CMS Response to Public Comments Received for CMS-10379

The Centers for Medicare and Medicaid Services (CMS) received comments from health insurance issuers, consumer advocate organizations, a state regulator organization, and a professional actuarial organization related to CMS-10379. The following is the reconciliation of the comments.

A. Consumer Disclosure Comments

Comment: Several consumer groups raised the following concerns related to the level of detail contained in the consumer disclosure:

- The Consumer disclosure did not provide sufficient information for consumers, advocates, and researchers.
- The disclosure should provide sufficient information for the public to fully evaluate the rate increase.
- HHS should collect and disclose rate-filing level data on all rate increases that are above the review threshold.
- HHS should either use the NAIC disclosure form or substantially increase the amount of information collected in the preliminary justification
- Average rate information should be labeled as "Monthly."

Response: We do not believe that it would be appropriate to collect detailed rate filing-level data from health insurance issuers implementing rates in effective rate review States, as we are deferring got those programs to conduct reviews and provide public access to data. CMS will publicly release detailed filing information when it is conducting the review. The form was edited to note that averages shown are monthly averages.

The consumer disclosure in its current form is intended to strike a balance between providing consumer with key quantitative and descriptive information on the underlying causes of the rate increase without providing overly-technical information related to the rate development process. More technical information will be available on the CMS website.

Comment: Several health insurance issuers and a state regulatory association, raised concerns that the information provided on the disclosure is not relevant to consumers:

- The presentation of information on the disclosure form will be misleading or not meaningful to consumers, as the form will not capture or describe an individual's actual premium increase.
- The effective date of the increase could occur on an individual's anniversary date, which in most cases will be different from the effective date of rate increase provided in a rate filing.

Response: The disclosure is intended to provide an explanation as to why the issuer is changing its existing rate structure - the underlying basis for determining every insureds underlying premium and the explanatory text included in the form describes the distinction between premiums and rates. While it is true that the overall product-level information provided on the form does not speak to an individual insured's rate increase, the disclosure does provides an overview of the reasons behind an issuer's increase proposal. The language regarding the effective date was amended to address rolling effective dates and the use of "rate" and "premium"

Comment: We received comments from a professional actuarial association and a health insurance issuer stating that the disclosure form will only work for individual market products. These commenters cited several areas on the form that in their view do not make sense in the small group market:

- The overall rate increase in the small group market could be affected by an employer's contribution,
- It is unclear how a maximum and minimum rate increase should be reported for small group products, and
- The text on the form currently does not distinguish between individuals and employers.

Response: Most of the information that appears on the consumer disclosure form is high level rate increase information that is relevant to both markets. However, based on the comments, we have made changes to the instructions to indicate how data should be provided for small group products (e.g., reporting the maximum and minimum premium increases). Changes have also been made to the text of the disclosure to accommodate information related to small group products.

Comment: We received several comments from health insurance issuers and a professional actuarial association stating that the introductory text in the disclosure does not accurately describe the rate review program. Problems perceived by commenters are:

1. The language should not bias consumers' interpretation of rates that are under review and should make it clear that the rate increases disclosed have not been found to be "unreasonable."
2. The language should not give consumers the false impression that HHS has the authority to approve or reject rate increases.
3. The first paragraph falsely states that the ACA requires health insurers to provide the preliminary justification information when they propose an increase over 10%

Response: The disclaimer language on disclosure clearly articulates the difference between a rate increase that is pending review and a rate increase that has been reviewed and found to be unreasonable. Additionally, as we continue to work on developing the rate review website, we will ensure that information is organized and labeled in a manner that clearly makes the distinction between rates that have been reviewed and rates that are pending review. No indication is given on the disclosure that CMS has the authority to approve or reject rate increases. However, we have made edits to the disclosure to resolve ambiguities regarding CMS' role in the rate review process. In addition, we removed the first paragraph so as not to mislead consumer about ACA requirements.

Comment: A health insurance issuer and a professional actuarial association suggested that all of the items currently grouped together under 'other' should be separately reported on the disclosure form, since it is collected separately on the data collection worksheet.

Response: The disclosure currently provides a breakdown of medical costs by service categories (e.g., inpatient, outpatient, etc.). This information includes an 'other' category, which captures medical cost changes related to capitated payments, cost sharing changes, and corrections for prior net claims estimates. These items were originally grouped into the 'other' category due to concerns that they were too technical to present to consumers, however we are pursuing the addition of a link to the data collection sheet on this table. "Capitation" has been broken out on the revised disclosure.

B. Preliminary Justification

Comment: Several health insurance issuers and a professional actuary association recommended that we modify the fields on the form that capture the maximum and minimum premium increases. These commenters stated that the use of the word 'premium' is inconsistent with the rest of the form, which captures information on 'rates'. These commenters also stated that the maximum and minimum values should be entered into the form, instead of calculated from changes in the minimum and maximum rates across years.

