

A PUBLIC POLICY PRACTICE NOTE

Exposure Draft

Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act

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Developed by the Rate Review Practice Note Work Group
of the American Academy of Actuaries



AMERICAN ACADEMY *of* ACTUARIES

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This practice note was prepared by the Rate Review Practice Note Work Group organized by the Health Practice Council of the American Academy of Actuaries. This document is intended to provide information to actuaries preparing, reviewing, or commenting on rate filings in accordance with Section 2794 of the Public Health Service Act, as amended by the Affordable Care Act (ACA). Section 2794 requires the Department of Health and Human Services (HHS) Secretary to work with states to establish an annual review of “unreasonable” rate increases. All rate changes, above and below the “unreasonable” threshold, are discussed in this practice note.

This practice note is intended for use as a reference tool only and is not a substitute for any legal analysis or interpretation of the regulations or statutes. This practice note is not a promulgation of the Actuarial Standards Board, is not an actuarial standard of practice, is not binding upon any actuary and is not a definitive statement as to what constitutes appropriate practice or generally accepted practice in the area under discussion. Events occurring subsequent to this publication of the practice note may make the practices described in this practice note irrelevant or obsolete.

This practice note is not an official or comprehensive interpretation of the ACA. Future regulatory and legislative activity may change materially certain information presented in this practice note. Because this is an emerging issue, there are a number of issues that still need to be resolved. As a result, to be timely, this practice note does not address various issues around which there is still uncertainty as regulations have not been finalized yet (e.g., essential health benefits, actuarial value, reinsurance, risk adjustment, etc.). The actuary should review state and federal regulations and related material continuously as HHS and states are expected to revise regulations and interpretations frequently.

We welcome comments and questions. Please send comments to healthanalyst@actuary.org.

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Introduction

This practice note is intended to provide actuaries with information to assist in the preparation and review of health insurance rate filings as required under Section 2794 of the Public Health Services Act (PHSA), as added by Section 1003 of the Affordable Care Act (ACA). The secretary of the Department of Health and Human Services (HHS) is responsible for developing an annual process for the review and disclosure of “unreasonable” rate increases. In May 2011, HHS published Code of Federal Regulations Title 45 Part 154 (45 CFR 154), which implemented the rate review provision in the ACA and clarified many outstanding questions, including the definition of an “unreasonable” rate increase. In this practice note, we rely on the authority of the regulation in cases in which it is more specific than Section 2794.

Primary source materials referenced in this practice note include:

1. Rate Increase Disclosure and Review (May 23, 2011, final rule)
http://cciio.cms.gov/resources/files/rate_increase_final_rule.pdf
2. Rate Increase Disclosure and Review: Definitions of “Individual Market” and “Small Group Market” (Sept. 6, 2011, amendment to final rule)
<http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf>
3. CMS Rate Review Instructions Manual—Health Insurance Issuer Reporting Requirements (Sept. 14, 2011)
http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf
 - a. Part I Instructions for the rate summary worksheet (excel spreadsheet)
http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf
 - b. Part II Instructions for the consumer disclosure form
http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf
 - c. Part III Instructions for filing rate increases
http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf
4. CMS Memorandum—*Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations* (Sept. 1, 2011)
http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf
5. Affordable Care Act Section 1003 (adding Section 2794 to Public Health Service Act)
<http://docs.house.gov/energycommerce/ppacacon.pdf>
6. CMS List of Effective Rate Review Programs (Oct. 24, 2011)
http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html
7. State rate filing requirements for Maine and Florida as of May 2011
8. CMS Rate Review Training
 - a. Technical FAQs—Set 1 (Aug. 1, 2011)

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http://cciio.cms.gov/resources/files/rate_review_training.html

b. Technical FAQs—Set 2 (Oct. 24, 2011)

http://cciio.cms.gov/resources/training/rate_review_faq.html

This practice note represents a description of practices the work group believes to be common among many but not all U.S. health actuaries, but other approaches also may be appropriate.

We expect Section 2794 to increase the public's awareness of the role of the actuary; the HHS website will display actuarial memoranda signed by actuaries. The new regulation affects actuaries who prepare or submit rate increases to HHS or states, regulatory or consulting actuaries who review rate increase filings, and actuaries who provide public comment on rate filings and reviews. This practice note is intended to encourage discussion on the issues set forth below, providing a framework to foster dialogue between the actuaries involved in the process.

Certain types of products currently are excluded from the rate review requirements set forth in PHSA Section 2794 and are not subject to this practice note, including but not limited to:

- Grandfathered plans (see 45 CFR 154.103)
- Certain excepted benefits (see PHSA Section 2791(c))
- Large group (see 45 CFR 154.103)

As the focus of the regulation is on rate increases, new benefit options and new product filings not previously rated are not subject to this practice note.

Background

Federal Requirements

PHSA Section 2794 requires the creation of a process for the review and disclosure of “unreasonable” rate increases. HHS promulgated 45 CFR 154 and supporting materials to implement Section 2794. One of the primary objectives of Section 2794 is to ensure that there is transparency and a way of monitoring insurers' rate increases for health plans to protect the consumer from unreasonably high rate increases.

The section specifically requires that each state establish a process for the annual review of potentially unreasonably high rate increases beginning with the 2010 plan year (this date has since been changed to rates filed beginning Sept. 1, 2011, or, for those states that do not have an effective rate review process, rates that are effective after Sept. 1, 2011) for individual and small group products. This means that the insurer will submit to the state and the HHS a justification for an unreasonable increase prior to the rate being implemented. The submitted information will be posted to the HHS websites and the state in which the increase is being requested.

In addition, the provision requires the ongoing review of rate increases, which necessitates the support of states. The states are tasked with providing HHS with information about trends in health insurance coverage rate increases and making recommendations to the state exchanges about whether an insurer should be excluded

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from the exchange based on a pattern or practice of excessive or unjustified rate increases.

Beginning in 2014, PHSA Section 2794 requires the monitoring of rate increases inside and outside the exchanges. This primarily is directed at large group plans. HHS and the states will work together to gather information about rate increase levels of large group plans and consider whether exchanges also should be developed for large group plans. Initially, however, large group product rate increases are not required to be reviewed by HHS. Discussion of rate review for large group, therefore, is beyond the scope of this practice note—although some states may choose to review large group rate increases.

Finally, from 2010 through 2014, HHS will have \$250 million at its disposal to provide to states to help in the development of these rate review processes. Section 2794 provides some guidance on how this money will be allocated.

States and Association Business

The actuary is expected to become familiar with specific state laws and/or regulations affecting rate filings and rate increases. To illustrate the complexity and scope of state requirements, Appendix I includes an overview and comparison of the differences in health filing requirements between Florida and Maine (based on state requirements as of May 2011).

State and federal regulatory processes are expected to evolve over time. Federal grants are available to states to assist them in updating their rate review processes, and regulatory positions will be clarified over time. States currently vary significantly in their regulatory review processes; this is expected to continue. The filing actuary is expected to become familiar with a state's regulatory process and be prepared for any modifications or adjustments to the review process.

Appendix III includes the Center for Consumer Information and Oversight (CCIIO) list of effective state rate review programs (as of Oct. 24, 2011). This list will assist the actuary in determining if a rate increase needs to be submitted to the state, HHS, or both. The actuary should check the CCIIO website periodically to identify any updates. Appendix III also includes information regarding association business. It is important to note that association business can be considered as individual, small group, or large group depending on state-specific issues.¹

In addition, the two association columns in the table differentiate between “sitused” and “non-sitused.” This refers to the “state of situs” of the association trust document, which generally determines items such as benefit coverage mandates.

Rate increase reviews are common for actuaries familiar with individual products. Small group and certain association business, which previously may not have required rate increase review, now may be subject to review by the appropriate regulatory authority. Note that CMS filing requirements apply to association business effective Nov. 1, 2011 (see Item 4 on Page 4 of this practice note). To assist actuaries less familiar with

¹ CMS Memorandum—[*Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations*](#) (Sept. 1, 2011).

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individual rate increase filings, Appendix IV includes a list of resources to help the actuary understand the nature of individual insurance.

Review of Unreasonable Rate Increases

Products subject to review

In an effort to be consistent with the review procedures already in place, “individual market” and “small group market” will be defined as they are under the applicable state’s rate filing laws—this is one of the few cases in which the ACA defers to state laws. Regardless of the state’s definition of group insurances, the regulation calls for the review of rate increases on individual and small group coverage. Those that are deemed to be “subject to review” are those individual and small group rate filings in which the proposed rate increase equals or exceeds the threshold determined by HHS (or a state-specific threshold that may be determined beginning in September 2012).

The regulation provides an example in which some states define a small group to include two to 25 employees for rating purposes. The small group rating requirements in these states do not apply to groups with 26 or more employees. Beginning in 2016, the definition of individual and group size will be based on the definition set forth in the ACA, as opposed to the states’ definitions.

Rate increases at or above the threshold would be subject to review beginning with those filed on or after Sept. 1, 2011 for states with rate review processes considered “effective” by HHS (see Appendix III). For states with rate review processes that have yet to be considered “effective,” rate increases at or above the threshold would be subject to review by CMS for filings with rates effective beginning Sept. 1, 2011.

At this time, in states that do not have regulations defining individual, small group, and large group coverage, the issuer should default to the definitions set forth in the ACA:

- **Individual coverage** is obtained in a “market for health insurance coverage offered to individuals other than in connection with a group health plan.”² It does not include short-term limited duration insurance.
- **Small group coverage** is offered through a small employer “in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.”³
- **Large group coverage** is offered through a large employer “in connection with a group health plan with respect to a calendar year and a plan year, an employer who

² ACA Section 1304(a)(2)

³ ACA Section 1304(b)(2)

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employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.”⁴

In plan years beginning before Jan. 1, 2016, states have the option to change the minimum number of employees in a large group from 101 to 51.

- **Association business** will be treated as individual, small group, or large group based on specifics of state law.

Exceptions to the review requirement

Grandfathered plans

PHSA Section 2794 does not apply to grandfathered health plan coverage (See 45 CFR 147.140). Grandfathered plans are those in which individuals and employers groups are enrolled on or before March 23, 2010. The actuary should be cognizant of how plans/individuals/groups can lose grandfathered status.

