirements and data collection enabling in-depth review. Collecting data underlying rate increases is crucial for effective review. States vary widely in the type and amount of information collected. Rate filings that are subject to full disclosure suggest that some carriers provide explanations and basic information to support increases, such as premium and cost projections. But some rate filings do not contain the historical claims data used to develop projections and other information relevant to the rate calculation. If medical trends are broken down by categories, such as unit cost or utilization, or by benefit category, rate filings may lack sufficient information to show how overall trends were developed from these components. States that conduct in-depth review with hearings in the individual market, such as Maine and Rhode Island, receive and analyze this type of data, but generally, it is unclear the extent to which states are collecting data underlying rate increase assumptions.

Further, while the NAIC's SERFF electronic system has resulted in some standardization of filings, attached actuarial memorandums tend to differ among carriers in the same state. HHS should consider whether the state has statutes, regulations or bulletins identifying the types of information that must be provided in a rate filing and whether the state requires standardized filings, so that all carriers are providing the same breadth of information in a similar format.

HHS criterion 1 for an effective rate review program provides that a state should receive "data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3)," which are (i) the reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and (ii) the health insurance issuer's data related to past projections and actual experience.

We support this criterion for data collection. The requirement that the state collect and review data showing how past projections related to actual experience is important to discourage issuers from "padding" cost projections or minimizing revenue projections. In addition to the language in (a)(1), this standard should specify that at a minimum, such data would include historical claims experience data for at least five years preceding the proposed rate increase and specific data to support any adjustments or assumptions that cause the projected loss trend to deviate significantly from historical patterns. It should also include underlying data supporting all rating factors applied to individual policyholders or groups and information showing how the rate increase was distributed across risk categories.

Further, the data collection standard should not be limited to the information related to actuarial assumptions in HHS criterion 3. States must collect data related to the factors in HHS criterion 4, such as changes in administrative costs, and those additional factors that we recommend for effective rate review programs.

4. Ability to conduct in-depth review of increases subject to review, with no deemer. Some states conduct reviews of data underlying rates and closely analyze the assumptions used

to project revenues and costs. Other states, even some that require support for actuarial assumptions, do not have the staff resources to conduct a careful review. In the past few years, we have seen several examples of carriers submitting cost projections based on medical trends that were found to be inflated, for example in California, Maine, and Connecticut. In addition, in several states in the individual market, we have seen carriers add factors such as duration, anti-selection, or leveraging to the medical trend. These "add-ons" result in significant increases to the cost projection (and are therefore likely to result in higher indicated rate increases), but the carriers do not provide supporting data for such factors or demonstrate whether the impact of such factors was removed from the calculation of the base medical trend. Other factors, such as "provisions for adverse deviation" (PFAD) that may be added to account for "uncertainty," are merely hidden profit margins.[4] While medical-loss ratio rebates may provide future corrections for mistaken or inflated projections, the hardship will already have been inflicted on consumers and businesses. For these reasons, it is critical for state insurance departments to closely examine assumptions to ensure they are reasonable and justified.

The only standard related to the depth of a state's review in the proposed regulation is HHS criterion 2 of Section 154.301(a)(2), which holds that a state would meet effective rate review in part if it "conducts an effective and timely review" of the data and documentation submitted. This presents a circular definition: effective review means, in part, that the state conducts "effective and timely" review of data. More specificity is needed to define what constitutes effective review. States that merely accept an insurer's actuarial certification that rates meet state laws and standards as proof that rates are reasonable should not be deemed effective.[5] States should be required to have an actuary independent of the insurer review the increases subject to review under Section 2794 using raw data that allows testing of the carrier's assumptions.

In addition, the state should review the reasonableness of past and anticipated administrative expenses, reserves, and profits or contributions to surplus.

Further, most states with prior-approval or file-and-use authority have a deemer period, which allows rates to be deemed approved if not disapproved within a specified time frame, usually 30 to 60 days (the time may vary by product or carrier type within a state). HHS must receive assurances from each state that they will not allow rate increases subject to review to go into effect before the state determines their reasonableness.

