December 21, 2012

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9972-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed rule on health insurance market rules and rate review and disclosure

To Whom It May Concern:

On behalf of the members of the American Academy of Actuaries'[1] Individual and Small Group Market Task Force and the Premium Review Work Group, we appreciate this opportunity to provide comments to the Centers for Medicare & Medicaid Services in response to its proposed rule on health insurance market reforms, which includes modifications to the final rule on rate review and disclosure requirements.

This letter includes comments on both the market reform rules and those modifications (including the current Standardized Data Template). We address the market reform rules first and subsequently the rate review requirements (Section H below). We offer general comments, as well as responses to selected specific questions posed by HHS, for each of these topics.

Specific Comments on Insurance Market Reforms

Part I—Executive Summary

C. Costs and Benefits

Rate Shock and Adverse Selection

As we have noted before, for a health insurance market to be viable, it must attract a broad cross section of risks. This will help minimize adverse selection and stabilize premiums. While the individual mandate and premium subsidies will help reduce the risk of adverse selection by encouraging lower-cost individuals to purchase coverage, in the proposed rule, HHS requests comment on additional strategies that might help encourage enrollment and/or stabilize premiums. We outline several options below[2]:

[1] The American Academy of Actuaries is a 17,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

[2] These options are based, in part, on options discussed by the General Accountability Office, "Voluntary Health Insurance Enrollment (GAO-11-392R)," February 2011. Available at: http://www.gao.gov/new.items/d11392r.pdf.

- Less frequent enrollment periods (possibly coupled with late-enrollment penalties) would encourage individuals to purchase coverage sooner rather than waiting until high health care needs arise.
- Penalties for late enrollment, such as increasing premiums for late enrollees or restricting access to coverage, could encourage individuals to purchase early. However, increased premiums for late enrollees may not be enough to offset the potential costs of those enrollees. As higher costs are spread to other enrollees, premiums could increase on the whole. Alternatively, restricting access to coverage could protect plans from premium increases, but in both cases lower-income individuals could be particularly vulnerable to higher costs and less generous coverage.
- Automatic enrollment for smaller employers could encourage them to facilitate enrollment of employees through the exchange, but it also could create an increased administrative burden for them.
- More generous subsidies or expanded eligibility for subsidies could lower premiums and increase the likelihood that younger, healthier individuals would purchase coverage; however, it also would increase federal costs.
- Greater variation in premium rates based on age could lower premiums further for younger individuals, but it would increase premiums for older individuals.
- Enhanced public outreach and education could encourage and facilitate enrollment.

These approaches include not only options that focus on attracting low-cost individuals into the insurance market, but also options that mitigate the costs associated with adverse selection. In some cases, these changes might require legislative action at the federal or state level.

High Risk Pools

We request clarification regarding any proposal to extend/continue high risk pools. In the Executive Summary of the proposed rule, it was emphasized that the Affordable Care Act (ACA) will provide affordable health insurance coverage to everyone, "notwithstanding any health problems they may have." Furthermore, in the section on the reinsurance program, the *Notice of Benefit and Payment Parameters* for 2014 proposes "A state may coordinate the entry of the state's high risk pool into the Exchange environment."

State high risk pools (HRPs)—unlike the temporary Pre-Existing Condition Insurance Plan (PCIP) implemented in 2010—generally require premium levels that are materially higher than those present in the individual market and would not provide an essential health benefit (EHB) level of benefits. The temporary reinsurance program for the first three years was established, in part, to address the influx of high-risk individuals into the insurance pool under a guaranteed-issue environment.

Individuals in HRPs will have the greatest financial incentives to participate in an exchange. They may have access to lower premiums (potentially with premium and cost-sharing subsidies through an individual market exchange) and improved benefits in non-grandfathered coverage in the individual market beginning in 2014.

Prohibiting this population from participating immediately in the individual market, particularly in an exchange, could be unfairly discriminatory.

Furthermore, delaying their entrance would not resolve any problems associated with these higher risks—it would only delay the problems. We recognize that some may argue that delaying entrance of this population into the individual market would give the market a chance to enroll more members who could subsidize them. Most of the funding available for the temporary reinsurance program will be in the first year, however. As a result, the largest per capita reinsurance subsidies, which in effect will reduce premiums below the amount they would be otherwise, occur in the first year. As mentioned, these subsidies are intended to offset, in part, the higher costs associated with the influx of high-cost participants, including those from the HRPs. If the movement of individuals from HRPs is delayed, there will be a mismatch in the need for reinsurance subsidies to cover these individuals and the availability of these subsidies.