Excepted benefits

Excepted benefits as defined in PHSA Section 2791(c) will be exempt from rate reviews as described in Section 2794. Plans must satisfy one of the following requirements to qualify as an exception under this section:⁵

- **Benefits not subject to requirements**
 - Coverage only for accident or disability income insurance
 - Coverage issued as a supplement to liability insurance
 - Liability insurance (general, automobile)
 - Workers’ compensation
 - Automobile medical payment
 - Credit-only
 - Coverage for on-site medical clinics
 - Other similar insurance coverage in which benefits for medical care are secondary or incidental to other insurance benefits
- **Benefits not subject to requirements if offered separately**
 - Limited scope dental or vision benefits
 - Long-term care, nursing home care, home health care, community-based care
 - Such other similar, limited benefits specified in regulation
- **Benefits not subject to requirements if offered as independent, non-coordinated benefits**
 - Specified disease or illness
 - Hospital or other fixed indemnity

⁴ ACA Section 1304(b)(1)

⁵ PHSA Section 2791(c)

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- **Benefits not subject to requirements if offered as separate insurance policy**
 - Medicare supplemental health insurance (as defined under Section 1395ss (g)(1) of the PHSA)

Large group

Although large groups currently are exempt from the regulation, the regulation does state that it may be amended in the future to incorporate the review of large group rate filings.

Review of exchange and non-exchange products

Through their commissioners of insurance, states are expected to provide HHS with information about changes in premium increases.

For any products issued on an exchange, rates will be reviewed separately for different market types (small group, large group, etc.). The regulation indicates that HHS will track the difference between similar products within the exchange and outside the exchange. It is important to note that identical products sold inside and outside the exchange must be priced identically. State positions on this issue may differ. This is an important point since it appears to some actuaries that exchange business will not be allowed to have minimum participation rules and, therefore, could face adverse selection.

The ramifications for exchange products is that issuers that demonstrate a pattern or practice of excessive or unjustified premium rate increases potentially may be excluded from the exchanges based on recommendations from the states.

For products not offered in the exchange, rate increase information will be monitored beginning in 2014. If a state or HHS notices that rate increases for some products are noticeably larger than for those products offered in the exchange, this could have a significant effect, including the development of new exchanges. Large group products will be the primary subject of these reviews.

Definition of an “increase”

PHSA Section 2794 directs HHS to establish a process for the annual review of unreasonable increases in “premiums;” however, HHS has interpreted this to mean “rates.” As explained previously, while PHSA Section 2794 directs HHS to establish a process for the annual review of unreasonable increases in “premiums,” HHS has interpreted this as referring to the underlying “rates” that are used to develop the premiums. This is consistent with how these terms are most commonly used by state regulators and the insurance industry. The rate review process performed by states often is one in which changes to the rating structure are reviewed for a plan or policy—as opposed to premium increases within the plan or policy that are derived from the underlying rating structure. As such, a “rate increase” alters the underlying rate structure of a policy form, while a “premium increase” can occur even without any increase (or change) to the underlying rate structure. As the duration of the policy advances for policies that are age rated, for example, premium changes that correlate with age bands are not “rate increases” since they do not change the underlying rate structure. For these reasons, the term “rate” is used instead of the statutory term “premium” throughout the text of the regulation.⁶

⁶ See Appendix II

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The percentage rate increase will be considered in aggregate, including all rate increases within the most recent 12 months, so the issuer will not be able to submit a series of smaller rate increases to achieve a larger increase. The increase will be calculated on an aggregate basis for all insureds at the product level. The product is defined as “a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies offered in a State.”⁷ Variable options do not make policies distinct under this definition. As such, rate increases will be submitted as one product even if the coverage is slightly different based on variable options (e.g., choice of deductible, coinsurance, or out-of-pocket maximum).

The regulation adds that an issuer may submit a “single, combined Preliminary Justification” for multiple products, provided “the claims experience of all products has been aggregated to calculate the rate increases, and the rate increases are the same across all products.”⁸ Since rate increases generally affect members’ premiums differently across the insured population, the filing will be presented in the form of a weighted average increase (weighted by premium; **not** by the number of enrollees). HHS notes that “the rule’s method for calculating a rate increase could be applied such that it is the same as calculating the rate increase as the percentage change between the old revenue and the new projected revenue. With respect to weighting, we note that weighting should not be done based on the number of policies; rather, premium volume is the appropriate weighting factor.”⁹

See Appendix II for examples provided by CCIIO on whether rate increases, particularly those filed more than once per year, meet or exceed the threshold requiring them to be subject to review.

Definition of an “unreasonable” rate increase

Whether a rate increase is “unreasonable” is determined after review by HHS or the state, if HHS has determined that the state has an effective rate review program. If a state has an effective rate review program, HHS will accept the decision of the state in determining whether a rate increase is “unreasonable.” The final regulation requires that increases meeting or exceeding 10 percent annually be subject to review in 2011. State-specific thresholds may be allowed in later years, based on the history of rate increases and other conditions in each state. These state-specific thresholds will be published no later than Sept. 15 prior to each calendar year to which the rate increases apply; CMS will assist states in determining these rate thresholds. We interpret this to mean the new threshold applies to rate filing submissions after Sept. 15 of each year a new threshold is published. If the state determines unreasonableness, it must have a standard of determination that is defined by statute or regulation. If HHS makes the determination, it will consider an increase unreasonable if it is “excessive, unjustified, or unfairly discriminatory,” as described below.

- An **excessive** rate increase is one that results in rates that are unreasonably high in relation to the benefits provided. A rate increase could be deemed excessive if it results in future loss ratios below the federal medical loss ratio (MLR) standard under PHSA Section 2718 (for the

⁷ 45 CFR 154.102

⁸ 45 CFR 154.215

⁹ 45 CFR 154.200

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applicable market), one or more of the assumptions on which the increase is based is not supported by substantial evidence,¹⁰ or the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

- An **unjustified** rate increase is one for which the insurer provides data or documentation to HHS that is incomplete, inadequate, or inconclusive.
- An **unfairly discriminatory** rate increase is one that results in premium differences, that are not permissible under state law, for a particular product between insureds within similar risk categories, or, if no state law applies, do not reasonably correspond to differences in expected costs.

Treatment of rate increases below the “unreasonable” threshold

If CMS determines that a state has an effective rate review program in the individual and/or small group markets, then the state regulation will apply. As a result, if the state regulation requires the review of rate increases below the threshold (e.g., all rate increases), then the issuer will have to satisfy the state’s filing requirements despite the HHS threshold.

If CMS determines that a state does not have an effective rate review program in the individual or small group markets, then rate increases less than the threshold and preliminary justification forms do not need to be filed with CMS.

Justification of the increase

For any rate increase subject to review, there are three parts to a required justification that must be filed. The first two parts must be provided to both the state and HHS—a rate summary worksheet (Part I) and a written explanation of the rate increase (Part II). Rate filing documentation (Part III) is required only when HHS is reviewing a rate increase (if a state’s review process has been deemed effective by HHS, the state would have its own rate filing requirements). The next section provides information on preparing the preliminary justification.

Implementation of an “unreasonable” rate increase

If a state has an effective rate review program, HHS will accept the state’s determination of whether an increase is unreasonable.¹¹ To have an effective rate review program, the state must receive sufficient data and documentation from health insurers to determine whether a rate increase is unreasonable, effectively review such data, and examine a list of specific aspects of the assumptions and data supporting the filing—including trends, benefit changes, changes in risk profiles, administrative expenses, medical loss ratios, and a company’s financial condition (surplus). The state must apply a reasonableness standard set forth in state statute or regulation. In addition, the state must provide a mechanism for receiving public comment on a proposed rate increase.

¹⁰ The phrase **substantial evidence** is not common in actuarial literature. The actuary would be wise to provide sound actuarial reasoning, data, and analyses supporting each assumption employed. This holds for the combination of all assumptions and results of the actuarial methodology employed in developing the proposed rate increases.

¹¹ 45 CFR 154.301

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If a state determines that a rate increase is unreasonable but the insurer legally is permitted and chooses to implement the unreasonable rate increase, the insurer must file a final justification as described in the next section of this practice note.

If HHS makes a final determination that a rate increase is unreasonable, an insurer must give timely notice if it decides not to implement the rate increase or decides to implement a lower increase. If the lower increase is still at or above the 10 percent threshold, it requires a new preliminary justification and is subject to additional review. If the lower increase is below the 10 percent threshold, then it is not subject to review by HHS. Whether the lower increase is above or below the 10 percent threshold, depending on relevant state law, an insurer may have the option to implement the rate increase even if the HHS deems the rate unreasonable.

If the insurer implements an increase determined by HHS or a state to be unreasonable, it must submit its final justification to HHS and post the information on its website. The purpose of the final justification is to respond to HHS's or a state's determination and to make the justification available to consumers.

The filer should be aware that some states that require rates to be approved prior to implementation may not allow an insurer to implement a rate increase that is deemed to be unreasonable.

Filings with MLRs less than the federal minimum

The regulation states that if the projected MLR for a filing after adjustment is less than the federal minimum, a justification must be provided. A rate increase for a portion of that market would not necessarily be considered unreasonable if its projected MLR is lower than the federal minimum. It is important to note that loss ratios typically used in rate development are calculated differently from the MLR calculation as defined in the ACA.

Treatment and disclosure of proprietary information

Information from Parts I and II of the insurer's preliminary justification and nonconfidential information from Part III will be posted on the HHS website. Based on the standards and procedures set forth in the Freedom of Information Act (FOIA), HHS will determine whether to post information designated as confidential. Section 5.65 of FOIA includes the basis for withholding records such as trade secrets and confidential commercial or financial information. One of the factors for judging information to be confidential, for example, is that its disclosure would harm substantially the competitive position of the entity that submitted the information. The filer must indicate in writing which records the filer considers to be confidential.