States should be required to demonstrate they have the staff, including actuarial support, to effectively review rates.

5. Compliance with federal and state medical loss ratios. When conducting rate review, HHS will consider the projected future medical loss ratio for the issuer (p. 81012-3). States should perform a similar review. Rate increases for plans with loss ratios below the 80

[4] A "PFAD" factor for "uncertainty" was included, for example, in the cost trend for Blue Shield of California that resulted in rate increases of up to 59% for some customers, due to three cumulative increases over six months. The third round of increases is still under review by the California Department of Insurance.

[5] See NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act, May 12, 2010: "Most states with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with state law…This allows the states to rely on the Code of Professional Conduct and the Standards of Practice that actuaries must follow."

percent threshold (or a higher state standard) should be subject to particular scrutiny, even if the issuer meets the MLR minimum or the state has received an MLR adjustment.

6. Strong standard of review applied in a manner that is most protective of consumers. The two most common standards of review in states that have rate review are that premiums should be "reasonable in relation to the benefits provided" or rates "shall not be excessive, inadequate, or unfairly discriminatory." Some states use either or both of those standards. Others use different standards for different products; for example, they may apply the excessive standard only to HMOs or non-profit carriers.

Most states interpret the "reasonable in relation to benefits" standard as a minimum medical loss ratio standard.[6] If carriers show that the anticipated or lifetime loss ratio will meet a certain minimum, rates will comply with the standard. This standard is therefore very narrow and states applying it may exclude a range of relevant factors from consideration.

The "excessive" standard is generally broader and provides greater review authority than the reasonableness standard; however, again, the effectiveness of the standard depends on how states apply it. In many states, these terms are not defined and can lead to a very subjective analysis by regulators.

For example, in states applying either of these standards (particularly in the individual market), regulators often narrowly focus their review on whether a specific policy or group of policies is profitable – that is, whether the projected revenues are going to cover projected costs and expenses and result in a reasonable medical loss ratio.[7] This narrow focus ignores (a) the broader solvency and financial strength of the entire company; (b) the insurer's risk pooling practices (which may be segregating high and low risk, resulting in unnecessarily high increases for certain policies or policyholders); (c) the effect and hardship on consumers; (d) the history of rate increases; (e) the balance of solvency against affordability for consumers; (f) the company's mission in the case of nonprofit insurers; and (g) the insurer's quality and cost control efforts. Indeed, perhaps most detrimentally, this type of narrow review does not examine specific underlying medical cost irregularities, provider contracts, or whether insurers use incentives for providers to improve quality and control costs. There is no analysis of market conditions, such as concentration of carriers or providers that can be exacerbating rate increases.

Effective rate review standards should allow regulators to consider these additional factors and to find a rate increase unreasonable based on any combination of some or all factors. The actuarial soundness of specific policies or groups of policies is important but must be viewed in light of the broader solvency of the company and balanced against consumers' needs for affordable coverage. The criteria for effective review should require states to apply their standard of review in the strongest way possible for the protection of consumers.

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[6] See e.g. the National Association of Insurance Commissioners, Guidelines for Filing of Rates for Individual Health Insurance Forms, Model Regulation 134 ("…benefits shall be deemed reasonable in relation to premiums" if the anticipated loss ratio is between 50% and 60%, depending on the renewability aspects of the policy).

[7] Insurers often argue that each policy or block of business must be independently profitable and they will attempt to impose large rate hikes on any policies reportedly producing losses despite large profits elsewhere in the company. In a widely-reported example, Wellpoint Inc., parent company of Anthem Blue Cross, claimed that the company lost $10 million in 2009 on individually-insured Californians, yet the company reported $2.7 billion of profit in the fourth quarter 2009, just as it tried to raise rates by up to 39% on some individuals. See Insurer Blames Health Costs for California Rate Hikes, LA Times, Feb. 24, 2010.

