DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Parts 146 and 148

Premium Review Process; Request for Comments Regarding Section 2794 of the Public Health Service Act

AGENCY: Office of the Secretary, HHS.

ACTION: Request for information.

SUMMARY: This document is a request for comments regarding Section 1003 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, which added Section 2794 to the Public Health Service Act (the PHS Act). Section 2794 of the PHS Act requires the Secretary to work with States to establish an annual review of unreasonable rate increases, to monitor premium increases and to award grants to States to carry out their rate review process. The Department of Health and Human Services (HHS) invites public comments in advance of future rulemaking.

DATES: Submit written or electronic comments by **[OFR: insert date 30 days from date of publication in the Federal Register].**

ADDRESSES: Written comments, identified by DHHS-2010-PRR, may be submitted to the Department of HHS by one of the following methods:

- Federal eRulemaking Portal: http://www.regulations.gov. Follow the instructions for submitting comments.
- Mail: Written comments (one original and two copies) may

be mailed to: Department of Health and Human Services, Attention: DHHS-2010-PRR, Hubert H. Humphrey Building, Room 445-G, 200 Independence Avenue, SW., Washington, DC 20201.

- Hand or courier delivery: Comments may be delivered to Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the DHHS-2010-PRR drop box located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.

Inspection of Public Comments. All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on the following public Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at 200 Independence Avenue, SW, Washington, DC 20201, Monday through

Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 202-690-5480.

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold, Centers for Medicare and Medicaid Services, Department of Health and Human Services, at (202) 690-5480.

Customer Service Information: Individuals interested in obtaining information about the Patient Protection and Affordable Care Act may visit the Department of Health and Human Services' web site (http://www.healthreform.gov).

SUPPLEMENTARY INFORMATION:

I. Background

Section 1003 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, enacted on March 23, 2010, added Section 2794 of the Public Health Service Act (PHS Act). In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which added title XXVII to the PHS Act, and parallel provisions to the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986. These amendments provided for, among other things, improved portability and continuity of coverage with respect to health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. Title XXVII of the PHS Act is codified at 42 U.S.C. 300gg, et seq. PPACA expanded Title XXVII of the PHS Act,

redesignated several sections, and created new requirements affecting the individual and group markets. In particular, among other provisions, Section 2794 requires health insurance issuers offering individual or group coverage to submit to the Secretary and the relevant State a justification for an unreasonable premium increases.

A. Initial Premium Review Process, Public Reporting, and Justification of Unreasonable Premium Increases for Individual and Group Coverage

Section 2794(a)(1) requires the Secretary, in conjunction with States, to establish a process for the annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health insurance coverage. Additionally, Section 2794(a)(2) provides that this process shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase, and prominently post this information on their Internet websites. Section 2794(a)(2) also requires the Secretary to ensure the public disclosure of information relating to these increases and justifications for all health insurance issuers.

B. Continuing Premium Review Process

For plan years beginning in 2014, Section 2794(b)(2)(A) requires the Secretary, in conjunction with States to monitor

premium increases of health insurance coverage offered through an Exchange and outside of an Exchange, consistent with the provisions of Section 2794(a)(2). (In this context, the terms "State Exchange" and "Exchange" refer to the State health insurance exchanges established under PPACA).

Section 2794(b)(1) also requires that, as a condition of receiving a grant from the Secretary to assist in carrying out the premium review process, States shall provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and make recommendations about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

Additionally, Section 2794(b)(2)(B) requires States to take into account any excess of premium growth outside of the Exchange, as compared to the rate of premium growth inside the Exchange, in determining whether to offer qualified health plans in the large group market through an Exchange.

C. Availability of Grants to States in Support of the Premium Review Process

Section 2794(c)(1) directs the Secretary to carry out a program to award grants to States during the five-year period beginning with fiscal year 2010 to assist in carrying out the

requirements of Section 2794(a). For example, these grants can be used to assist States in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and providing information and recommendations to the Secretary under Section 2794(b)(1).

Section 2794(c)(2)(A) provides for an appropriation to the Secretary of $250,000,000 out of all funds in the Treasury not otherwise appropriated, to be available for expenditure for the State grants. Section 2794(c)(2)(C) requires the Secretary to establish a formula for determining the amount of any grant to a State under this subsection that considers the number of plans of health insurance coverage offered in each State and the population of the State (with the requirement that no State qualifying for a grant shall receive less than $1,000,000 or more than $5,000,000 for a grant year).

Additionally, Section 2794(c)(2)(B) provides that if these appropriated amounts are not fully obligated under the above mentioned State grants by the end of fiscal year 2014, any remaining funds are to remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under Part A of the PPACA.

D. Effective Dates

Section 1004(a) of the PPACA provides that the provisions of Section 2794 of the PHS Act shall become effective for fiscal

years beginning with fiscal year 2010.

II. Solicitation of Comments

A. Information Regarding Regulatory Guidance

The Department is inviting public comment to aid in the development of regulations regarding Section 2794 of the PHS Act, and is especially interested in the perspectives of researchers, policy analysts, health insurance issuers, and States. To assist interested parties in responding, this request for comments describes specific areas in which the Department is particularly interested.