Information from Part I is used to populate the consumer disclosure form and this form will be posted online at www.healthcare.gov. The Part I spreadsheet can be viewed only via the system used to submit filings to CMS—the Health Insurance Oversight System (HIOS).

Reasonability of assumptions

Actuarial Standard of Practice (ASOP) No. 8, *Regulatory Filings for Health Plan Entities*, specifies in Section 3.2.9 that, "The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually." It is possible that a rate increase based on such assumptions may be

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judged “unreasonable” by a state or HHS. If the rate increase is not changed this would not require the actuary to change the assumptions from those the actuary considers to be reasonable. If the rate increase were modified, this may require a change from assumptions the filing actuary deemed reasonable. In these situations in which agreement on assumptions cannot be achieved, the reviewing and filing actuaries may have differing opinions on the reasonableness of assumptions. The filing and reviewing actuaries should refer to ASOP No. 41, *Actuarial Communications*, in these situations.

Recommendations for Completing HHS Required Documentation

The following section outlines and offers some information on completing the preliminary justification, which includes the rate increase summary (Part I), the written explanation of the rate increase (Part II), and the rate filing documentation (Part III). Parts I and II must be completed for all increases that meet or exceed the threshold; Part III must be completed only for those rates being reviewed by CMS. This practice note includes those elements of the preliminary justification for which we are providing instruction; not all elements of the preliminary justification are included. **Text taken directly from the CMS Rate Review Instructions Manual—Health Insurance Issuer Reporting Requirements (Sept. 14, 2011) is noted in italics and is included because of the importance of the content and/or as an introduction to a specific topic.** The actuary should check the CCIIO website for updated versions of the instructions—<http://cciio.cms.gov/resources/training/index.html#rir>

Instructions for Completing Part I of the Preliminary Justification Form

Sections A and B of the worksheet require issuers to provide historical and projected claims experience data (referred to on the form as base period data and projection period data, respectively).

- **Base Period Data:** The instructions indicate the same data used to develop the rate increase and/or prepare any applicable state rate filing should be used. There may be instances in which following the instructions verbatim is not practical. In those instances, the actuary will need to document the reasons and be prepared to defend the conclusions. Such situations, for example, may include:
 - If a smaller company uses special studies or data from other blocks of business or base periods for one or more service categories;
 - If a product was released during the current year and insufficient credible data is available;
 - New providers are added and/or existing providers are replaced;
 - The plan is expanding into additional service areas.

The following language is from the CMS instructions (dated Sept. 14, 2011). It is included because it is important to understand the limitations of the structure of Part I.

The worksheet uses the inputted data on claims, admin, and underwriting information for the 12 month periods immediately before and after the rate increase effective date to calculate an overall rate increase in Section C. This rate increase may not always match the rate increase

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derived from the subject to review threshold test (this value is reported separately on the form in Section F).

The two rate increase values may be the same when issuers are not implementing multiple or phased in rate increases such as for example a one time 11% increase that is assessed to all beneficiaries on the rate increase effective date.

However, the calculated rate increase amount in Section C will not match the threshold rate increase in cases where an issuer implements multiple periodic increases. For example, the threshold increase will not match the overall rate increase calculation in Section C if the issuer is proposing a rate increase implemented quarterly upon policy renewal.

The rate increase exercise on the worksheet requires issuers to show how their anticipated costs will change between the current year (status quo) and under the rate increase. Issuers should always enter Sections A, B, and C with historical and projected data that represents their actual experience and trend assumptions. Issuer should not modify their data in order to make the overall rate increase calculation in Section C match the threshold rate increase.

Description of Worksheet Data Elements

Section A: Base Period Data

- ***Base Period Data - Start and End Periods:*** The span of start and end periods in the entire rate summary worksheet assumes 12-month periods.
- ***Member Months:*** *Where necessary, the Issuer should total membership for base medical coverage for all service categories for purposes of PMPM (per member per month) calculations in Parts 1 and 2 of the preliminary justification form. For the formulas in the rate summary worksheet to work appropriately, it is suggested that total base medical coverage membership be used even for those benefit categories that may not have the same membership (e.g., due to riders or options). The prescription drug service category, for example, is one in which covered membership would not necessarily be the same as for base medical coverage. The base medical coverage membership values, however, still should be used for this service category.*
- ***Total Allowed:*** *Enter amount of claims incurred in the base period by service category on an allowable basis including estimates of unpaid claims. If IBNR¹² values are not developed on an allowed basis, the Issuer should adjust this value accordingly. This value may also be adjusted for coordination of benefits. Not all issuers will have allowed claim dollars. The allowed dollars reflected here need to be related to the paid claim dollars included in the net claims. The coordination of benefits effect, for example, already is built into the paid claim dollars. As such, it would need to be removed from total allowed dollars. This can be accomplished by adding the member actual cost share paid to the paid claim dollars. If the coordination of benefit effect is not removed from total allowed dollars, the value of coordination of benefits could be reflected inappropriately in cost share. In addition, incurred*

¹² The authors interpret this to mean incurred but not paid (IBNP) or unpaid claims.

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provider incentive payments could be included in the values related to their appropriate service categories. It is suggested the actuary retain backup documentation and be prepared to justify all assumptions and methodologies used.

- **Net Claims:** In addition to other net claims, include the value of provider incentives if it is included in the total allowed cost.

Section B: Claims Projections

B1. Adjustment to the Current Rate

This section projects allowed costs from the base period to the projection period for current rates¹³ based on updated pricing assumptions.

The comparisons of PMPM rates throughout the rate summary worksheet need to be performed on a static single population (mix of demographics and benefits). The base period typically is an average of membership (demographics and benefit mix¹⁴) across the period. The projection to current rating period may need to include an adjustment factor to get from the base period average population to the most recent population, excluding members known to have cancelled. In addition, products not being continued (and their membership) would need to be removed with an adjustment factor.

New members projected to buy current products may be included in the single population. For example it may be appropriate to include new member projections when a new company in its second year of rates (with a rate increase) requires consideration of the surplus requirements resulting from fast growth. For a more mature product filing, however, the actuary may determine that projecting new membership on current products may not be appropriate.

New products would not be included in the rate increase filing since these products would not have a rate increase.

Adjustments to reflect changes in demographics underlying the base period in Section A to the demographics reflected in the single population used in Section B1, B2, and C could be included in the trend factor in this section. Another option is to adjust the base period experience to reflect the population used throughout the rate summary worksheet. Note that the prior estimate of current rates should be based on this single population (Section C).

- **Start and End Periods:** The span of start and end periods in the rate summary worksheet assumes 12-month periods. If it has been more than 12 months since the last proposed rate increase, the formulas still will work as long as the periods reflected remain 12 months each and 12 months apart. If it has been less than 12 months since the last rate increase, the user will need to adjust the “current rate period information” to reflect the last 12 months’ worth of rates and their interim increases.¹⁵

¹³ The authors interpret this to mean current rating period, and that is the terminology used throughout.

¹⁴ This is sometimes referred to as a “product mix.” The authors are using the term “benefit” since HHS has a specific definition of “product.” In this context, “benefit mix” means “various benefit design options within the product filing.”

¹⁵ Examples have been provided in the *Rate Review Instruction Manual—Health Insurance Issuer Reporting Requirements* and in Appendix II in this practice note.

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- **Overall Medical Trend:** Trend is by service category—it is an attempt to project the current rating period experience (for Section B1) from the base period reflected in Section A. This would allow an estimate for how different the current rates are compared to what the rates would have been if based on actual emerging experience. At a minimum, most issuers will have developed total PMPM trends based on paid amounts. This section requests allowed PMPM trends by service category. The actuary may need to determine these trends by starting with projected net claims PMPMs, determining resulting member cost shares, and then calculating projected allowed PMPMs.

With respect to which trend to use, one option would be to use the actual trend rate between the experience period one year before the base period reflected in Section A and the experience in the base period in Section A. One problem with using this trend is that it may not accurately account for the expected additional change in trend due to provider contracting or other changes expected in the carrier's business model. This method assumes past experience is an accurate predictor of future experience. The actuary is expected to document and be prepared to defend all trends components. If detailed estimates for provider contract implementation dates and the effect on claims are available, the actuary could make that adjustment.

A second option would be to assume the projected trend (used originally in the development of the current rate) from the base period in Section A to the midpoint of the current rating period. This assumes that the experience through the updated base period would not continue but would be the same as originally predicted. One problem with using this trend is that it may not reflect new information affecting expected trend to the end of the current rating period—although it does account for what already has happened as reflected in the base period experience.

A third option would be to use the trend developed for the future rating period (as estimated for Section B2 claims projections) from the base period and apply the appropriate number of months of trend from the base (experience) period to the midpoint of the current rating period (Section B1). This would project what the claims would be for the rest of the current rating period. Using this trend assumes that the trend used to develop the claims costs for the future rating period would be the same as that expected for the rest of the current rating period. It may not reflect what may happen if variation in provider reimbursement levels or utilization pattern is not the same from the base period to the current rating period and then to the future rating period.

When considering what may be experienced in the rating period, the actuary would be prudent to document any considerations that affect the trend. For example, the actuary would include a description of the source of any additional information and the approach used to develop appropriate trends that reflect that information in Parts II and III of the preliminary justification. An example of additional considerations might be population information, such as infectious diseases or other emerging trends. Whatever approach is used (the three above or a different approach), the actuary would need to make sure it is sound and can be supported with reasonable assumptions.

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- **Cost Sharing:** This value should include the projected percentage of allowed PMPM that is expected to be paid by the member.

B2. Claims Projection for Future Rate

This section projects the claims experience from the midpoint of the projection period for the current premium rates to the midpoint of projection period for future premium.¹⁶

- **Projection Period for Future Rates – Start and End Period:** *The end date should be exactly one year after the start date.* If this period is not for 12 months, the actuary will likely need to use the retrospective 12-month period from the end date of the new effective period. See Appendix II for examples.
- **Overall Medical Trend:** Comments that apply here are similar to those mentioned under B1 Adjustment to the Current Rate. The worksheet applies the trend to the allowed PMPM from the previous Section B1 to calculate projected allowed PMPM by service category for the future rating period. The trend used would likely reflect the appropriate amount for the one-year period from the estimated current rate period experience (Section B1) to the new rate effective period (which should be 12 months). If the actuary does not develop allowed trends, then trends based on net paid claims and cost sharing may need to be used to calculate allowed trends, since the cost share trend is likely to result in a leveraged trend that needs to be reflected.

