February 14, 2011

Office of 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

In Re: Proposed Regulations on Rate Increase Disclosure and Review under the Patient Protection and Affordable Care Act

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulations. Proposing regulations subject to notice, comment and hearing rather than unilateral promulgation of Interim Final Regulations is the right process for governing in this important area.

Section 2794 of the Public Health Services Act, as amended by the Patient Protection and Affordable Care Act, provides in pertinent part “The Secretary, in conjunction with States, shall establish a process for the annual review... of unreasonable increases in premiums for health insurance coverage... The process established...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.”

The ultimate patient protection is a solvent insurer. Only the state has the dual responsibility for the protection of consumers and the ongoing solvency of insurers, and the state must therefore continue to have primary rate review authority, not the subordinate position defined by the proposal.

A process for review established under the statutory authority defined above would appear to be required to adhere to three principles:
- The process is limited to unreasonable increases, however defined;
- The process is established in conjunction with the states; and
- Any rules imposed represent a lawful exercise of Federal jurisdiction.

The subject proposal fails on all three points.
Unreasonable Premium Increases

Rather than defining 'unreasonable' in conjunction with the states according to objectively verifiable standards as anticipated by the statute, the proposed rule opts for a "we'll know it when we see it" approach not unlike Supreme Court Justice Potter Stewart's definition of obscenity. This subjective determination is reserved primarily to HHS, and only ceded to the state if HHS deems the state's review process 'effective'. The initial trigger for this review is a rate increase of ten percent or more. The preamble to the proposal states "...the majority of increases in the individual market exceeded ten percent each year for the past three years". The rationale for casting such an extraordinarily wide net is that ten percent exceeds medical inflation - but many factors affect rates even if prices stayed flat - new technologies and medical treatments, increased utilization, sicker populations as healthier groups flee to self-insured plans to avoid regulatory burdens, etc. To the extent an unreasonable rate increase is one that can be controlled by insurers, any reasonable filtering process should also consider these causes, and not apply to the majority of all rate filings. This process goes well beyond any reasonable definition of unreasonable increases as anticipated by the law.

The proposed regulation provides little objective criteria HHS will apply in making a determination that an increase is unreasonable for states without an 'effective' rate review process. The terms 'excessive', 'unjustified' and 'unfairly discriminatory' are as subjective as the term 'unreasonable'. Actuaries may disagree on future costs and utilization, and the delivery of medical care is very different from state-to-state. Absent HHS certification of the state's process, however, the discretionary authority is entirely within HHS. One of the few objective criteria that HHS would use is that rate differences between insureds within similar risk categories reasonably correspond to differences in expected costs. The business of insurance, however, is all about subsidies. A requirement that rate differences based on age not exceed a 3:1 ratio is in and of itself a requirement that differences in premiums not be strictly tied to differences in expected costs for insureds within similar risk categories - i.e. younger members subsidize older members. Rate increases may appropriately be inconsistent with expected costs for a particular risk category, if the purpose is to subsidize and therefore mitigate an otherwise higher increase for a different risk category.

A determination by HHS that a rate increase in a state is 'unreasonable' based on these largely subjective criteria could be very destabilizing to a local market. The proposed regulation, however, provides no opportunity for state input into that determination if made by HHS. It also appears that the determination is final and unappealable, without opportunity for notice and hearing. Even a determination of obscenity is appealable to the Supreme Court.

The proposed rule neither defines unreasonable nor identifies clear objective criteria HHS will apply when making that determination. A stable insurance marketplace requires predictability in pricing.

Established In Conjunction with the States

While representing that state autonomy remains intact, the regulation delineates areas states must review or cede the 'unreasonable' determination to the federal
Government. The threshold established in the proposed regulation for the use of the
preliminary form is a proposed increase of ten percent or more. For these rate filings,
insurers would be required to file with the state and HHS a justification. States that
do not want to cede their authority to HHS would then have to provide and explain their
determination as to whether it is unreasonable within five days of making it.

The regulation is prescriptive on the elements a state must review to be 'qualified'
by HHS to make its own determination. Make no mistake; an effective rate review
process is a critical element of the state oversight of insurance. A deeper dive into the
construction of insurance rates has much to tell us about the drivers of rate increases,
whether due to medical cost, utilization, waste or abuse at any level of the health care
delivery or financing system. These, however, are determinations lawfully left to the
states. States know their markets best, and may even reasonably decide that an
effective rebating requirement on the back end moots the need for some of the rating
detail on the front end. States should not have the burden of justifying their rate
actions to HHS, much less having to do so on the majority of all rate filings.

The proposed regulation provides that the format of the preliminary justification would
be provided in guidance. This would appear to circumvent the notice and hearing
inherent in a more formal regulatory process, and again avoid the statutory requirement
to establish the process in conjunction with the states.

This is not a process established in partnership with states, but a conscription of state
resources and usurpation of authority. It is the state charged with both responsibility
for both consumer protection and the ongoing solvency of insurers. It is the state,
therefore, that must continue to have primary rate review authority.

*Lawful Exercise of Federal Jurisdiction*

The proposed regulation exceeds the bounds of Federal law, unlawfully impinging on the
seq.) gives states the authority to regulate the "business of insurance" without
interference from federal regulation, unless federal law specifically provides otherwise.
That Act provides that the "business of insurance, and every person engaged therein,
shall be subject to the laws of the several States which relate to the regulation or
taxation of such business." It further provides that no act of Congress shall invalidate
any state law unless by its express terms. Nothing in the Affordable Care Act provides
any authority for the Federal Government to establish standards for state rate review, to
require state reporting of the results of that review to HHS, or to review and opine on
the majority of all rate filings in states without a review process they deem acceptable.

Consistent with the foregoing, the proposed regulation should be revised:

- For states with a rate review process as defined by the state, to defer to state
  law on what constitutes an effective rate review process and any determination
  of reasonableness. States should not be required to conform to any Federal
definition of an effective review process. In the alternative, the National
Association of Insurance Commissioners (NAIC) can establish rate review
standards required for state accreditation, similar to the current process for state
overview of insurer solvency.
• For states with no review process, HHS should work in a collaborative manner with the NAIC in an open process that includes establishing the circumstances under which rates could be determined to be unreasonable, developing any forms for capturing data necessary to make that determination, and uniform instructions for their use.

Very truly yours,

[Signature]

Thomas B. Considine