We request consideration and clarification of several related issues and questions:

- Is it correct that the federal temporary PCIP reinsurance program will sunset and that discussion of extending HRPs is exclusively a reference to state HRPs?
- Can state HRP members move out of these plans into coverages previously unavailable to them in the small group or individual market that may be more advantageous because of the new rating rules and benefit requirements?
- The movement of HRP individuals was a consideration in the development of individual market reinsurance and risk corridor protections and any delay diminishes the impact of those temporary programs.
- All else being equal, phasing in HRP members, combined with an already increasing enrollment in eligible plans and a decreasing amount of total reinsurance dollars could further exacerbate potential rate increases in the individual market, as the per capita reinsurance subsidy declines.[3]
- It appears that high risk pools fall outside the ACA because they are not "insuring" entities or "issuers." We request clarification on which ACA provisions apply to HRP entities and covered members (e.g., benefit protections).
- If state HRPs remain open:
    1. Are continuing members subject to mandate penalties because they do not have minimum essential coverage or government-sponsored minimum essential coverage, as defined?
    2. Would the HRPs be open to new members?

[3] See discussion of the reinsurance subsidy impact in the American Academy of Actuaries comments on the proposed rule for standards related to risk adjustment, reinsurance, and risk corridors: http://www.actuary.org/files/publications/RSWG_comment_letter_on_3R_proposed_rule_111028.pdf (Oct. 28, 2011).

3. HRPs typically are not self-supporting. If carrier subsidization is continued for state high risk pools in which it exists now, will such subsidization be allowed as an adjustment to risk-corridor calculations and MLR rebates as a state fee or tax?
4. Can a person who wants to leave an HRP do so only during the annual open enrollment period for an exchange?

Part III—Provisions of the Proposed Regulations

A. Fair Health Insurance Premiums (Section 147.102)

Family Rating

With respect to per-member rating, we have considered three aspects—pricing accuracy, equitable application of premiums to insured people, and complexity of implementation. For ease of discussion, we have contrasted the proposed method (per member capped) with an alternative method (per member uncapped), in which a family premium is the sum of the premiums for each family member. The proposed per-member capped method for family contracts would limit the number of family members younger than 21 to the three oldest.

A primary aim of premium methods is to accurately reflect costs. The per-member capped method is less accurate than the per-member uncapped method. Since any children beyond the first three are free to a family, all those who do not have large families would pay more to compensate for the costs. This upward pressure on rate levels is expected to be small, however, because the cost of free children in comparison to the entire insured block is expected to be small.

Issuers will increase premium rates across the risk pool to compensate for the covered free children. Those issuers that enroll more large families will have higher costs but will not be compensated by higher premiums. This is likely to be a small inaccuracy for issuers, assuming large families are distributed equally across insurers, since all issuers will use the same rating rules. Because the stated intent of the family cap is to limit the rate impact to larger families during the transition to member rating, we recommend increasing the cap over time and eventually removing the cap altogether.

Considering the equivalent application of premiums, the following example highlights a concern. As we interpret the regulation, for a young family aged 20, 20, 4, and 2, the 2 year-old would be free. But, for a young family aged 25, 25, 4, and 2, the 2 year-old would not be free. This distinction based on the age of the parents appears incongruous. One option might be to exclude parents under age 21 from the cap.

When considering complexity of implementation, there does not appear to be a material difference in the difficulty of using the proposed per-member capped method instead of the per-member uncapped method in offering or billing premiums. However, restricting the number of children appears to increase the complexity of several aspects of ACA implementation. There could be other significant operational, administrative, and process

changes for some carriers due to member rating. The risk adjustment requires an extra step. For coverage purposes, family members under age 26 do not require financial dependency, as they do for federal income tax purposes, so the appropriate treatment of affordability of the individual mandate appears to us to be less clear. Likewise, attributing premium expenses for the purposes of subsidy payments is more complicated and possibly less accurate.

These disadvantages in accuracy, equity, and complexity should be compared with the stated policy objective of avoiding one-time disruption to large families with current coverage that does not require paying for children per capita.

Rating for Geography

CMS is charged with reviewing the adequacy of the rating areas established by a state. If the state's rating areas are inadequate…..or a state does not act, CMS may establish such rating areas. A rating area factor should be actuarially justified to ensure that issuers do not charge excessively high premiums.

We support this approach, suggesting that CMS rely on actuarial review and justification to approve or establish rating area factors. There are Actuarial Standards of Practice (ASOPs) already in place to provide guidance for actuaries.

Determining a geographic area involves the following considerations:

- Consumer equity—Creating a geographic rating area that includes both a high-cost and a low-cost area will mean that consumers in the low-cost areas would subsidize those in the high-cost area.
- Competitive level playing field—Since issuers with limited service areas will be competing against issuers with broader service areas, those with limited service areas could gain or seek a competitive advantage in rates. This would depend on the relative size of the limited service area compared with a larger geographic rating area with higher cost components.
- Population risk to issuers—Large geographic rating areas encompassing multiple cost levels create a population distribution risk to issuers. This also could compromise the equity of the risk adjuster.