7. Consideration of differential impacts on particular populations. While we generally support HHS's definition of "product," states should also conduct cross-product comparisons of rate increases. Health insurance issuers may use product design to segment their market, encouraging healthier and lower cost individuals, such as young men, into particular products as a way to continue using factors such as health status and gender to set premium rates, even though the use of such factors will be prohibited by federal and state law by 2014. States should use cross-product comparisons to unmask health insurance issuers surreptitiously using prohibited factors to set premiums by creating products and promotional materials that, in effect, push healthy and lower-cost individuals into certain products while attracting sicker and more costly individuals into other products.

HHS should be particularly wary of proportionally greater rate increases for products that have a disproportionate number of individuals from groups that traditionally have been subject to higher insurance premiums. For example, when permitted by state law, insurance companies in the individual market charge women more than men for health insurance coverage, even when it does not include maternity care. In the small-group market, insurers charge more to cover groups that have more women than men compared to groups that have more men than women. A study conducted by the National Women's Law Center found, in one example, that a 25-year-old woman was charged 84 percent more than a 25-year-old man for health insurance coverage that did not include maternity care.[8] By 2014 all insurance companies in the individual and small-groups markets will be barred from using gender to set premiums. However, if insurance companies create products and marketing materials that segregate men and women into different products, they will be able to continue charging women more than men for insurance coverage. In addition, the insurance issuers could compound the harmful effects of such market segregation by disproportionately increasing the rates for products that have more women than men. Beginning in 2014, rate review must also ensure that carriers are using a single risk pool, rather than carving risk between products. Cross-product comparisons of rate increases can alert HHS to such prohibited behavior and will allow the states and HHS to discourage such behavior.

8. Adequate transparency and consumer input. Many states have indicated that they will use rate review grant funds to improve transparency. Consumers need more plain language information about rate increases, how premiums are set, and the factors driving healthcare costs. States should also gather and disclose historical rate increase data by insurer and by policy. State rate filings, as well as *all parts* of justification forms should be disclosed in their entirety online to maximize insurer accountability. In addition, the criteria for effectiveness should include a requirement for at least some level of consumer input, such as a comment period, hearings, or consumer group intervention in rate review. Consumer participation maximizes accountability and allows regulators to better assess the impact of a rate increase on individuals, families and employers. It also sheds light on the effectiveness of state review as regulators are forced to respond to specific consumer concerns.

9. Adequate notice of a proposed rate increase. HHS should consider whether the state provides at least 60 days notice of a proposed rate increases to consumers. Sixty days is the minimum reasonable amount of time required to allow consumers to learn more about

[8] Lisa Codispoti et al., The National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), *available at* http://nwlc.org/reformmatters/NWLCReport-NowhereToTurn-WEB.pdf.

the increase, using available information, shop around for a new policy if necessary and feasible, or make budget adjustments.

10. Strong rate review track record or demonstrable progress toward implementing effective review. An additional criterion for effective state review should be that states have a history of reviewing rate increases and negotiating with carriers for lower rates. If certain states are just implementing rate review programs using premium review grants, the state should demonstrate that it is on track to fulfill all grant requirements and that the resulting program will meet the criteria described above. In addition, as provided for in Section 154.301(c), HHS should reserve the ability to determine that a state no longer meets the standard for conducting "effective rate review." HHS should specify how it will make that determination and on what evidential basis. HHS may consider random audits or "spot-checking" of reasonableness determinations made by states.

Strengthen HHS's rate review

By incorporating stronger criteria for effective state review, the regulation would move states toward more vigorous oversight of potentially unreasonable rate increases than is currently contemplated in the proposed regulation. Consumers in every state can have the benefit of this type of review if HHS improves its own standards for reviewing rates in states that do not meet the criteria. In states where HHS will review rates, the proposed rule would determine rates to be unreasonable if they are "excessive, unreasonable or unfairly discriminatory." As with similar state review standards, this measure is subjective. State regulators appreciate the flexibility of subjective standards, but unfortunately, this flexibility is not always used to the benefit of consumers. While HHS lacks the authority to reject a rate increase that is found to be unreasonable, HHS can make up for this statutory deficit by adopting the improvements listed above to ensure the effectiveness of its own rate review.