With respect to capitation, it is reflected on the rate summary worksheet as a separate service category, with its own member cost share. It is important to ensure that encounter data is as complete as possible to estimate an appropriate member cost share if copays or other cost shares exist on services that are reimbursed on a capitated basis. These values should reflect the average of the entire region that the rate filing represents.

Section B3. Medical Trend Breakout

The authors recommend reflecting “pure” utilization trend and “pure” unit cost trend components, including mix, severity, and other items in the “all other” component trend. For example:

Utilization

- Some plans may not calculate an overall utilization change since there are many different types of service with different counting metrics (e.g., inpatient admissions, physician office visits, pharmacy prescriptions, etc.). This form requests an overall utilization change component. There may be different methodologies to calculate this. One example is to weight the utilization change from each type of service by the PMPM for that service category. Whatever the methodology chosen to calculate overall utilization change, it should be consistent with published actuarial literature and actuarial standards of practice and be disclosed in Part II.

¹⁶ The authors interpret this to mean future rating period, which is used throughout this document.

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Unit Cost

- It is suggested that that the unit cost change (medical price changes) be estimated by excluding the effect of changes due to the severity, service, and provider mix (collectively referred to as “mix”). As such, it would represent a pure unit cost trend and the trend analysis would be based on a common basket of services from both the proposed and prior periods. For example, the unit cost increase would be the percent increase in the physician fee schedule and the mix increase would be the impact of the shift in usage from lower-cost procedures to higher-cost procedures. It may be more difficult to estimate unit cost increases when payments for certain procedures might be based on a percent of charges or another less definitive method.
- Any additional trend component due to mix then may be included in the “Other” category. If a plan does not have the level of detail available to separate the mix component from the unit cost component, then the unit cost line will include the effect of mix. Whatever the methodology chosen, a description would need to be disclosed in Part II.
- A similar comment can be made for the unit cost change as made for the utilization change—some plans may not calculate an overall unit cost change since there are many different types of service with different counting metrics. One approach would be to weight the unit cost change from each service category by the PMPM for that service category. The methodology chosen should be based on considerations of applicable actuarial literature and consistent with actuarial standards of practice and disclosed in Part II.
- Any changes in capitated or other provider payments that can be attributed to changes in unit cost or price would be considered by actuaries to be included in this category as well.

Other

- The “Other” portion of the effect on medical trend is included as a “catch-all” for other items not specifically addressed in utilization or unit cost. This category may include but is not limited to:
 - Impact on trend due to change in the severity, service, or provider mix (if this was not included in unit cost or utilization above);
 - Impact on trend due to the leverage impact of fixed cost sharing;
 - Impact on trend due to changes in global capitated arrangements or any other provider payments, such as provider payment incentives that cannot be attributed to one of the items listed above;
 - Impact on trend due to anticipated demographic changes.

The following examples show different ways to determine the effect of the various trend components of weighting by PMPM:

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Example of Positive Utilization Trend

Assumes Carrier has Measures of Price, Utilization, and Mix/Severity for the 4 service categories.														
Service Category	SubCat	Detail Trend		Service Category	SubCat	Rolled Up Trend								
		%	Factor			%	Factor	price	util	pricutil	total	new wt.		
Price	Prof	-0.94%	99.06%	PriceMix	Prof	-0.93%	99.07%							
	IP	5.85%	105.85%		IP	7.97%	107.97%							
	OP	5.85%	105.85%		OP	9.04%	109.04%							
	Rx	3.80%	103.80%		Rx	3.80%	103.80%							
Util	Prof	5.03%	105.03%	Util	Prof	5.03%	105.03%							
	IP	1.97%	101.97%		IP	1.97%	101.97%							
	OP	5.00%	105.00%		OP	5.00%	105.00%							
	Rx	3.90%	103.90%		Rx	3.90%	103.90%							
Mix/Sev.	Prof	0.01%	100.01%											
	IP	2.00%	102.00%											
	OP	3.01%	103.01%											
	Rx	0.00%	100.00%											
								Price trend applied first						
								Impact of Price/Mix Combined						
		% Factor		% Factor		Price trend applied first		Price and Mix Combined		Pure Effects				
SubCat	Weight	PriceMix	Utilization	PriceMix	Utilization	PriceMix	Utilization	PriceMix	Utilization	price	util	pricutil	total	new wt.
Prof	164.41	-0.93%	5.03%	99.07%	105.03%	162.87	171.07	(1.53)	8.27	(0.08)	6.66	171.07		
IP	69.80	7.97%	1.97%	107.97%	101.97%	75.36	76.85	5.56	1.38	0.11	7.05	76.85		
OP	110.41	9.04%	5.00%	109.04%	105.00%	120.39	126.40	9.98	5.52	0.50	15.99	126.40		
Rx	86.15	3.80%	3.90%	103.80%	103.90%	89.43	92.92	3.27	3.36	0.13	6.76	92.92		
	430.77	4.01%	4.28%	104.01%	104.28%	448.05	467.24	17.28	18.53	0.66	36.46	467.24		
			11.04%		111.04%	17.28	19.19	4.01%	4.30%	0.15%	8.46%			
					% total change	47.4%	52.6%	47.4%	50.8%	1.8%	100.0%			
Assumptions														
1 Mix and severity factors are combined with price.														
2 In measuring the effect, the interaction of pricemix and utilization is assigned to utilization (order)														
3 Assigning interaction effects to PriceMix, instead, shown below:														
								Util trend applied first						
								Price and Mix Combined						
SubCat	Weight	PriceMix	Utilization	PriceMix	Utilization	PriceMix	Utilization	PriceMix	Utilization	PriceMix	util	pricutil	total	new wt.
Prof	164.41	-0.93%	5.03%	99.07%	105.03%	171.07	172.68	(1.53)	8.27	(0.08)	6.66	171.07		
IP	69.80	7.97%	1.97%	107.97%	101.97%	76.85	71.17	5.56	1.38	0.11	7.05	76.85		
OP	110.41	9.04%	5.00%	109.04%	105.00%	126.40	115.93	9.98	5.52	0.50	15.99	126.40		
Rx	86.15	3.80%	3.90%	103.80%	103.90%	92.92	89.51	3.27	3.36	0.13	6.76	92.92		
	430.77	3.99%	4.30%	103.99%	104.30%	467.24	449.30	17.28	18.53	0.66	36.46	467.24		
						17.94	18.53	4.01%	4.30%	0.15%	8.46%			
					% total change	49.2%	50.8%	47.4%	50.8%	1.8%	100.0%	Same as above		
Impact of moving the interaction effect to pricemix instead of utilization (changing order)														
is small in this case.														
Blue goes to rate review sheet														
Calculate the effect of Price, Utilization and Mix Separately														
Changes to separate price and mix, V1 - Order is price, mix, utilization														
SubCat	Weight	Price	Mix	Util	Price	Factor	Util	Effect	Price	Mix	Util			
Prof	164.41	-0.94%	0.01%	5.03%	99.06%	100.01%	105.03%	162.86	162.87	171.07				
IP	69.80	5.85%	2.00%	1.97%	105.85%	102.00%	101.97%	73.88	75.36	76.85				
OP	110.41	5.85%	3.01%	5.00%	105.85%	103.01%	105.00%	116.87	120.39	126.40				
Rx	86.15	3.80%	0.00%	3.90%	103.80%	100.00%	103.90%	89.43	89.43	92.92				
Total	430.77	2.85%	1.13%	4.28%	102.85%	101.13%	104.28%	443.04	448.05	467.24				
								12.26	5.01	19.19	36.46			
								Share of Chg.	33.6%	13.8%	52.6%	100.0%		
Goes to rate review sheet														
Changes to separate price and mix, V2 - Order is price, utilization, mix														
SubCat	Weight	Price	Util	Mix	Price	Factor	Mix	Effect	Price	Util	Mix			
Prof	164.41	-0.94%	5.03%	0.01%	99.06%	105.03%	100.01%	162.86	171.05	171.07				
IP	69.80	5.85%	1.97%	2.00%	105.85%	101.97%	102.00%	73.88	75.34	76.85				
OP	110.41	5.85%	5.00%	3.01%	105.85%	105.00%	103.01%	116.87	122.71	126.40				
Rx	86.15	3.80%	3.90%	0.00%	103.80%	103.90%	100.00%	89.43	92.92	92.92				
Total	430.77	2.85%	4.28%	1.13%	102.85%	104.28%	101.13%	443.04	462.02	467.24				
								12.26	18.98	5.22	36.46			
								Share of Chg.	33.6%	52.1%	14.3%	100.0%		
Goes to rate review sheet														

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Example of Negative Utilization Trend

Assumes Carrier has Measures of Price, Utilization, and Mix/Severity for the 4 service categories.