The rule proposes that a state could establish no more than seven rating areas within the state.

We recommend further review and consideration of this proposal. Capping rating areas at seven may be appropriate in many states but not necessarily all states. California and Texas, for example, have more than seven unique geographic areas, with different costs of health care. Capping rating areas at seven is too limiting (when actuarial review and justification would suggest more than seven rating areas).

We understand the desire for an upper limit on the number of rating areas, but it may be difficult to determine a "limit" that is appropriate for all states without further analysis. One option might be to allow states to choose seven or fewer rating areas; however, a

safe harbor could be added so that states could choose more if an actuary certifies its reasonableness.

The proposed rule includes three standards for geographic divisions…… (1) one rating area for the entire state; (2) rating areas based on counties or three-digit zip codes; (3) rating areas based on metropolitan statistical areas (MSAs) and non-MSAs.

From an actuarial perspective, based on current claims variation in both the group and individual markets (including rating factors used in the majority of states), options 2 or 3 are appropriate and justified. Option 1, a single-rating area for the entire state, will not be actuarially appropriate in all circumstances.

In the event that a state does not establish rating areas consistent with the proposed standards, the one-area-per-state standard would apply, unless we applied one of the other standards to designate rating areas in a particular state.

The *one-area-per-state provision* will lend itself to simplicity but will cause other issues (e.g., a single-rating factor may not be actuarially justified for all states). We encourage CMS to apply the MSA option in the event the state does not establish rating areas. It should be noted that many states have more than seven MSA/non-MSA areas, which reinforces our earlier recommendation to consider increasing the limit of seven in the proposed rule.

Rating for Age

Many states currently have no restriction on age rating, and existing rates in the individual and small group markets have adult ratios of 4:1 and 5:1 (some may be even greater). For these states, a transition period of two to three years would be less disruptive to the current market; however, these changes may require some legislative activity at the state level. We would welcome the opportunity to work with CCIIO to develop a transition that fits within the parameters of the ACA.

Per the HHS recommendation to reduce administrative expenses and avoid having individuals and small groups experience more than one rate increase during a policy year, age should be calculated at policy issuance and renewal.

We also suggest applying the same age-band structure to both the individual and small group markets to align more closely with per-member rating. This would minimize rate disruption when individuals move between the two markets, as well as facilitate the combination of the two markets into a single risk pool.

We would suggest a single age band for adults 64 and older, which is consistent with current market practices.

The application of single-year age bands is preferable for several reasons:

- Since many currently-allowed rating variables will not be allowed beginning in 2014, the remaining variables, from an actuarial perspective, should have as much precision as possible.
- The use of single-year age bands is consistent with the approach used in several states in the individual market and therefore will be less disruptive.
- The use of single-year age bands is less common in the small group market, but given that age bands in use today are not always consistent, there likely will be disruption regardless of the bands chosen. The move to single-year age bands will result in some rate winners and some rate losers, but after the first year, rate shock due to advancing age will be minimized compared to today's practices.
- Single age bands also would produce more accurate rating for families in a member-level rating structure and less annual rate change (every member ages one year) than if wider bands were used.

We are in general agreement with the proposed approach for fitting the adult age curve to the statutorily specified 3:1 premium ratio. Starting around age 56, the percentage changes from one age to the next oscillates somewhat. It might be helpful to smooth out the percentages, by having the factors increase 4 percent for ages 56 and 57, 3.5 percent for ages 58 to 60, and 3 percent up to age 64 and older.

B. Guaranteed Availability of Coverage (Section 147.104)

CMS requested comment on whether year-round open enrollment for employers and an open enrollment period for individuals consistent with exchanges sufficiently addresses the open enrollment needs of individual market customers whose coverage renews on dates other than Jan. 1. Is aligning open enrollment periods with policy years (based on a calendar year) in the individual market more desirable? We recommend that for CY2014 only , the renewal date for policyholders within the individual market could be considered a qualifying event, which would allow the policyholder to enroll in an individual market product offering outside of the open enrollment period.

D. Applicability to Student Health Insurance Coverage

CMS requested comment on whether the final rule should allow issuers to maintain a separate risk pool for student health coverage, or whether it should be included in the individual market pool as proposed. It's important to note that the *Notice of Benefit and Payment Parameters* excludes student health coverage from the risk-adjustment mechanism. Further, student health is aggregated separately from individual market business for purposes of the MLR rebates. As such, it would be inconsistent to pool student health coverage with individual coverage for rating purposes.

CMS also requested comment on whether the final rule should provide any modifications with respect to the generally applicable individual market rating rules in connection with student coverage. As student health coverage is usually related to an association-type plan sponsored by the school, some modifications may be needed such as allowing open enrollment to coincide with school enrollment periods (rate changes would then become effective at the beginning of the school year) and recognizing the narrower network scope (or those services provided through school facilities).