Response: CMS has replaced the word 'premium' with the word 'rate' on the worksheet and in the instructions. Additionally, the maximum and minimum dollar fields have been replaced with fields that allow issuers to input the minimum and maximum *percent* increases.

Comment: Several health insurance issuers recommended that we modify the fields on the worksheet that collect historical information on rate increases to take into account new products for which no rate history information is available.

Response: We have added a new field in this section that issuers can use to indicate that the product was either in its initial implementation year or did not exist for all any part of the three-year period tracked on the form.

Comment: Several health insurance issuers commented that the use of the term "Member Cost Sharing" to describe cost sharing could be confusing because some of the cost sharing may be paid through coordination of benefits arrangements (as opposed to members).

Response: We have removed the term 'Member' from all references to cost sharing in the form and instructions.

Comment: A health insurance issuer and a professional actuarial association asked for clarification in instructions about the problem of lost encounter data under capitation arrangements and its impact on the calculation of cost sharing. Commenters stated that the cost sharing estimate would be understated as it does not include capitation.

Response: We have addressed this concern on the form by allowing issuers to estimate the cost sharing amount associated with capitation.

Comment: We received comments from health insurance issuers and a professional actuarial association stating that some issuers may not have their claims and trend data available in a manner that is consistent with the worksheet.

Response: We appreciate that issuers may have different approaches for tracking claims data and developing their trend assumptions. However, all issuers should be able to provide the summary level claims and trend information called for on the worksheet, regardless of their internal reporting or rate development processes. Additionally as noted in the instructions, issuers will be permitted to make reasonable allocations for their trend and claims reporting.

Comment: Two health insurance issuers commented that the instructions should be modified to more clearly articulate that a single population, in force at certain period of time, should be used to ensure the calculation reflects a measure of the rate change, not other factors or the change in the mix of business in a block.

Response: We agree that the worksheet is intended to capture a single fixed population, and we have added additional clarifying language emphasizing this point in the instructions.

Comment: Several health insurance issuers and a professional actuarial association made general comments suggesting that CMS should provide more technical details in the instructions for the Preliminary Justification (particularly the rate filing documentation instructions).

Response: We have reviewed the form instructions and have added additional technical actuarial instructions and additional definitions of terms throughout the document. In general these changes clarified the reporting requirements and did not materially changing them.

Comment: We received comments from a state regulatory association and health insurance issuers addressing concerns that the form only works for 12-month increases (e.g., it cannot be completed for quarterly increases).

Response: We do not agree with this comment. The reporting threshold in the rate review regulation requires health insurance issuers to consider the cumulative effect of rate increases over a 12 month period. If the threshold is met due to multiple increases, the issuer would be required to provide12 month claims and trend assumptions that reflect the cumulative impact of all of the increases in the past 12 months. We have added substantial technical information to the instructions that addresses how issuers should address multiple increases on the form.

Comment: Several health insurance issuers requested the removal of risk based capital from the list of rate filing documentation data elements, as this data element is not considered in most states' rate reviews.

Response: In the final rule list of effective rate review program review criteria, we replaced 'risk based capital' with 'surplus and capital'. As this list of review criteria applies to both State and CMS rate reviews, CMS has replaced 'risk based capital' with 'capital and surplus' in the rate filing documentation requirements.

Comment: Several health insurance issuers and a professional actuarial association requested clarification on the instructions for the three loss ratio calculations contained in the rate filing documentation requirements.

Response: We have added additional details in the instructions on how each of three loss ratios should be calculated:

1. The cumulative loss ratio and a description of how it was calculated (for individual only).
2. The projected future loss ratio (a one year projection from the effective date of the rate increase) and a description of how it was calculated. This is not the "adjusted" federal loss ratio.
3. The projected lifetime (a projection of the kind normally used in calculating a state level lifetime loss ratio, and the future loss ratio included is not the same as the future loss ratio in (7) above – the future loss ratio is not "adjusted" and is not under the federal standard) loss ratio that combines cumulative and future experience, and a description of how it was calculated. This is for individual business only. Include a loss ratio exhibit that shows the details of the loss ratio.

Comment: Several health insurance issuers and a professional actuarial association stated that the reference to Generally Accepted Accounting Principles (GAAP) should be removed from the instructions for reporting administrative costs, as (GAAP) is not commonly used standard for reporting these costs.

Commenters stated that issuers should be allowed to follow applicable state standards for reporting administrative costs.

Response: We have removed the reference to GAAP in the instructions.

C. Rate Review NPRM

Comment: Many of the commenters expressed concerns with the overall rate review process outlined in the NPRM, including feedback on effective rate review program determinations, and state and HHS review responsibilities.

Response: In general, these comments reiterated concerns that were received during the public comment period for the NPRM (in many cases individual commenters either referenced or restated their NPRM comments). These comments are outside of the scope of this PRA were addressed in the preamble to the final rule.