Service		Detail		Service		Rolled Up							
Category	SubCat	%	Factor	Category	SubCat	%	Factor						
Price	Prof	-0.94%	99.06%	PriceMix	Prof	-0.93%	99.07%						
	IP	5.85%	105.85%		IP	7.97%	107.97%						
	OP	5.85%	105.85%		OP	9.04%	109.04%						
	Rx	3.80%	103.80%		Rx	3.80%	103.80%						
Util	Prof	-1.00%	99.00%	Util	Prof	-1.00%	99.00%						
	IP	-1.00%	99.00%		IP	-1.00%	99.00%						
	OP	-1.00%	99.00%		OP	-1.00%	99.00%						
	Rx	-1.00%	99.00%		Rx	-1.00%	99.00%						
Mix/Sev.	Prof	0.01%	100.01%										
	IP	2.00%	102.00%										
	OP	3.01%	103.01%										
	Rx	0.00%	100.00%										
								Price trend applied first					
								Impact of Price/Mix					
								Combined					
		%		Factor						Pure Effects			
	SubCat	Weight	PriceMix	Utilization	PriceMix	Utilization	PriceMix	Utilization	price	util	pricutil	total	new wt.
	Prof	164.41	-0.93%	-1.00%	99.07%	99.00%	162.87	161.25	(1.53)	(1.64)	0.02	(3.16)	161.25
	IP	69.80	7.97%	-1.00%	107.97%	99.00%	75.36	74.61	5.56	(0.70)	(0.06)	4.81	74.61
	OP	110.41	9.04%	-1.00%	109.04%	99.00%	120.39	119.18	9.98	(1.10)	(0.10)	8.77	119.18
	Rx	86.15	3.80%	-1.00%	103.80%	99.00%	89.43	88.53	3.27	(0.86)	(0.03)	2.38	88.53
		430.77	4.01%	-1.00%	104.01%	99.00%	448.05	443.57	17.28	(4.31)	(0.17)	12.80	443.57
							17.28	(4.48)	4.01%	-1.00%	-0.04%	2.97%	
							% total change	135.0%	-35.0%	135.0%	-33.7%	-1.4%	100.0%
Assumptions								Blue goes to rate review sheet					
1 Mix and severity factors are combined with price.													
2 In measuring the effect, the interaction of pricemix and utilization is assigned to utilization (order)													
3 Assigning interaction effects to PriceMix, instead, shown below:								Util trend applied first					
		%		Factor				Price and Mix Combined					
	SubCat	Weight	PriceMix	Utilization	PriceMix	Utilization	PriceMix	Utilization	PriceMix	util	pricutil	total	new wt.
	Prof	164.41	-0.93%	-1.00%	99.07%	99.00%	161.25	162.76	(1.53)	(1.64)	0.02	(3.16)	161.25
	IP	69.80	7.97%	-1.00%	107.97%	99.00%	74.61	69.10	5.56	(0.70)	(0.06)	4.81	74.61
	OP	110.41	9.04%	-1.00%	109.04%	99.00%	119.18	109.31	9.98	(1.10)	(0.10)	8.77	119.18
	Rx	86.15	3.80%	-1.00%	103.80%	99.00%	88.53	85.29	3.27	(0.86)	(0.03)	2.38	88.53
		430.77	4.01%	-1.00%	104.01%	99.00%	443.57	426.46	17.28	(4.31)	(0.17)	12.80	443.57
							17.11	(4.31)	4.01%	-1.00%	-0.04%	2.97%	
							% total change	133.7%	-33.7%				
								Blue goes to rate review sheet					
Impact of moving the interaction effect to pricemix instead of utilization (changing order)								is small in this case.					
Changes to separate price and mix, V1 - Order is price, mix, utilization													
	SubCat	Weight	Price	Mix	Util	Price	Factor	Util	Price	Effect	Mix	Util	
	Prof	164.41	-0.94%	0.01%	-1.00%	99.06%	Mix	99.00%	162.86	Mix	162.87	161.25	
	IP	69.80	5.85%	2.00%	-1.00%	105.85%	Mix	99.00%	73.88	Mix	75.36	74.61	
	OP	110.41	5.85%	3.01%	-1.00%	105.85%	Mix	99.00%	116.87	Mix	120.39	119.18	
	Rx	86.15	3.80%	0.00%	-1.00%	103.80%	Mix	99.00%	89.43	Mix	89.43	88.53	
	Total	430.77	2.85%	1.13%	-1.00%	102.85%	Mix	99.00%	443.04	Mix	448.05	443.57	
									12.26		5.01	(4.48)	12.80
									Share of Chg.	95.8%	39.2%	-35.0%	100.0%
								Goes to rate sheet					
Changes to separate price and mix, V2 - Order is price, utilization, mix													
	SubCat	Weight	Price	Util	Mix	Price	Factor	Mix	Price	Effect	Util	Mix	
	Prof	164.41	-0.94%	-1.00%	0.01%	99.06%	Util	100.01%	162.86	Util	161.23	161.25	
	IP	69.80	5.85%	-1.00%	2.00%	105.85%	Util	102.00%	73.88	Util	73.14	74.61	
	OP	110.41	5.85%	-1.00%	3.01%	105.85%	Util	103.01%	116.87	Util	115.70	119.18	
	Rx	86.15	3.80%	-1.00%	0.00%	103.80%	Util	100.00%	89.43	Util	88.53	88.53	
	Total	430.77	2.85%	-1.00%	1.13%	102.85%	Util	101.13%	443.04	Util	438.61	443.57	
									12.26		(4.43)	4.96	12.80
									Share of Chg.	95.8%	-34.6%	38.8%	100.0%
								Goes to rate sheet					

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Section C: Components of Current and Future Rates

This section collects information on the net claims, administrative, and underwriting gain/loss components of the current and future rates. The administrative and underwriting gain/loss components should be reported consistent with how these terms are determined for state rate filings and financial reporting.

Future Rates

- ***Line 3 – Underwriting Gain/Loss:*** This value is the projected contribution and risk component built into the rates (on a PMPM basis).

- ***Line 5 – Overall Rate Increase:*** This item is calculated automatically and assumes a 12-month period between the current and future rate periods. The worksheet does not use the dates input in the sections. If it is more than 12 months, an adjustment will need to be made to fit the assumed 12-month period. If the time period is less than 12 months, the prior estimate of current rate information will need to be adjusted to reflect the estimated “current rate” values from the last 12 months. See Appendix II for examples.

Prior Estimate of Current Rate

Complete these fields with the net claims PMPM and projected non-claim expenses PMPM based on the pricing assumptions in an earlier rate filing for the current rate. These values should all be based on the single population (demographics and benefit mix) included in B1 and B2.

- ***Line 1 – Projected Net Claims:*** Enter prior estimate of net claims from prior rate filing using enrollment and product mix that will be affected by the increase. The estimated projected net claims should be developed from the rates that were in effect 12 months prior to the proposed rates and reflect the same population and benefits that are included in the claims projections in section B2. If recent filings have been on a more recent basis than annual, base this value on the most recent filing (i.e., the claims estimate being updated in the current requested rate increase). Prior estimates for net claims from the initial rate development or the prior rate filing may be available since the intent is to use the same population (demographics and benefit mix) as the single population used for comparison. One option to determine the appropriate net claims PMPM is to calculate it based on the premium PMPM updated for the current population, removing assumed administrative cost and underwriting gain targets from prior rate filing or rate development.

- ***Line 2 – Administrative Costs:*** Enter prior estimate of estimated administrative costs for the current rate. This value should be adjusted as appropriate for the updated demographics and benefit mix.

- ***Line 3 – Underwriting Gain/Loss:*** Enter prior estimate of the underwriting gain/loss for the current rate period. This value should reflect the assumptions for contribution and risk used in the current rate filing, adjusted as appropriate for the updated demographics and benefit mix.

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Section E: List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

- ***Implemented:*** Rate increases may not have been by calendar year; effective dates of rate increases should most likely be used. In addition, if a filing has different rate increases by quarter, use the average or cumulative percentage change over the 12-month period, depending on how the rate increases are applied throughout the year. See Appendix II for examples.

Section F: Range and Scope of Proposed Increase

- ***Number of Covered Individuals:*** Enter the number of covered individuals as of the effective date of the increase. This is the same population as used in the comparisons in other sections of the spreadsheet (Section B and C).
- ***Threshold Rate Increase:*** This is the rate increase calculated under the “subject to review” threshold test. In many cases, the percent value entered in this field will not match the overall rate increase amount calculated in Section C. There is little information in the instructions explaining the calculation of the threshold test. Review of the examples in Appendix II, however, may provide some insight.

Instructions for Completing Part II of the Preliminary Justification Form

Part II Instructions¹⁷

Issuers must provide a brief, non-technical description of why the Issuer is requesting this rate increase. The actuary will want to avoid the use of technical jargon such as “adverse selection” and instead include a simplified explanation of the concept.

*This explanation should help consumers interpret the rate summary data provided in Part I of the Preliminary Justification. Accordingly, it should identify and explain the **key drivers of the rate increase in Part I of the Preliminary Justification**. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why hospital costs are increasing. (emphasis added) The actuary may wish to consider the extent to which various components are driving a particular rate increase when determining “key drivers.” It is suggested that at a minimum, the top two drivers be discussed. The actuary may choose to split the service components of the increase into unit price and utilization. Any description of the “correction to prior period estimates” should be nontechnical, including a statement that the rating is prospective and that the insurer is not recouping past losses.*

The explanation should include information on the following components related to the rate increase:

- ***Scope and range of the rate increase:*** Provide the number of individuals impacted by the rate increase. If the increase takes effect on renewal, the number of affected individuals for each anniversary month for the 12-month period beginning with the earliest rate effective date

¹⁷ In the future there may be a standard format developed for Part II, but nothing has been released as of the publication date of this practice note.

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affected by the proposed change would need to be provided. This is the same population that was used in Part 1 (Sections B and C). No attempt would need to be made to project new sales that would be subject to the new rates since these new members would not be receiving an “increase.” The same population (demographics and benefit mix) that was used in the development of the rates should be used here. When the policyholder is an employer, we recommend showing both the number of policyholders affected and the number of enrollees covered under affected policies. *Explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premium).* If the increase is not uniform (i.e., some parts of the rate schedule change more than others), these changes should be noted. In all cases, the word “premium” should be replaced with “rates,” consistent with the distinction made in the consumer disclosure form.