E. Single Risk Pool (Section 156.80)
Premium (index) rate will be based on all individual or small group non-grandfathered claims experience, and for any plan could not vary from the index rate except for: (1) AV and cost-sharing design of the plan; (2) plan's provider network and delivery system, and utilization management; (3) plan benefits in addition to EHB, and (4) expected impact of specific eligibility categories for catastrophic plans.

We request more clarification regarding the extent to which actuarial value, as produced by the AV calculator or otherwise certified according to regulation, is used to determine pricing relativities between the AV metal tiers. According to the proposed rules, premium rates are allowed to vary based on the actuarial value and cost sharing of the plan. However, it is not clear whether the determination of actuarial value for pricing purposes is required to use the same data and methods as those used to categorize plans into the metal tiers. More clarification is needed regarding the appropriate data and methods to determine actuarial value for pricing purposes. In addition, more clarification is needed on whether plans in different metal tiers that are similar except for specific cost-sharing provisions would be expected to have premiums that vary solely by the actuarial value relativities as produced by the AV calculator.

Regarding Items 2 through 4, we believe it is reasonable that the index rate should reflect adjustments for network, delivery system, utilization management, plan benefits in addition to EHB and adjustments for catastrophic plans.

We would assume that adjustments for network, delivery system, and utilization management could vary by plan year. For example, changes in provider contracting occurring during plan year 2014 would be reflected in the 2015 adjustment for the plan's provider/network/delivery system/utilization management adjustment. Similarly, changes made to utilization management in 2014 would be reflected in this 2015 adjustment.

We also are concerned that this section could place restrictions on updating allowable rating factors. It is important for carriers to be able to modify factors based on actuarial justification to provide as equivalent rates as possible. If, for example, a carrier discovers it has mispriced an area factor, it is important to correct this prospectively as soon as possible. Thus, clarification is needed regarding a carrier's ability to modify rating factors.

Index rate, market-wide adjustment for payments and charges for risk adjustment and reinsurance, and individual plan variations must be actuarially justified.

We fully support the need for transparency in the implementation and application of adjustments to reflect payments and charges for risk adjustment and reinsurance. Similarly, we support consistency with the state and federal rate review process in fully justifying adjustments to specific plan variations.

Allow additional flexibility in product pricing in 2016 after issuers have accumulated sufficient claims data.

We appreciate that an additional degree of flexibility is contemplated for pricing in 2016 and later. We recommend additional flexibility to begin for products priced in 2015 or later if the actuary has accumulated sufficient credible claims data to support those changes. Consistent with the comments above regarding transparency, we would recommend that these adjustments be actuarially justified.

H. Rate Increase Disclosure and Review

General Comments

We appreciate the opportunity to work with Center for Consumer Information and Insurance Oversight CCIIO to understand these new requirements, especially those included in Parts I and III of the Rate Filing Justification as well as the accompanying instructions. We also understand there may be additional changes to come. We recommend HHS allow additional time to comment as new items are added or changed in the form, regulation, or instructions.

We have a few general comments on the data template and modifications to the final review and disclosure rules:

- Part I (Standardized Data Template) has been revised. Between now and 2016, there will be many changes. Rates effective 2014 will use 2012 claims experience. Rates effective in 2016 most likely will use 2014 claims experience. There is some information that we will not have now, but will for rates effective for 2016. The Standardized Data Template should be as flexible as possible to accommodate those changes.

- The revised rate review rule, the draft Standardized Data Template (Part I of Rate Filing Justification), and the draft Actuarial Memorandum (Part III of Rate Filing Justification) provide new instructions for filing requirements, which are different from the previous rate review rule and Preliminary Justification, Parts I and III.

  The new Rate Filing Justification appears to have a different purpose, mainly tracking experience data and index rates. It does not appear to include typical actuarial rate filing or increase information related directly to the development of rates or rate table increases. We recognize this is a departure from the previous requirements. While we understand the need for the requirement for reporting the data, the new worksheets appear designed as an overall gauge of the relativities of emerging experience to those of competitors in a market. We would like clarification on how the information in Parts I and III will be used to determine whether a rate increase greater than the threshold is reasonable.

- Proprietary and confidential information is a concern. A competitor may be able to study Parts I and III and potentially infer information that may be characterized as

confidential or proprietary in nature. The current Section 154 addressed this issue appropriately.