The proposed rule fails to identify a formal role for consumers in the HHS rate review proceedings. This should be amended. Consumers will raise issues that will enable HHS to make a more thorough evaluation of proposed rate changes by insurers. Consumers should have a role at both the federal and state levels through formal comment and hearing processes. Additionally, consumers should be given the formal role of an intervener and have access to all rate filing documents.[9] HHS or states also should fund consumer groups to serve as interveners and to secure the actuarial and other assistance necessary to serve as an effective counterbalance to insurers. For instance, California has intervener funding in the property/casualty and HMO markets.[10]

The regulation should expand on the definition of "excessive." The term excessive means excessive in relation to the benefits offered and considering the insurers medical loss ratio. The definition of excessive should be expanded to include anticipated consumer response. For example, a rate could be reasonable in relation to the benefit conferred but result in

[9] One example of a consumer-friendly intervener process is in Massachusetts [M.G.L. 176G s. 27(d)(2)]: "At the hearing, the person filing the statement, the health maintenance organization, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby, shall have the right to present evidence, examine and cross-examine witnesses, offer oral or written arguments in connection therewith, and shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the superior court department of the trial court. All discovery proceedings shall be concluded not later than 3 days before the commencement of the public hearing."

[10] California Health and Safety Code Section 1348.9

many consumers switching from richer benefits to weaker benefits because they can no longer afford the premiums.

The rule should clarify the definition of unjustified. In many rate review proceedings, rates are justified through the insurer's actuarial documentation, rather than independent actuarial review. This practice allows insurers to police themselves and harms consumers. Actuaries consider rates to be sound based on assumptions they have made in the development of the rates. These assumptions ensure that the rates are sufficient to pay claims so the carrier remains solvent. However, solvency is not the only criterion for a rate to be justified; affordability of premium also should be considered. As such, insurers should be required to provide sufficient information for the rate to be independently analyzed, in addition to the actuarial certification. For example, the insurers should be required to justify contributions to surplus, profits, and increased provider reimbursement rates.

HHS should expand the definition of "unfairly discriminatory" to include any rate increase that violates federal law. Section 154.205(d)(1) currently states that a rate increase is unfairly discriminatory if it would result in premium differences between insureds with similar risk categories that "Are not permissible under applicable State law." We suggest you change Section 154.205(d)(1) to read "Are not permissible under applicable State *and Federal* law." Section 1201 of the ACA, adding section 2701(a)(1)(iii) to the Public Service Act, permits insurance rates in the individual and small group markets to vary by: (a) whether the plan covers and individual or family; (b) the rating area; (c) age, not to exceed a ratio of 3:1; and (d) tobacco use, not to exceed a ratio of 1.5 to 1. This provision goes into effect in 2014. While all states should ensure that their laws and regulations are consistent with federal law, the rule should reiterate that violations of federal law would cause a rate increase to be deemed unreasonable.

Improve public disclosure of rate increases and justifications

Public disclosure of premium rate increases and justifications is central to Section 2794. The statute requires the issuer and the Secretary to "prominently post" the premium subject to review and its justification on their respective Internet websites.

We are pleased that HHS determined that consumers should have "immediate access" to rate justifications while they are under consideration as unreasonable and will post these justifications online (page 81015). We also support the requirement for an insurer implementing an unreasonable rate increase to post on its website all information made public by HHS, the final determination of the unreasonableness of the rate and the insurer's final justification. This level of transparency is clearly the intent of the statute.

We recommend several improvements to strengthen the disclosure requirements. First, HHS should clarify that all information regarding the rate-review assessment will be maintained on HHS's website, including the insurer's preliminary justification of a rate subject to review. This information is necessary to analyze patterns in rate requests and the results of state or federal review of such requests. Also, HHS and the insurer should publicly display this information for the entire life of the plan, instead of just three years.