- *Changes in benefits: Describe any changes in benefits and explain how benefit changes affect the rate increase.* These are across-the-board benefit changes (e.g., changes in cost shares such as deductibles, copays, coinsurance, maximum out-of-pocket levels; changes in coverage of services) and those arising from regulatory mandates. These are not changes in benefit elections by policyholders. Most actuaries would calculate the increase on the basis of current benefit elections, as clarified by comments that a single population be used to determine the rate increase. *Issuers should explain whether the applicable benefit changes are required by law.* This could be a challenge, since in some cases, the manner in which the benefit changes are made is modified or simplified because of administrative or operational limitations. In those cases, some part of the increase actually is required by law and the remainder is from the inability of the insurer strictly to provide only the benefit enhancements required by the law. If the actuary knows how to split the total effect, there is no issue. Another option is for the actuary to treat the benefit change as required by law but footnote any changes that went beyond a narrow reading of the law. Changes to state mandated benefits would need to be noted separately. Starting in 2014, state mandates beyond the essential benefits would be paid for in some portion by the state. This would not necessarily affect the premium, unless adding mandated benefits would increase other services not explicitly covered by the mandate (e.g., lab or other tests required for the new mandated service).
- *Administrative costs and anticipated profits: Identify the main drivers of changes in administrative costs.* Some standard categories to consider include salaries, facilities, and technology upgrades (not capitalized). *Discuss how changes in anticipated administrative costs and underwriting gain/loss are impacting the rate increase.* The authors recommend including a discussion of how retained earnings are used and why an insurer needs them to be considered as an ongoing concern—whether a not-for-profit or a for-profit entity.

Instructions for Completing Part III of the Preliminary Justification

Part III Instructions

Issuers are only required to complete Part III of the Preliminary Justification, the rate filing documentation, when CMS is reviewing the rate increase. HIOS will automatically prompt Issuers to submit Part III when it is required.

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The final rule¹⁸ states that CMS will conduct the rate review using the criteria that the effective rate review states will follow. This review must take into account, to the extent appropriate, the following factors:

1. *The impact of medical trend changes by major service categories;*
2. *The impact of utilization changes by major service categories;*
3. *The impact of cost-sharing changes by major service categories;*
4. *The impact of benefit changes;*
5. *The impact of changes in enrollee risk profile;*
6. *The impact of any overestimate or underestimate of medical trend for prior years related to the rate increase;*
7. *The impact of changes in reserve needs;*
The authors interpret “reserve” in this instance to mean liabilities that are held in reserve. As of the date of publication, “reserve” has not been defined, so care should be taken to ensure that the actuary includes reserves that are pertinent to the filing.
8. *The impact of changes in administrative costs related to programs that improve health care quality;*
9. *The impact of changes in other administrative costs;*
10. *The impact of changes in applicable taxes, licensing or regulatory fees;*
11. *Medical loss ratio; and*
12. *The health insurance issuer’s capital and surplus.*

Documentation and descriptions must be reported for all required elements. This information would include the source of the data or assumption and the methodology used to develop or adjust the data or assumption. If an item is not relevant to the development of the rate increase, it needs to be identified, including a description of why it is not applicable.

List of Part III Reporting Requirements:

2. ***Brief Description:***
 - i. *Type of Policy*
 - ii. *Benefits*
 - iii. *Renewability (individual business only)*
 - iv. *General Marketing Method*
 - v. *Underwriting Method* Describe how groups or individuals are underwritten and the rating rules applied. For example, are groups/individuals community rated?
 - vi. *Premium Classifications (an explanation of rating factors used for the product). Issue Age or Attained Age Rating Structure, Issue Age Range (individual business only)*

3. ***Scope and reason for the rate increases.*** This section would likely explain the reason for the increase—breaking the increase down into elements, such as insufficiencies of prior rates, anticipated changes in reimbursement, changes in administrative costs, benefit changes, etc. This section also would likely provide commentary on the scope of the increase, including the number of policyholders and individuals affected and the maximum and minimum increase that would be applicable to policyholders. This section would describe the renewal date schedule for current

¹⁸ 45 CFR 154

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policyholders and the number of policyholders renewing by months. Information by renewing month may not be necessary when open enrollment periods with one renewal date are required in the individual exchange. This would depend on how the plan addresses current membership prior to Jan. 1, 2014.

4. Average annual premium per policy, before and after the rate increase.

- a. Describe past rate increases. For any increase having even partial implementation in 2008 or later, give implementation details including the initial effective date, range of effective dates, and the method of implementation (on policy anniversaries, etc.).* This section would likely outline the history of all effective rate changes, indicating the incremental base rate impact since the last filing and the annual rate increase at the effective date of the filing.
- b. Description of Proposed Increase in Dollar Amount.* Under the description of the proposed increase in dollars, the form asks for the average annual per policy dollar difference before and after the rate increase. In calculating the average annual per policy amount after the increase, the population (enrollment mix and benefit design mix) should be the same as that reflected in Section B of Part I.

5. Past experience, and any other alternative or additional data used.

- a. Number of Policyholders:* Policyholder counts would need to be provided in aggregate for the experience period, consistent with the level of claims detail provided, and for the single population used in the rate increase development. More detailed back-up (e.g., by plan and/or by month) should be available if the reviewing actuary requests additional information. If a carrier is developing and filing rates only for the next quarter, rather than a full 12 months in advance, the actuary would need to be aware of any state requirements related to filing for a period shorter than 12 months. Carrier use of total experience for all groups versus the experience for only renewing members in the quarter may depend on the historic practices of the carrier and the state. One approach could be to use the entire experience of the membership, rather than the experience of the members renewing in a particular quarter, to balance the entire revenue needs of the product under filing.
- b. Number of Covered Lives:* Covered lives counts should be provided in the same format as number of policyholders is provided.
- c. Total Written Premium*
- d. Experience Period, Projection Period*
- e. Past Experience, including:*
 - i. Cumulative Loss Ratio (Historical/Past)*
 - ii. Any Alternative Experience Data Used*
- f. Credibility Analysis:* If credibility analysis is used in the determination of the rate increase, methodology and associated calculations to develop the experience weights (if applicable) should be provided and documented with supporting literature.¹⁹ Refer to NAIC Model Regulation No. 134, *Guidelines for Filing of Rates for Individual Health Insurance Business*.

¹⁹ NAIC Model Regulation 134, *Guidelines for Filing of Rates for Individual Health Insurance Business*, 2000.

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- g. Claims incurred but unpaid included in the experience in (e) above, with disclosure of the “paid through” date of the claims used to generate that data. The “paid through” date should be the same for purposes of these claims incurred but unpaid as for the calculation of paid claims. A summary document and description would likely be sufficient, but the actuary may need to be prepared to provide more detail. For example, issuers could submit a summary sheet by incurred month reporting paid and incurred claims, the calculated completion factors and ratios, the estimated incurred claims, enrollment counts, and calculated pure premium (incurred claims PMPM) levels. Summaries of claim lag triangles (or other relevant data summaries) would be provided if requested by the reviewer so that the reviewer is able to replicate the reserve estimates using the provided data and development documentation. In addition, all calculated and manual adjustments need to be documented. The experience period should be subtotaled and tied to the claims incurred but unpaid estimates reported elsewhere in the preliminary justification. The reserve development methodology would need to be documented in detail. Part I of the preliminary justification requires allowed claims experience to reflect incurred but unpaid estimates. The instructions say to estimate this value if incurred but unpaid values are based instead on paid amounts. The actuary should have documentation to support the estimate of incurred but unpaid values for allowed amounts.*
- h. Contract Reserves: Contract reserves should be summarized by plan as of the end of the experience period. The methodology used to develop the contract reserves should be documented, including the reasons they were established.*

6. A description of how the rate increase was determined, including the general description and source of each assumption used.

a. Expenses

The actuary should consider the level of detail to provide in this section—in particular breaking out expenses before and after adjustment for the MLR calculation.

i. Profit and Contingency: In general, the target underwriting gain/loss level should be described. Additional information on the need for underwriting gain/loss and/or contingency contribution related to supporting the business on an ongoing concern basis would be provided here.

ii. Commissions and Brokers Fees

iii. Taxes, License and Fees

iv. General Expenses: At a minimum, this section should be supported by documentation that details historical elements of the general expense and the anticipated adjusted levels in the projection period.

v. Other Administrative Costs

vi. Reinsurance

b. Impact of Statutory Changes, including Mandates

c. Overall Premium Impact of Proposed Increase, showing the

i. Average Annual Premium Per Policy

ii. Before and After Rate Increase

d. Descriptive Relationship of Proposed Rate Scale to Current Rate Scale: The actuary would need to describe any changes to the slope for any rating factors, if applicable. By

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2014, for example, it is likely in many states that the age slope would need to be changed (if not already) to meet the 3:1 maximum. That will change the slope/scale of the rates. In addition, by 2014, many other rating variables, such as underwriting factors and gender, will be eliminated. The effect of these changes would need to be provided at the time the changes are made.

e. Premium Basis

i. Brief Description of How Revised Rates were Determined, including:

- 1. General Description*
- 2. Source of Each Assumption Used*

The actuary would provide a narrative describing the development of the claims data, adjustments, application of assumptions, and all other work used to determine the revised rate. In addition, the documentation on methodology would include algorithms and projection methodology, supported by documentation (including any spreadsheets used to create exhibits that would be available on request) that illustrates the logic.

ii. For expenses, including:

- 1. Percent of Premium*
- 2. Dollars Per Policy or Dollars Per Unit of Benefit*

iii. Trend Assumptions: Note that the trend assumption likely will be included in the description of the rate development in Item e above.

iv. Interest Rate Assumptions: If interest rate assumptions are not used in the development of the rates, an explanation would need to be included.

v. Other Assumptions, including but not limited to Morbidity, Mortality and Persistency

f. Company Financial Condition

i. Company Surplus: The historical surplus (for multiple periods) should be provided to illustrate the surplus direction for the company. The projected surplus level should be provided to demonstrate how surplus is projected to change in consideration of the current rates. If the actuary has any concerns related to the material impact of the surplus level affecting the company, he or she should provide additional discussion here.

7. The cumulative loss ratio and a description of how it was calculated (for individual only).

8. 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.