- We have a number of questions on proposed revisions to Section 154:

  - What is the purpose of Part I? How is it to be used to determine if rates are unreasonable?
  - Should Part I be an annual experience reporting form?
  - What is the definition of "index rate"? Is it claim costs only for EHB excluding administrative charges, or is it premium level for EHB including adjustments, in aggregate for reinsurance and risk adjustment and administrative charges? We recommend it be the premium level as we understand the index rate is intended to track premiums and not claims.
  - If a filing is done for a quarter's worth of renewals in the small group market, for example, is the index rate based on the entire projected population or just the portion of the membership that is renewing during the filed quarter? We recommend it be the entire population.
  - We have questions related to Worksheet 2 of Part I. After the release of the paperwork reduction act (PRA), there was discussion about filling out Part I—Worksheet 2 of the Standardized Data Template for 2014 effective dates. It was indicated that experience from 2012 would not need to be broken out by EHB, state mandate, and other benefits (other than EHB). Can this be clarified in the instructions?

    Experience in 2013 for pre-ACA products and plans to be used for the 2015 product filing and the experience in 2014 for pre-ACA products to be used for the 2016 product filing also will not necessarily have the full EHB benefits included. This is because experience would be on products that existed before the Jan. 1, 2014 ACA requirements and even in 2014, the ACA requirements come into play on renewal throughout the year. We recommend flexibility on filling out Worksheet 2 of Part I so that the experience of pre-ACA products and plans not be required to be broken out into the three different categories—EHB, state mandates, and other.

- The detail requested in the Standardized Data Template on allowed and paid per member per months (PMPMs) by service category may be very difficult to develop for some carriers, such as Health Maintenance Organization (HMOs), that may normally develop rates based on total revenue needs, reflecting a top-down approach to rating rather than one that builds up from the bottom. It must be recognized that allocation algorithms will be used by most insurers in populating the forms and developing pricing assumptions, even after 2015.

- We understand that revised Section 154 asks for the actuary to include an actuarial attestation in the actuarial memorandum (Part III), and by reference to Part I, that Part I was completed correctly.

We are concerned by the lack of specifics in connection with such actuarial attestations on which to comment. Academy members (MAAAs) have to comply with a Code of Professional Conduct, which includes Actuarial Standards of Practice (ASOPs) and U.S. Qualification Standards. The Code of Professional Conduct sets forth high standards of conduct, practice, and qualifications, thereby supporting the actuarial profession's responsibility to the public. It also identifies the credentialed actuary's responsibilities to his or her client or employer. ASOPs, promulgated by the Actuarial Standards Board, are used by credentialed actuaries in the United States to ensure that actuarial services are performed in accordance with appropriate actuarial practice. The U.S. Qualification Standards promulgated by the Academy ensure that credentialed actuaries perform actuarial services only when qualified to do so on the basis of basic and continuing education and experience. In preparing an actuarial attestation the credentialed actuary is required to meet certain high qualification standards and to follow the appropriate applicable ASOPs, and other aspects of the Code of Conduct, as well as meeting all applicable state and federal laws and regulations.

These credentialed actuaries are expected to use professional judgment with guidance from ASOPs when developing assumptions, interpreting data, and reviewing results. The same high standards set forth in the Code of Professional Conduct (including ASOPs and qualifications) apply not only to the work of the pricing actuaries but also the work of credentialed actuaries who perform pricing reviews. In the event any such credentialed actuary commits a material violation of the Code of Professional Conduct, including ASOPs and qualification standards, such actuary could be subject to investigation and ultimately receive disciplinary action. This could include suspension of credentials or expulsion from his or her credentialing organizations.

While the attestation instructions and wording for Part III are not finalized, we have included proposed attestation language consistent with Academy requirements and options based on 1) state and federal submission of a rate increase or 2) federal only submission of a rate increase.

Here is proposed language for the actuarial attestation or certification. It includes language for federal compliance:

> *I, [Name], am [Position] for [Company]. I am a member of the American Academy of Actuaries and I currently meet the Qualification Standards promulgated by the American Academy of Actuaries to render the actuarial opinion contained herein. I certify that to the best of my knowledge and judgment the entire rate filing, including supporting forms and documents, is in compliance with the applicable actuarial standards of practice, laws and regulations of the Federal Government and of the state to which it is submitted and that the benefits are reasonable in relation to premiums.*

Note that some states have specific language and mandatory references to law that may be required. In such instances, state-specified language should be followed.

If the rate filing and actuarial memorandum is to be reviewed only by HHS, and not by a state, then the underlined words above would be deleted.

In addition, the actuary should identify the ASOPs used by the actuary and, per ASOP No. 41, *Actuarial Communications*, disclose any deviation(s) from guidance contained in such ASOPs.

The suggested wording and notes are intended to handle 1) current state requirements, 2) federal requirements for 2016 effective dates and later, and 3) allow for flexibility in federal filings through 2015.

Standardized Data Template Comments

Worksheet 1

Section I
Instructions indicate that the experience period must be 12 months, but some carriers likely will use a multi-year period to develop rates.

We understand that the claims in the experience section would need to be adjusted to reflect the EHBs, at least during the experience periods that did not contain requirements on EHB coverage. If this is done, it will be difficult to determine information related to benefit changes on the form. We recommend a separate adjustment reflecting changes in the benefits and not adjusting experience to reflect benefits that were not provided during the experience period.