This request for comments identifies a wide range of issues that are of interest to the Department. Commenters should use the questions below to assist in providing the Department with useful information relating to the development of regulations regarding Section 2794 of the PHS Act. However, it is not necessary for commenters to address every question. Individuals, groups, and organizations interested in providing information relating to one or more of the topics discussed herein may do so at their discretion by following the above mentioned instructions.

Specific Areas in which the Department is interested include the following:

1. Rate Filings and Review of Rate Increases

The Act requires the Secretary, in conjunction with States, to establish a process for the annual review of unreasonable

increases in health insurance premiums. A justification for an unreasonable premium increase is also required.

a. To what extent do States currently have processes in place to review premium rates and rate increases?

1. What kinds of methodologies are used by States to determine whether or not to approve or modify a rate or a rate increase? What are the pros and cons of these differing methodologies?

2. Are special considerations needed for certain kinds of plans (for example, HMOs, high deductible health plans, new policies, and closed blocks of business)? If so, what special considerations are typically employed and under what circumstances?

b. Where applicable, do health insurance issuers currently provide actuarial memorandums and supporting documentation relating to premium rate calculations, such as trend assumptions, for all premium rates and rate increases that are submitted, and/or for all premium rates and rate increases that are reviewed?

1. How is medical trend typically calculated?

2. Are specific exhibits, worksheets or other documents typically required? If so, are these documents generally submitted to the State Insurance Department directly, and if so, in what format?

3. To what extent do issuers use the following categories to develop justifications for rate increases: cost-sharing, enrollee population including health risk status, utilization increases, provider prices, administrative costs, medical loss ratios, reserves, and surplus levels? Are there other factors that are considered?

c. What level(s) of aggregation (for example, by policy form level, by plan type, by line of business, or by company) are generally used for rate filings, rate approvals, and any corrective actions? What are the pros and cons associated with each level of aggregation in these various contexts?

d. What requirements do States currently have relating to medical trend and rating calculations? What are the pros and cons of these different requirements, and what additional requirements could potentially be set?

1. Do States generally allow enrollees under the same policy form to be further subdivided for purposes of calculating medical trends and rates?

2. Do States generally allow enrollees under different policy forms to be grouped together for these calculations, and if so, how?

2. Defining Unreasonable Premium Rate Increases

The Act provides that the initial and continuing rate review process under Section 2794 is only to be undertaken for

unreasonable premium rate increases.

a. In States that currently have rate review processes, are all rates or rate increases generally reviewed? If so, for what markets and/or products? If not, what criteria do these States typically use when determining which rates or rate increases will be reviewed? To what extent do States require that these reviews take place before the proposed rate increases can be implemented?

b. To what extent have States developed definitions of what constitutes a premium rate increase warranting review?

3. Public Disclosure

The Act requires that health insurance issuers prominently post the justification for an unreasonable premium increase on their Internet websites prior to implementation of the increase.

a. To what extent is information on premium rates and premium rate increases, and related justifications, currently made available to the public?

1. To what extent are annual summaries of premium rate increases currently made available to the public on State or consumer websites, and/or made available by request? Where available, to what extent is this information generally provided by policy form, type of product, line of business, or some other grouping?

2. To what extent are rate filings with actuarial justification and supporting documentation generally made

available to the public? In what format(s) are rate filings currently made available to the public? What format(s) would be most useful to the public?

3. What kinds of supporting documentation are necessary for consumers to interpret these kinds of information?

b. What kinds of information relating to justification for an unreasonable premium increase could potentially be made available?

4. Exclusion from Exchange

For plan years beginning in 2014, States receiving grants in support of the rate review process must make recommendations, as appropriate, to the State Exchange about whether particular insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

a. To what extent have States developed definitions of what constitutes an excessive or unjustified premium rate increase and/or a pattern or practice of such increases? How could a pattern or practice of excessive unjustified premium increases be defined in this context, and what are some of the pros and cons of the various approaches that are available?

b. What criteria could be established to determine whether insurers have engaged in a pattern or practice of excessive or unjustified premium increases?

5. Grant Allocation

The Act directs the Secretary to allocate $250 million in grant money to States to carry out the rate review process.

a. What factors could be considered in grant allocation?

b. What weighting could be given to different factors and why?

B. Information Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of Section 2794 of the PHS Act will be economically significant. A rule that has an annual effect on the economy of $100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans,

employers, and issuers and, in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many "respondents" will be required to comply with any "collection of information" requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $135 million.

The Department is requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What policies, procedures, or practices of health

insurance issuers and States may be affected by Section 2794 of the PHS Act?

a. What direct or indirect costs and benefits would result?

b. Which stakeholders will be impacted by such benefits and costs?

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

2. Are there unique costs and benefits for small entities subject to Section 2794 of the PHS Act?

a. What special consideration, if any, is needed for these health insurance issuers or plans that they sell?

b. What costs and benefits have issuers experienced in implementing requirements relating to rate review under State insurance laws or otherwise?

3. Are there additional paperwork burdens related to Section 2794 of the PHS Act, and, if so, what estimated hours and costs are associated with those additional burdens?

Signed at Washington, DC this 8th day of April, 2010.

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Donald B. Moulds,
Acting Assistant Secretary for Planning and Evaluation,
Office of the Secretary
Department of Health and Human Services.

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