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9. *The projected lifetime loss ratio²⁰ 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. Issuers should provide this information in a manner that will allow for testing associated with any applicable State lifetime loss ratio calculation. In the absence of a State standard, Issuers should provide data that will allow for lifetime loss ratio testing under the National Association of Insurance Commissioners' Model Rule, "Guidelines for Filing of Rates for Individual Health Insurance Forms" (MDL 134) (2000).*

10. *The Federal medical loss ratio (MLR) standard in the applicable market to which the rate increase applies. Issuers must provide a 12-month projected loss ratio for the period of the rate increase both at the market level and at the applicable filing level using the loss ratio calculation provided in the Federal MLR regulation. Consistent with the regulation, Issuers may make adjustments for costs related to quality improvement, taxes and fees. However, Issuers may not apply the credibility adjustments described in the regulation. Rather, Issuers should take credibility into account as part of their projection estimates, using the assumptions and adjustments that they would normally apply to address credibility in projection calculations. Issuers must provide data supporting their projected loss ratio, including data supporting any applicable adjustments. Note that this requirement is not consistent with the federal MLR regulation—the time period is the effective period of the rate increase. The actuary would need to develop MLRs for this time period for both the market level (assuming use of credibility) projected to this period and for the products included in the rate filing. This would include allocation of quality improvement administrative expenses and taxes and fees at the rate filing and market levels on a projected basis for the new rating period.*

State Reporting Requirements to HHS

After rate increases are reviewed, PHSA Section 2794 indicates that states receiving grants should report information on trends in premium increases by rating area. States also would be asked to recommend whether an insurer should be allowed to participate in an exchange based on its history of rate increases. This section addresses reporting premium increases to HHS, determining whether an insurer is allowed to participate in an exchange, and using grants to improve state review processes.

Reporting trends by area, product, market, and benefit level

PHSA Section 2794 specifies that premium increase trends should be reported by area. There are other characteristics, however, that could result in different trends. The authors suggest actuaries employed or engaged by each state report trends in premium rate increases based on at least the following categories:

- Area—reported based on three- to five-digit zip code prefixes as deemed appropriate.

²⁰ *The projected lifetime loss ratio is a projection of the kind normally used in calculating a state level lifetime loss ratio. A traditional state lifetime loss ratio does not include quality improvement expenses, for example, which is included in the Federal standard. The future loss ratio included is not the same as the future loss ratio in (10) above, in that this is not "adjusted" and is not under the federal standard.*

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- Product—reported by different products, such as a health maintenance organization (HMO), preferred provider organization (PPO), consumer driven health plan (CDHIP), etc.
- Market—reported separately by individual, small group, and large group market. This category should differentiate between whether a premium rate increase applies to an exchange or non-exchange block of business.
- Benefit level—identified by deductible level in cases in which insurers vary premium increases by benefit level, since products with lower levels of benefits, such as high deductibles or copays, are likely to require higher premium increases assuming similar allowed claim trends.

Determining participation in a state exchange

The law directs states to consider whether an insurer should be allowed to participate in an exchange based on whether it has shown a pattern of premium rate increases that have been unjustified or excessive. For those states that do not have an “effective rate review program,” HHS will review a filed rate increase to determine whether it is unjustified or excessive. The state would need to base its decision partially on whether an insurer has shown a pattern of filing unjustified or excessive premium increases on the HHS review. The definition of the term “pattern” is outside the scope of this practice note.

Rate increase differences between exchange and non-exchange products

PHSA Section 2794 specifically directs HHS and the states to monitor rate increases separately for exchange and non-exchange policies. The purpose is to determine the difference in trend for rate increases and experience under these different marketing methods. Even though exchange and non-exchange premium increases are tracked separately, the regulation indicates that rate increases for exchange and non-exchange products should be filed together. The implication is that it may be acceptable to file different rate increases for exchange and non-exchange plans, but this interpretation may differ by state. It should be noted that identical products sold inside and outside the exchange must have the same rates (although the regulation is not clear on how to determine if products are identical).²¹

If insurers want to combine experience and file the same premium increase for these two groups of plans, it would be up to each state to determine whether this would be allowed. In either case, we suggest that each insurer provide states with its exchange and non-exchange experience in both separate and combined exhibits. This may better illustrate the effect exchanges have on the insurer’s business.

Use of grants to improve rate review processes

Under the ACA, a state has the opportunity to obtain grants to improve its current rate review process. To obtain these grants, a state is required to develop and submit a plan that outlines improvements to its current process. The amount of funds allocated to each state will depend on the number of plans available as well as the population in the state. Knowing how a state plans to improve its review process will help actuaries to better determine the type of information that should be included in each rate filing submitted.

²¹ ACA Section 1307(a)(1)(C)(iii)

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With grants provided for the 2011 legislative year, the following is a list of some expansions that states have proposed:

- Require rates be reviewed (to determine if they are justified and not excessive) and approved prior to being implemented in states that previously have been file and use.
- Require rates to be filed for review and approval in states in which rates did not have to be filed.
- Expand the number and types of carriers and/or markets (large group, small group, and individual) for which they will be reviewing rate increases.
- Expand and refine rate review processes (e.g., develop new analytical tools or ensure consistent review with federal regulation) in states in which rates already have to be reviewed and approved.
- Post rate filings (or expand which filings are posted) for public information.

Implementation of the grants, however, could lead to longer approval times, particularly for file-and-use states. But even in states in which filings are currently reviewed, the expansion of procedures could result in more questions for insurers, which would delay final approval. This would be a factor for insurers determining when to submit rate increases.

Considerations for Developing Rate Increases for Health Benefit Plans Subject to ACA

This section discusses factors an actuary may wish to consider when developing rate increases under the ACA, specifically the type of information that may be needed for filing rates and providing justification as appropriate. With expanded review, actuaries may need to provide more specific information in response to requests from the state. Such requests may require actuaries to have access to more detailed information to better justify their rate increase requests.

Administrative Expenses

The actuary needs to describe the basis of administrative expense assumptions, including a general description and source of the assumptions. A good starting point for classifying expenses is Part III of the preliminary justification. Expense categories include:

- General expenses;
- Commissions and broker fees;
- Health care quality improvement expenses;
- Other administrative costs;
- Reinsurance;
- State taxes, licenses, and fees;
- Federal income taxes.

The actuary may wish to use a consistent approach at the state level to allow for the ability to convert from state to federal loss ratio calculations. This will allow for an easier transition from federal to state regulation on a market basis.

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It is suggested the actuary document expense allocation and distribution methodology. As an example, depending on the expense tracking system used by the insurer, “other administrative costs” expenses may be identified by function (e.g., claims administration, enrollment, provider contracting, etc.) and whether they are fixed or variable based on function activity. This approach would allow for a greater explanation of expense levels ratios to premiums.

In cases in which the administrative expenses deviate significantly from past experience, sensitivity or variance tests may be performed to assess the effect on federal MLR under different scenarios.

Some typical studies used to project administrative expenses are:

- Historic administrative cost trends;
- Definition of basis of projected trends (e.g., CPI, budgets, etc.);
- Effect of quality improvement efforts;
- Effect of cost-containment efforts;
- Demonstration of projected administrative trends/costs with explanation of any capital expenditures over \$X.

Claims Trends

Premiums for plans in the health insurance market typically increase every year due to increases in claim costs. The following factors are from an issue brief developed by the Academy’s Individual Medical Market Task Force outlining the major component parts of historical claims trend:²²

- External factors driving medical-cost increases;
- Policy duration (for medically underwritten business);
- Policyholder lapses/changes in enrollment mix;
- Leveraging effect of deductible;
- Correction of prior estimates.

Actuaries typically perform various actuarial analyses in computing historical claims trends, including component pieces. Three-month and 12-month rolling averages typically are calculated to eliminate monthly fluctuations. The three-month average sometimes can be a leading indicator of trend direction while the 12-month trend reveals the magnitude of annual trends. The analyses will depend upon available data or outside information. Analyses identifying cost and utilization components by service type often would be performed. Some examples of service type are hospital inpatient-surgical, hospital outpatient-emergency room, hospital outpatient-ambulatory surgery, prescription drug-generic, prescription drug-brand, radiology, and pathology.²³

Finally, an analysis reconciling aggregate annual historical trend into its component pieces is suggested. Once this is done, the actuary can estimate or project future expected trends as needed. As future trends are based on judgment, they are not guaranteed. But they are expected

²² American Academy of Actuaries, *Premium Setting in the Individual Market* (March 2010 issue brief): http://www.actuary.org/pdf/health/premiums_mar10.pdf.

²³ See *Premium Setting in the Individual Market* (March 2010 Academy issue brief) for an in-depth listing of the types of special claims trend studies actuaries may perform.

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to be best estimates with appropriate margins for adverse deviation. Thus, when the next set of premiums is developed, an adjustment to “true-up” prior estimates typically is part of the process.

It is important to note that many analyses need homogeneous data and such data are not likely to be available at the discrete level of most rate filings. Many of these analyses are done at the market level, or for all medical markets combined. However the analyses are performed, it is suggested the actuary document the analyses, data sources, and methodology employed.

Lapse Rates

Until 2014, historical lapse rates may be used for guidance when developing multi-year projections. For 2014 and later, however, prior lapse experience may not be a reasonable proxy for future lapse experience due to the significant differences in pre- and post-2014 underwriting and enrollment requirements. Variance analyses may be appropriate for the actuary to best outline and present scenarios to management and regulators. Experience and cause-and-effect analyses will be developed over time. It is anticipated such analyses will be tied to adverse selection studies and demographic analyses of new entrants and lapsers. The actuary is cautioned to do variance analyses when using lapse assumptions as part of the rate increase development process. The filing actuary should be cognizant of assumptions for which the state’s reviewing actuary typically raises concerns or questions.

Capital and Surplus

The actuary may consider capital and surplus requirements in determining rate increases. The insuring organization should be considered as a viable ongoing concern that will meet state statutory capital requirements. There may be circumstances when contributions to surplus are necessary to maintain the insuring organizations’ financial soundness. If this is the case, the actuary may wish to include contributions to surplus in the rate increase calculations. On the other hand, some states have set limits on rate increases dependent on high levels of capital, which the actuary should be aware of when developing rates.

Historic Experience

Experience exhibits showing the historical experience (i.e., earned premium, incurred claims, loss ratios, member count, policy count, claim count, etc.) would need to be prepared. Some states may require a complete history from the first day of a product line grouping; other states may require only several years of data. The actuary should be familiar with state historic experience requirements.

According to the instructions for Part III, it appears HHS will require data for 2008 and later.