Section II: Allowed Claims, PMPM basis
Adjustments from Experience to Projection Period—Flat Adjustments
The population risk morbidity item reflects a single adjustment to utilization. In the small group market, employers historically have chosen a single carrier (or possibly two) with a handful of plans to offer their employees. Participation and contribution requirements helped to limit potential adverse selection across the group's members. Now permitting employee choice across an employer's chosen metal level, which allows employees to choose any plan in the metal from any carrier, will remove the protections for a single carrier in place under the prior employer choice method. This additional selection effect could be included in the "population risk morbidity" adjustment column.

The spreadsheet notes that the "other" category would include items such as demographic, benefit, and network changes. To the extent that "other" would include an adjustment that is more likely to affect utilization (e.g., demographic mix), putting the adjustment here may be inappropriate. Revision of the spreadsheet headings to be broader, referencing utilization or cost adjustments, would be reasonable. Typically the actuarial memorandum (i.e., Part III) would contain descriptions of these headings.

While these changes appear to be good additions to account for demographic mix shifts, policy changes, etc., the instructions will need to be flexible enough to allow for these changes. For example, if the average deductible has decreased from the experience period, this shift could be included in "other," although this is not an explicit benefit change.

Adjustments from Experience to Projection Period—Annual Trends
The prior version of the worksheet combined trend by service category, but service categories now are split into utilization and cost. The same types of issues carriers may have had filling out the prior spreadsheet remain with these splits. We recognize, however, that the reasons for this segmentation are not unreasonable.

Credibility Manual Values
This may be a good addition to account for issues related to the credibility of data. However, we recommend that CMS consider including the credibility calculation in Section III versus Section II so that the weighting is done at the aggregate level. If included in Section II, carriers may need to back into the segmentation using similar values from experience or a benchmark. It may be that some carriers will need to rely heavily on the manual rate, especially for plans with little or no prior credible experience.

Section III: Projected Experience
Paid-to-Allowed Ratio
The proposed Part I form has an aggregate paid-to-allowed ratio, which may be more reasonable than the current Part I form in which cost sharing impacts are split out by service category.

We would like clarification on what would be included in the "paid to allowed" factor. If the factor reflects the projected period benefits, then there would be nothing included in Worksheet 1 that reflects changes in the benefit levels. Where would the items not included in the paid to allowed factor be reflected on Worksheet 1.

Projected Risk Adjustment and Reinsurance Recoveries
The effect of the ACA reinsurance recoveries can be projected based on the program definitions and structure. However, it is the reinsurance recoveries net of reinsurance premium that is included in this section. This creates a projected incurred claims value that is not truly expected incurred claims. Rather, it is expected incurred claims less reinsurance assessment premium. For transparency purposes, it is more appropriate to adjust claims only for the reinsurance recoveries, not for reinsurance recoveries net of reinsurance premiums, and then include the reinsurance assessment premium as a separate line below the administrative expenses of the carrier.

In addition, the projected risk adjustments will not be known for two years of filings. The risk adjustment results for 2014 will not be available until mid-2015, after the expected date of filing for 2015 rates. Therefore, it should be expected that the first time a risk adjustment amount will be able to be included in this form is for the 2016 rate filings. We

expect many companies may assume they will incur an average risk level until experience indicates otherwise.

Administrative, Profit, and Tax Adjustments
In the current Part I form these inputs were on a PMPM basis. Now they are on a percent of premium basis. This seems reasonable and to the extent that carriers using a percent of premium method had to convert to PMPM in the current Part I form, those that use PMPM will need to convert to percent of premium in the proposed Part I form.

The administrative expense load should have two sections for transparency purposes:

- A section for carrier administrative expense, which could be broken out as shown on Worksheet 1, for actual administrative expense, and another for profit and risk load (more often called contingency and risk load in practice).
- A section for ACA and other taxes, licenses, and fees. This second section should show the reinsurance assessment, the Patient-Centered Outcomes Research Institute (PCORI) fees, the FIT, the risk adjustment fee, premium tax and exchange user fee, identified separately for transparency.

Worksheet 2

Worksheet 2 requests information on each product/plan sold during the experience period and during the projection period. It is possible there are some carriers that would need to use this form for pre-2014 products that are filed after April 1, 2014. We recommend that this proposed form not be used for rate filings with effective periods prior to Jan. 1, 2014, as most of this spreadsheet seems to be for ACA-based 2014 products. We recommend, instead, that current rules regarding filing the current Preliminary Justification remain in use for these filings.

For this discussion, we have assumed that the Worksheet 2 filing uses a calendar year (CY) 2012 experience period and is being filed for CY2014. Thus, there is a two-year period between the two. We also assume that this filing is for a carrier that has CY rates, so the "current rate table" is for CY2013, and the experience period reflects the rate table from CY2012.

