DISCUSSION DRAFT #2
3/2/2012
State-Specific Thresholds - Recommended Approach

I. Introduction

The Patient Protection and Affordable Care Act (Pub. L.111-148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (Pub. L 111-153) was enacted on March 30, 2010. In this paper, we refer to the two statutes collectively as the Affordable Care Act. The Affordable Care Act reorganizes, amends, and adds new sections to the provisions of Part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act which directs the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with the States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage," The statute provides that this process must require health insurance issuers to submit to the Secretary and the applicable State justifications for unreasonable premium increases prior to the implementation of the increases.

II. Authority

The charge to develop a system to review unreasonable rate increases presented the conundrum of identifying a proposed rate increase as "unreasonable" before it is reviewed. To address that challenge, the concept of a "subject to review" threshold was developed. The subject to review threshold is intended to help identify rate increases that are most likely to be unreasonable and are required to be reviewed, as well as to prevent the number of filings requiring review from surpassing CMS capacity.

The subject to review threshold for the initial year of the rate review program (September 1, 2011, through August 31, 2012) was established at 10 percent. The preamble to the Notice of Proposed Rulemaking for the Rate Increase Disclosure and Review regulation (75 F.R. 81004 (Dec. 23, 2010)) explains that, in determining the appropriate subject to review threshold, a number of sources were considered. The sources included the medical component of the Consumer Price Index (CPI), the Center for Medicare and Medicaid Services' National Healthcare Expenditures (NHE) data, the Standard & Poor's Healthcare Economic Commercial Index, and the limited rate increase data that was available on State web sites. The preamble states, "Our review of the limited data available suggests that the majority of increases in the individual market exceeded 10 percent each year for the past three years. . . . Trends are slightly lower in the small group market, but over 40 percent of increases still exceeded 10 percent." According to the preamble, "The 10 percent threshold established in this regulation exceeds these major indices and in doing so balances industry concerns that any threshold would be over-inclusive with the competing concern that it would subject to review too few rates that may be unreasonable."

The regulation provides for a single, national threshold to be applied for the first year of the program, and for state-specific thresholds to be established thereafter. It requires the Secretary to issue a notice by June 1 of each year announcing any State-specific thresholds that will apply for a 12-month period beginning on September 1 of that year. If no State-specific threshold is established, the 10% threshold will continue to apply.

In establishing the 10% threshold that applied in 2011-2012, "the Secretary balanced the need to set a standard that would effectively capture unreasonable increases, while avoiding unnecessary filing burdens for health insurance issuers with regard to increases that are likely to be reasonable."

The regulation provides that State-specific thresholds would "be based on the same kind of analysis used in establishing the . . . 10 percent threshold, but would account for State-specific variations in rate increases based on the cost of health care, utilization patterns, and other factors affecting health insurance rates in a State. HHS would use trend data and other information made available to HHS from States receiving premium review grants and through the reporting and notification requirements of this . . . regulation to develop State-specific thresholds, when possible." The goal in establishing a State-specific threshold is the same as it was when the initial, national threshold was set: to capture as many rate increases as possible that ultimately will be determined to be unreasonable, while minimizing the burden on issuers of having to file rates that are likely to be found to be reasonable.

At the time the national threshold was set, it was not known how many States would be deemed to have an Effective Rate Review Process and would therefore be reviewing rate increases and reporting their decisions pursuant to the regulation. Currently, 43 States and the District of Columbia are reviewing rate increases for non-association coverage in both the individual and small group markets. Most of those States review all rate increases, without regard to the 10% threshold. Moreover, many of those States are requiring issuers to submit the same Preliminary Justification data that is submitted to HHS, whether or not an increase is over 10%.

In addition, based on available data, it appears that medical costs are not increasing at a faster rate than they were in December 2010, when the proposed regulation was published. This would appear to argue against any increase in the threshold for reviewing rate increases. The process described below would provide an opportunity for States to present evidence of unique conditions that would justify a threshold higher than 10%. However, HHS would be more inclined to grant a request from a State that the threshold be lower than 10%.

III. Other Factors

While the analysis that was used to arrive at the 10% threshold must be a significant part of the determination of State-specific thresholds, it is important to recognize certain key considerations related to State-specific variations in rate increases:

- A large share of the variation often found in rate increases does not have a State-specific basis and, instead, is specific to the circumstances of individual issuers. Factors such as changes in provider networks, re-estimates of past projections, and deductible leveraging can often play a much larger role in the magnitude of the increase than State-specific healthcare trends. State-specific historical rate increase data may present problems when considered as a sole predictor of future rate increase trends because large increases could be due to inefficient insurance markets or lack of oversight authority. However, this data may prove to be useful when factored into a threshold determination.
- State-specific health care cost data is not closely tied to year-to-year rate increases. State-specific variation in health care costs to some extent can explain differences in premiums across States, but health care cost inflation does not track very precisely with rate increase trend (as noted above, rate increase variation is largely based on issuer specific considerations).

