

Health Reform Update

Final Regulations on Rate Review

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Final Regulations on Disclosure and Review of Unreasonable Rate Increases by Health Insurer

On May 19, 2011, the Department of Health and Human Services issued final regulations regarding the requirement for review of certain rate increases under the new health reform law (the proposed regulations were issued back in December 2010 – see our website). The proposed regulations, effective as of July 1, 2011, required that proposed rate increases of 10% or higher must be disclosed and reviewed to determine whether they are unreasonable. The final regulations incorporate the provisions of the proposed regulations, with a few changes. Key concepts from the final regulations are addressed below:

Review not Applicable to Large Group Market: the final regulations confirm that only the individual and small group markets (and at this time, not large group markets) are subject to review of proposed rate increases. The markets will be determined by applicable state law, or in the absence of a state-law, under the PPACA definition (using a 50-employee cutoff until 2016, and a 100-employee cutoff thereafter). Grandfathered plans, retiree-only plans and excepted benefits continue to be outside the scope of the regulations.

Effective Date: the effective date of the regulations has been moved to September 1, 2011. The new effective date will give insurers in the small group and individual markets a two-month extension to comply with the new provisions.

Initial Threshold Remains at 10%: the final regulations maintain the 10% initial threshold for determining which rates will be subject to review. As of September 1, 2011, insurers seeking rate increases of 10% or more are required to publicly disclose the proposed increases and the justification for them. The final rule ensures that information about rate increases is available to consumers in a simple and easy-to-read format. The increases will be reviewed by either state or federal experts to determine whether they are reasonable. The initial threshold of 10% is intended to be transitional until state-specific thresholds are put into place beginning September 1, 2012. CMS will work with the states and the NAIC to develop a process and identify data and methodologies for setting state-specific thresholds, which should be updated annually.

States have Primary Role for Review: the final regulations confirm that where states have an effective rate review program, as determined by HHS under standards set out in the regulations, the states will have primary responsibility for reviewing rates. New York and New Jersey (but not Pennsylvania) already require prior approval of rate increases. States will be notified by HHS by July 1, 2011 (2 months before the filings are first due) as to whether their programs are effective. If a state does not have an adequate review process, HHS will conduct the rate reviews; however, HHS expects the vast majority of states will conduct them.

Review Process: the final regulations follow most of the details set forth in the proposed regulations regarding the review process, with a few changes. HHS declined to provide safe harbors or expedited rate review procedures. The final regulations also make it clear that HHS only has the authority to require justification and disclosure of proposed rate increases; it does not have the authority to rescind an unreasonable rate or impose penalties on an insurer for proposing an unreasonable rate.

What does this mean for consumers?

The government's intent is to help bring down costs for consumers. The required review will ensure that increases are based on reasonable estimates and real-time data on medical cost trends and health care utilization. The PPACA has already helped many states strengthen or create rate review processes. Currently, 43 states and the District of Columbia are using \$44 million in grants provided by HHS to help them improve their oversight of proposed health insurance rate increases. These new rate review provisions work hand-in-hand with the Medical Loss Ratio regulations (released in November 2010), which require insurers to spend at least 80% of premium dollars on direct medical care or work to improve the quality of care for patients. Both of these reform provisions are designed to make the health insurance marketplace more transparent and increase the value consumers receive for their money, as well as strengthen oversight actions to assure consumers that any increase in their premium is reasonable and that their premium dollars are being spent on their medical care.