For carriers that are closing down old products and plans and moving to new products and plans, when filing this form for 2014 products and plans there will be data in only portions of the page for the old and new products. Old products will have experience-period information, and new products will have projections-period information. But neither will have both sections filled out. Once 2016 products and plans are filed, this issue should resolve itself.

Section I (product and plan information and rate increase percentages)
"Rate Change % (over prior filing)" is a typical rate filing increase percentage, based on the calculation using a single population and reflects the rate table change from one rate table to the next rate table. The detail on the development of this increase normally would be included in a rate filing and actuarial memorandum provided to a state that requires it.

However, based on our understanding of the intent of the form and the new Part III Actuarial Memorandum, that information is not required to be included in the new Rate Filing Justification. Such data, however, would be available in backup documentation. Your confirmation or clarification of this interpretation would be greatly appreciated.

We understand that "Cumulative Rate Change % (over 12 mos prior)" is meant to be the increase percent against which the threshold (10 percent currently) for rate review would be compared. Again, based on our understanding of the intent of the form and the new Part III Actuarial Memorandum, the detailed development of this calculation is not being requested in the new Rate Filing Justification.

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)
This will be new information carriers will have to develop since this information is not something that typically is broken out by service category in a rate filing. In particular, this will require cost models by service category to be developed for each and every plan design within the product. This has not often the case. More typically, benefit relativities by plan design are developed at an aggregate level across the scope of benefits within a plan design. Therefore, changes in PMPMs by service category, by plan design, and product may be difficult to develop for a carrier, especially if that carrier is an HMO or other carrier that develops rates based on projected revenue needs.

In the first year of new products being offered, this section will provide full PMPM values by plan design, as the change in PMPMs will be from $0 PMPM to the underlying expected claim costs PMPM by service category for new products. Note that this is confidential and proprietary information that, if made public, could be used by competitors to gain market advantage. The current Section 154 allowed for the identification of proprietary/confidential information, but that allowance appears to have been excluded in the recent revisions. We request clarification on this issue.

Section III: Experience Period Information
We would encourage HHS to provide clarification and guidance in the instructions for each of the items below:

- The experience period information would be blank for new products/plans being filed.
- It is our understanding that for experience of pre-2014 ACA products, the portions related to the lines entitled, "EHB basis or full portion of TP (or TAC)," do not need to be filled in. (Or, per the comments above, these proposed forms would not be required for pre-ACA products.)
- The line "Allowed claims which are not the issuer's obligation" seems to be the member cost share.
- The line "Portion of above (referencing allowed claims which are not part of the issuer's obligation) payable by HHS's funds on behalf of insured person, in dollars" seems to be the cost share reduction portion of the plan design and not the portion of

the premium tax subsidy. If this line item also is meant to reflect premium tax subsidies, then they would not be a portion of the member cost share.

- In addition, plans are expected to be filed separately in the qualified health plan (QHP) application for each of the silver CSR plan designs. Will this form include the silver CSR plan designs separately from the standard silver plan design, or does this assume—for this form only—that all the silver variations of standard and CSR are filed as one plan design?
- The "Net Amount of Risk Adj" also will be blank for the experience period for the first two years for the individual market filing, assuming the same CY2012 and CY2013 experience periods for the 2014 and 2015 filings, respectively. We expect many companies may assume they will incur an average risk level until experience indicates otherwise.

Section IV: Projected (12 months following effective date)
We understand products offered during the experience period that are not going to be offered during the projection period will have no values for the projection period. This is likely to occur for many carriers for the 2014 and 2015 Rate Review Justification filing periods, as experience is likely to be from CY2012 and CY2013, prior to the new ACA product requirements (EHBs and metal levels). We recommend clarity on this understanding be included in the instructions.

We have the same comments with respect to the definition of what looks to be the member cost share as noted above.

In this projected section, the net amount of risk adjustment will not be able to be determined based on actual risk adjustment experience until the 2016 Rate Review Justification filing, since carriers in the commercial market do not know what each of the various carriers' risks are compared with others. Since the 2014 risk adjustments will not be known until the middle of 2015—after the expected time period of filing the 2015 rates—carriers will not know their risk adjustment charges or receipts until they can use the 2014 amounts in the 2016 rate filing. There is an expectation for carriers to make some assumptions for risk adjustment, but what adjustments would they make if they assume an average composite market risk?

Worksheet 3

The template appears to anticipate that issuers will make projections by product for both paid and incurred claims and incurred but not reported (IBNR) claims. While such detail is important for historical periods, issuers typically do not make claim projections at this level of detail. Once historical values have been established, the total incurred claims are the most important value on which to make projections. We recommend removing the requirement to provide projected values for both paid and incurred claims and IBNR.