Some State-specific factors that are predictive of variation in rate increases may not appear relevant to consumers or other stake holders. In identifying such potential factors, there are two categories to consider. The items in the first list below are analytically oriented, while the items in the second list are policy oriented.

The following are examples of *analytically*-oriented items that might have predictive validity for rate increases:

- History of average rate increases in individual and small group markets;
- Benefit design (such as deductible levels);
- Mix of open versus closed blocks;
- Mix of individual versus small group (overlaid with association versus non-association);
- Aggregate MLR levels for the business in the State (with MLR levels far enough below the State MLR threshold to put downward pressure on rate levels); and
- Various State-specific factors that individual States may be able to prove have caused their average requested rate increases to be substantially higher or lower than the current 10% threshold (e.g., medical cost increases, provider network consolidation or expansion, etc.).

Such factors likely explain a share of any observed State-specific variation and could result in adjustments to the threshold.

Analytically-oriented factors relevant to State-specific thresholds should meet two criteria:

- First, a concept should be objectively measurable and the State should prove (rather than speculate) that it has predictive validity in determining attributes of the distribution of rate increases for a State.
- Second, it should not be subject to gaming.

Once the State has validated that a particular item or set of items has predictive validity and is not subject to gaming, it could attempt to show that a significant majority of the items indicate

the need for a higher or lower threshold. If such a showing can be made, the State might propose moving the threshold in the appropriate direction.

A different approach might be an actual direct mathematical adjustment of the existing 10% threshold by expected differences in the State item's value versus the national item's value. This approach could be particularly useful for such items as average deductibles (via deductible leveraging).

Below, are examples of items that might give a State *policy* reasons to move their threshold. These are the types of subjective factors that a State would present in a narrative report:

- The competitiveness of State markets,
- The scope and effectiveness of a State's rate review program,
- The effectiveness of a State's public comment process,
- A large volume of public comments about the need to move the threshold,
- Evidence of gaming by the industry (such as a recent unusual volume of rate increase requests just below the present threshold),
- Evidence that a given threshold might or might not be a burden on the industry (hence warranting a reduction if the possibility of a burden had previously been a concern),
- Approvals above and/or disapprovals below the present threshold that might demonstrate a need to move the State's threshold.
- Other policy considerations that may be unique to a particular State.

IV. Process

The issues described in the above section complicate the development of a State-specific threshold adjustment based strictly on available health care metrics. While it may be difficult to develop a purely formulaic approach to calculate State-specific thresholds, the regulation points to specific policy criteria that should be taken into account once the appropriate State-specific factors have been identified:

The threshold should meet the following policy criteria:

- Effectively capture rate increases that may be found to be unreasonable upon review.
- Be low enough to provide for the disclosure of a meaningful amount of public information about rate increases.
- Balance the first two needs with the potential issuer, State, and HHS burden associated with rate increases that are not likely to be found unreasonable.

The approach that HHS envisions is one that would allow States to request that the subject to review threshold for filings in their states be moved in one direction or another from the 10% default threshold specified in the regulation. The process would work as follows:

1) HHS would work cooperatively with the NAIC to identify data elements and types of information that States could use as bases for a proposal for a State-specific threshold.

2) HHS will review Rate Review Grant program reporting data to identify factors relevant to the determination of a State-specific threshold, such as the percentage increase of the majority of filings in the individual and small group State markets;
3) HHS will publish guidance establishing a process by which States desiring a State-specific threshold different from 10% can submit data and narrative information to support a State-specific threshold determination and describing the types of data and information that HHS views as most relevant;
4) HHS will determine and publish State-specific thresholds, where applicable.

V. Conclusion

Since the concept of the subject to review threshold was first conceived to reconcile the awkwardness of statutory language requiring the review of unreasonable increases it has been the topic of much discussion. Although the 10% threshold seems to be yielding the desired results, the provision allowing for the threshold to be tailored to the needs of individual States was intended to calm concerns that 10% was a "one size fits all" number not applicable to all State markets. The approach described here would accomplish the intended goal.

A process that allows States to propose their own thresholds, within established parameters, using State-specific data and information, and balances State interests with the ACA goal of greater transparency, should produce credible thresholds. Thus, the State-initiated approach should accomplish the intended goals for determining the State-specific thresholds to be initiated on September 1, 2012.