HEALTH REFORM IMPACT

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No Surprises Here:
HHS Issues Final Rule Establishing Review of Health Insurance Rate Increases

June 27, 2011

The Department of Health and Human Services ("HHS") issued a final rule (the "Final Rule")[1] implementing the mechanisms for disclosure and review of unreasonable premium increases by health insurers, as required by the Health Reform Legislation.[2] With only a few clarifications, the Final Rule is essentially unchanged from the original proposed version of the rule discussed in a previous issue of *Health Reform IMPACT*.[3] The Final Rule establishes a rate review program for non-grandfathered small group and individual health plans, ensuring that all rate increases that meet or exceed an established threshold are reviewed either by a state insurance regulatory agency or HHS to determine whether the rate increases are "unreasonable."[4] While creating the first federal scrutiny of insurance premium rate increases, the Final Rule is not, as a practical matter, expected to present a material impediment to proposed rate increases on health insurance policies issued in Tennessee.

Rate Review Program

Effective September 1, 2011, a proposed rate increase of 10 percent or more will be considered "subject to review." Beginning in September 2012, state-specific thresholds that should reflect the insurance and health care cost trends in each state will begin to replace the 10 percent threshold. For each state, HHS will publish notice on or before June 1 of each year stating whether the 10 percent or state specific threshold will be used for each state.

The Final Rule provides that HHS will adopt a state's determination of whether a rate increase is unreasonable if the state has an "effective" rate review program and if the state provides to HHS its final determination of whether a rate increase is unreasonable, which must include an

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[1] 76 Fed. Reg. 29964 (May 23, 2011).
[2] References to "Health Reform Legislation" or "Health Reform" mean The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.
[3] Please see "HHS Proposes Review of Health Insurance Rate Increases" published February 16, 2011.
[4] Note that the large group market is not subject to this rule as, according to CMS, few states review rates for large groups. In addition, CMS found that "state regulators, industry and employers generally agreed that the large group market should not be subject to the final rule, noting that large employers are generally sophisticated purchasers, that rates generally are based on each large employer's own experience, and that the proposed rule's filing requirements were not aligned with State large group market practices." 76 Fed. Reg. 29964, 29966 (May, 23, 2011).

explanation of how its analysis of certain factors caused the state to arrive at its determination. These factors include: 1) 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 2) the health insurance issuer's data related to past projections and actual experience.

In those states where the review process is either absent or deemed ineffective, HHS will conduct a review of the proposed rate increases to determine whether they are unreasonable. HHS defines the standard for unreasonable as whether the rate increase is "excessive," "unjustified" or "unfairly discriminatory." An increase is "excessive" if the increase causes the premium to be unreasonably high in relation to the benefits provided under the coverage, taking into account the projected medical loss ratio, or if the projections underlying the medical loss ratio are not supported by substantial evidence, or if the assumptions on which the rate increase are unreasonable. An increase may be "unjustified" if the health insurer provides data that is incomplete, inadequate or does not provide HHS with the information needed to determine the reasonableness of the increase. A rate increase may be "unfairly discriminatory" if the premium differences between insureds within a similar risk category are either not permissible under state law or, if state law does not address this issue, do not reasonably correspond to differences in expected costs. If HHS determines that a rate increase is unreasonable, HHS will provide its final determination to the health insurer.

Justification Process and Ramifications

The Final Rule requires insurers proposing rate increases "subject to review" to provide a preliminary justification to the applicable state and to HHS, intended to provide consumers with a description of the rate increase and the factors contributing to the increase, including both a descriptive and a quantitative analysis. One change from the proposed regulations to the Final Rule is the additional requirement that where states are providing the reasonableness determination, states must provide an opportunity for public input on the evaluation of rate increases subject to review. While this requirement does not dictate public hearings, states must implement a process for receiving public comments.

If the health insurer implements a rate increase determined unreasonable, it must provide HHS a final justification in response to the unreasonableness finding. HHS will post the final determination and the health insurer's final justification on HHS's website and the insurer must post the same on its website, with such information to be available on the websites for at least three years.

Effective Rate Review Program and Tennessee

Tennessee is one of the 43 states identified by HHS that already has in place a statutory requirement that proposed increases in health insurance premiums must be found reasonable by the Commissioner of Commerce and Insurance; specifically, the Commissioner must find policy benefits to be reasonable in relation to the premium charged by the carrier.[5] In addition, the state of Tennessee recently passed legislation intended to strengthen and clarify Tennessee's rate review statute to ensure it fully conforms with the policy intent of the Final

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[5] Tenn. Code Ann. § 56-26-102(a).

Rule and the Health Reform Legislation.[6] Staff at the Department of Commerce and Insurance anticipates there will be no HHS involvement in the Department's standard review of rate increases filed for use in Tennessee. However, multistate health insurers are advised to check with the various insurance departments in states where licensed to confirm whether each state has a rate review process identified by HHS as effective.

Comments Requested

While the Final Rule sets forth the rate review program for policies involving small group and individual policies (that are not considered grandfathered under the Health Reform Legislation), HHS received a number of comments related to these types of policies sold through associations. Since associations generally sell policies to small employers structured such that all of the employers are considered one large group, and therefore exempt from state oversight, HHS stated in the Final Rule that it is inclined to amend the Final Rule so that the requirements would include small group and individual policies sold through associations. However, since HHS did not address the issue of associations selling small group and individual policies in its proposed rule, it is soliciting comments related to this issue.

If you have questions regarding the information in this alert, please contact any of the attorneys in our **Insurance and Managed Care or Healthcare Practice Groups** listed below.

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[6] 2011 Tennessee S.B. 1539 (Pub. Ch. 344 on June 2, 2011), 107th General Assembly.

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