Why are future loss ratio calculations important after Year 1? The template requires that future projections go out to the end of the life cycle of the product. Does this means that

some basis for the population is to be assumed? If so, we recommend such guidance be included in the instructions.

It is not clear how premiums and claims are to be projected forward beyond the filed effective period. There are two commonly used approaches: (1) Assume 0 percent trend for both premiums and claims, or (2) assume that trend for both premiums and claims are equal to some reasonable, non-zero value (e.g., 8 percent). Either assumption is to be used after the rate effective period. We recommend that guidance on this issue be included in the instructions.

True measures of historical experience for federal reinsurance, risk adjustment, and risk corridor payments (by HHS) and charges (payments to HHS) will not be available until mid-2015. This means that rate filings related to all years 2014 through 2016 will be made on the basis of estimates. Instructions for dealing with revisions to prior estimates in all worksheets should be developed.

Finally, we recommend the earned premium amount on this page be net of the MLR rebate and be clarified in the instructions.

Section 154 Comments

Section 154.220

The language in this section is the same as language in the previous version, with the dates and the name of the form changed. The first sentence in the current draft states, "A health insurance issuer must submit a Rate Filing Justification for all rate increases that are filed in a State on or after April 1, 2013, or effective on or after January 1, 2014 in a State that does not require the rate increase subject to review to be filed, as follows:…"

The intent of the revisions to Sections 154.210, 154.215, 154.220 is to align rate review with the new rules for the individual and small group markets taking effect Jan. 1, 2014. The new rules include EHB, the single risk pool, exchanges and available subsidies (i.e., advance tax credits), among other provisions. Since these newly defined features are not effective until Jan. 1, 2014, the revisions to rate review should apply to premium rates intended to be effective on or after Jan.1, 2014. For any premium rates intended to take effect prior to Jan. 1, 2014, the current rate review provisions without the new features should remain in effect.

As some filings taking effect before Jan. 1, 2014 will be filed April 1 or later, we recommend that the first paragraph be changed as follows to avoid premature adoption:

"A health insurance issuer must submit a Rate Filing Justification for all rate increases ~~that are filed in a State on or after April 1, 2013, or~~ effective on or after January 1, 2014 ~~in a State that does not require the rate increase to be filed~~, as follows:…"

Section 154.301

Subsection (a)(3)(iv) provides that the states should review rates based on additional rules and methods, such as the use of a market-wide single risk pool, requirements of EHB

starting Jan. 1, 2014, use of actuarial value, and other market reforms. The terms "implementation and ongoing utilization" are somewhat confusing and clarity on some other items also would be helpful. We recommend that the language in Section (a)(3)(iv) be changed to "*The health insurance issuer's data related to the use of a market-wide single risk pool as a starting point for the rate filing (see page 1 of Part I of the Rate Filing Justification), the requirement to cover essential health benefits for plan or policy years starting on or after 1/1/2014, the actuarial values as calculated by the HHS provided Actuarial Value Calculator reflecting a standard population, and other market reforms as required by the Affordable Care Act*."

Subsection (a)(4)(iii) includes a review of cost-sharing changes by major service category, including "actuarial value." This appears to refer to the HHS definition and calculation of actuarial value. While it may be of interest to review AV as part of the rate filing, it is highly likely that carriers will not use the results of the AV calculation to estimate the impact of changes in cost-sharing. They will either use their own proprietary version of an AV calculator based on their experience, provider contracts, utilization management, etc., or they will use some other proprietary version purchased from third party. We recommend that a review of AV be a separate line item, apart from a review of cost-sharing changes. It also should be noted the current version of the AV calculator does not provide an estimate of cost-sharing changes by major service category.

Subsection (a)(4)(iv) describes one of the factors for review includes "The impact of benefit changes, including essential health benefits and non-essential health benefits." We request clarification on whether the effect of benefit changes noted here include:

- the expansion or contraction of current product coverage of benefits that previously excluded the EHBs or had broader coverage than required by the newly defined state EHBs, and
- the change in the coverage level as required by the new metal tiers and requirements for the AV +/- the de minimis level.

We assume it does, but would need clarification on this issue.

Subsection (a)(4)(v) states, "The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Services Act." The change in pricing due to rating limitations should be separated out from this line item. We recommend adding an item (xiii), which does not currently exist as follows: "(xiii) The impact of rating limitations for age and tobacco use under section 2701 of the Public Health Services Act." In addition, Section (a)(4)(v) would then need to be changed as follows: "The impact of changes in the enrollee risk profile (or population risk morbidity, as described on Part I, Worksheet 1)." Is the intent of this item after the results of risk adjustment are known meant to adjust actual carrier experience to the average of the market, or is this meant to reflect other changes in enrollee risk profile? Please clarify in the instructions.

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We welcome the opportunity to discuss with you at your convenience any of the comments presented in this letter. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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