The average consumer may not know about the HHS or state review process and therefore may not seek out the information available on the HHS and insurer websites. In addition to posting information on the Internet, insurers notifying enrollees of rate increases greater

than 10 percent should also alert the consumer that the rate hike is "subject to review" by HHS or the state because it exceeds 10 percent and direct the consumer to the HHS website to track progress of the rate review. In addition, HHS should require insurers to send written notices to enrollees in plans that have been found to be unreasonable. HHS should also denote plans with unreasonable rate increases on the healthcare.gov health plan finder in order to alert consumers of the determination.

The rule asks for comments on the specific disclaimer language that would be posted with the preliminary justifications of premiums that have not yet been declared unreasonable. The language as currently written is ambiguous. A consumer reading that the preliminary justification "does not represent a determination that the rate increase. . . is unreasonable. . . ," may incorrectly believe the increase has been determined to be reasonable. We recommend using language that summarizes why the premium information has been posted and what will happen next in the process, such as:

> "This insurer has provided notice to HHS that this plan's base premium will increase by more than 10 percent. The preliminary justification explains the insurer's proposed increase. HHS will use this information to determine if the premium increase is unreasonable."

Stengthen transparency requirement and prohibit shielding of data

We support HHS's assertion that information contained in the preliminary justification is not confidential. We believe that information contained in part 3 of the preliminary justification also is not confidential. The ACA does not reference any exceptions to the disclosure requirements or any protection for "trade secrets." All materials relevant to rate reviews should be disclosed. This information is necessary for interested parties to independently analyze rate increases.

The FOIA definition of confidentiality referenced in 154.215 does not appear in the ACA and should not be used to shield data from public scrutiny. The information requested meets none of the tests for confidentiality. Its disclosure is necessary to enhance the government's ability to obtain other necessary information and to ensure effectiveness of the rate review statute. Disclosure cannot be said to harm the competitive position of the company that submits it, since the requirement is uniform among companies with similarly high rate increases and the information requested by HHS does not include information such as contracted rates.

The FOIA protection for insurers' "private interests" is at odds with the explicit transparency goals of the statute. It is also problematic that the FOIA definition of confidentiality is based, in part, on the "general custom or usage" of the information. The custom of secrecy in rate filings is a problem that is addressed by the ACA's broad disclosure requirements, without identified exceptions. Making rate filings more available to the public also is a goal of 42 states and the District of Columbia in their use of rate review grant awards. Transparency will not be improved if vast sections of insurer submissions are redacted.

Disclosure of this information should build on the noteworthy trend toward improved transparency in other aspects of insurer behavior and pricing. For instance, much of this information will be requested and disclosed to meet other requirements of the statute, such as the medical loss ratio or risk adjustment calculations, so it doesn't make sense to limit its availability for the purpose of premium rate review. Likewise, the New York Attorney

General's settlements with UnitedHealth Group and Aetna require both to participate in an independent procedure-pricing database to disclose out-of-network costs. In the California law, the only items that are confidential are contracted rates between providers and carriers and contracted rates between large groups and carriers. Everything else is expressly public. During the implementation of a ballot measure implementing rate regulation for auto and homeowners insurance, an auto insurer claimed everything, including the amount of the rate increase itself, was a trade secret. The California Department of Insurance was forced to take the issue to the California Supreme Court to achieve that basic disclosure. Information gathered through the rate-review process should not be subject to similar shielding.

Thank you for the opportunity to offer these comments. A strong rate review rule will provide consumers with important protections against unjustified and unreasonable premium rate increases. For additional information on these comments, please contact Tara Straw with Health Care for America Now at tstraw@healthcareforamericanow.org.

Sincerely,

Alliance for a Just Society
American Academy of Family Physicians
American Cancer Society Cancer Action Network
American Federation of State, County and Municipal Employees (AFSCME)
American Medical Student Association
Campaign for America's Future
Center for Community Change
Community Catalyst
Community Organizations in Action
Consumers for Affordable Health Care (ME)
Direct Care Alliance
Families USA
Health Access California
Health Care for All (MA)
Health Care for America Now
Main Street Alliance
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