The actuary may wish to maintain source data for back up and documentation purposes—at a minimum, data by year and month for the prior five years if such data are available. All claims, premiums, and count data would need to be reconciled to data supplied via NAIC quarterly reporting forms as well as data in statutory statements. The actuary should be familiar with ASOP No. 23, *Data Quality*.

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Projections/Rating Methodology

The following illustrates what could be taken into consideration in developing future experience projections; some items that are common for individual but that may be rare for small group. Other approaches also are possible.

- Base period claims and premium experience (preferably monthly)
- Claims trend and premium increases, historical and projected
- Adjustment to claims such as credibility, large claim pooling, and seasonality
- Plan mix change for premium and claims, if applicable
- Durational claims adjustments (index or curve by policy duration)
- Durational premium adjustments (index or curve by policy duration)
- Relationship between durational claims and premium index
- Policy renewal distribution by calendar month
- Lapse assumptions
- Cohort of members used in projection (members in force 12 months after the rate increase effective date)
- Interest rate to accumulate past experience and discount future projections
- Number of projection years

The durational claims index should be determined by a company's experience, if credible, or by industry experience adjusted for a company's underwriting practice.

A durational premium index would depend on state regulation and a company's pricing philosophy. For many companies, the premium index would be higher than the claims in early durations and lower than the claims for the later durations. Since it is difficult to project accurately the level of future claims, it is acceptable to assume the same premium increase and claims trend after a certain policy year (e.g., year 10) so as not to bias the lifetime loss ratio projections in the future years. Higher claims trend and premium increase assumptions in future years, however, will increase the lifetime loss ratio.

Sensitivity tests would need to be performed to assess the effect of assumption variances under different scenarios.

The software model the actuary uses may produce projected results by month, with the ability to summarize by appropriate calendar period for determining rate increases, preparing the actuarial memorandum, providing documentation, completing Parts I and II of the preliminary justification, and answering questions from the reviewing actuary.

MLR Calculations

For individual business, the cumulative historical loss ratio and the projected future lifetime loss ratio are common state requirements. HHS instructions in Part III request future and lifetime loss ratio calculations when reviewing individual business.

The actuary would likely need to describe how the loss ratios were calculated and the assumptions and methodology used. This information would need to be provided in a manner that will allow for testing associated with any applicable state lifetime or federal future loss ratio

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calculations. If the state does not have a requirement, this information should allow for lifetime loss ratio testing under the NAIC's Model Regulation 134. At a minimum, yearly (normally calendar year) claims and premium experience, prior experience accumulated to date with interest, and future projected experience discounted to date with interest should likely be prepared. In addition, claims activity and member data should be prepared, corresponding to claims and premium experience, as required by the state.

The federal MLR reporting requirements and regulations can be found on the CCIIO website: <http://cciio.cms.gov/resources/regulations/index.html#mlr>. The CCIIO reporting form includes information needed to determine federal MLRs for each market. The MLR generally can be expressed as:

$$\text{MLR} = \frac{[\text{Incurred Claims} + \text{Quality Improvement Expenses}]}{[\text{Earned Premiums} - \text{Taxes} - \text{Fees}]}$$

Note that in 2014 additional adjustments will come into play.

As of the publication date of this practice note, the NAIC was in the process of developing recommendations for HHS on the following:

- Interaction between MLR/rebates and the 3Rs (i.e., reinsurance, risk corridors, and risk adjustment);
- The timing of the MLR report and rebate due date in conjunction with the interchange of funds resulting from the 3Rs;
- The possibility of “double-dipping” between rebates and risk corridors;
- Three-year MLR calculation for 2013 and beyond;
- Build partial credibility;
- Interaction between “unreasonable” rate increase reviews and MLR;
- The treatment of producer compensation in the MLR calculation.

It is highly recommended that the actuary actively review the CCIIO website for updates and additional information.

It is important to recognize that federal MLRs will be tracked and computed at the market level (in addition to state and legal entity), which may coincide with product groupings used for rate increases. It would be the responsibility of the actuary to reconcile experience used in the rate filing to that used to determine federal MLRs and provide support for any differences when required.

MLR Rebates

If the carrier has issued, or is expected to issue, rebates as the result of MLR requirements, the actuary would need to consider the base period experience used and describe how the rebate is estimated and reflected in the rate development process.

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Attestation

Actuarial memoranda generally are included with most rate filings that are reviewed. It is important to note that approval for a rate structure is requested in the memorandum. While the new rate structure may be the result of a rate increase, the rate structure is what the actuary is attesting. Current state regulations typically require an actuary who is qualified under the U.S. Qualification Standards to provide an attestation indicating that the premium rate filing complies with applicable state statutes and requirements.

The rate-filing actuarial memorandum typically references specific ASOPs followed in determining the premium rate or rate increase. In its May 14, 2010, letter to HHS, the Academy's Premium Review Work Group noted that "Generally, a rate filing contains an actuarial attestation that states that the actuary is a member of the American Academy of Actuaries, the rates were developed following appropriate Actuarial Standards of Practice (ASOPs) and the profession's Codes of Professional Conduct, the actuary has the education and experience necessary to perform the work, and the rates are reasonable in relation to the benefits provided and meet state statutes and requirements. This would include any loss ratio minimum requirements and any other state requirements."²⁴ The critical aspect of the state review process is that premium rates are appropriate, not excessive or inadequate. State regulations generally focus on premium adequacy and meeting loss ratio requirements—not rate increases.

When attesting to compliance with ASOPs and other professional requirements, the actuary particularly would need to be familiar with ASOP No. 41, *Actuarial Communications*. Section 3.2 states (emphasis added):

"The actuary should complete an actuarial report if the actuary intends the actuarial findings to be relied upon by any intended user. The **actuary should consider the needs of the intended user in communicating the actuarial findings** in the actuarial report.

An actuarial report may comprise **one or several documents**. The report may be in several different formats (such as formal documents produced on word processing, presentation or publishing software, e-mail, paper, or web sites). Where an actuarial report for a specific intended user comprises multiple documents, the actuary should communicate which documents comprise the report.

In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary **with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report.**"

Documentation

Requirements for filing documentation vary by state and product type but documentation always should be prepared in accordance with ASOPs and include an attestation signed by a member of

²⁴ Academy's Premium Review Work Group comment letter to HHS on the request for information on the new rate review process under the ACA.

http://www.actuary.org/pdf/health/aaa_premium_peview_rfi_response_051410_final.pdf

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the American Academy of Actuaries. Supporting documentation would include some, or all, of the following:

- General information about the product or product grouping;
- Exhibits of historical experience (earned premium, incurred claims, loss ratios, member count, policy count, claim count, etc);
- Experience exhibits for rebates, risk adjustments, and reinsurance;
- Experience projections that support the requested rate increase;
- Rate tables and factors composing the rate structure;
- Detailed explanation of the proposed changes in the rate structure, including support for changes;
- Explanation and support for all significant actuarial methods and assumptions (i.e., claims trend, lapse rates, administrative expenses, etc), as applicable;
- Sample rate calculation or rating algorithms to demonstrate how a rate is calculated;
- Rate increase distribution and averages, as applicable;
- Distribution of the enrolled population by risk characteristic and policy option;
- Capital and surplus considerations.

Much of the information listed above is appropriate for most rate filings. To the extent that types of information and formats reasonably can be standardized, it may simplify both the preparation and review of filings. The actuary would need to be familiar with the specific requirements for the state of rate filing submission. (See *Instructions for Completing Part III of the Preliminary Justification* for a list of the submission requirements for HHS.) Proper documentation of any actuarial estimate and/or projection would need to provide support for any rate increase.

Actuarial Standards of Practice

An actuary is expected to adhere to the Code of Professional Conduct, meet continuing education requirements described in the U.S. Qualification Standards, and follow relevant ASOPs. To the extent an actuary deviates from any ASOP, he or she is expected to identify such deviations. For the purpose of this practice note, an actuary may need to be familiar with the following:

- ASOP No. 5—*Incurred Health and Disability Claims*
- ASOP No. 8—*Regulatory Filings for Health Plan Entities*
- ASOP No. 12—*Risk Classification (for all practice areas)*
- ASOP No. 23—*Data Quality*
- ASOP No. 25—*Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*
- ASOP No. 26—*Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*
- ASOP No. 41—*Actuarial Communications*

Communications

In addition to ASOPs, the actuary must adhere to the profession's Code of Professional Conduct when engaging in the rate development, submission, and review process. All 14 precepts of the Code need to be followed. The following briefly summarizes several pertinent precepts from the Code:

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- Precept 1: An actuary should act with integrity and competence in a manner to fulfill the profession's responsibility to the public.
- Precept 2: An actuary shall perform actuarial services only when qualified to do so on the basis of basic and continuing education, experience, and satisfaction of applicable qualification standards.
- Precept 3: An actuary shall ensure that actuarial services performed satisfy applicable standards of practice.
- Precept 4: An actuary shall take appropriate steps to ensure that the actuarial communications are clear and appropriate to the circumstances and for the intended audiences.
- Precept 10: An actuary shall perform actuarial services with courtesy and cooperate with others.

Please remember that the filing actuary is attesting that assumptions, methodology, and rates are appropriate and reasonable. When the reviewing actuary approves the proposed rates, he or she is guided by the laws and regulations of the state. In both cases, the actuaries are bound by the legal requirements, professional codes of conduct and ASOPs. An open communication is encouraged so that appropriate rates result from the development and review process.

Rate Review Principles

The rate review process should ensure premiums for health insurance policies are set to adequately pay projected claims, administrative expenses, margins for adverse deviations, profit/contribution to surplus, premium taxes and other applicable state taxes and fees, and federal taxes on earnings. In addition, all assumptions and methodologies employed should be demonstrable and based on data and actuarial analyses. The purpose of the review is to ensure that premium rates meet state and federal requirements. There are many cases in which the rate submitted or approved may not be adequate to cover these amounts. Some examples of these are:

- Desire for one product to subsidize another as in the case of the products offered to higher risk individuals being subsidized by other products;
- Desire to keep premiums competitive;
- Need to increase surplus levels that are imprudently low;
- Desire to provide lower rates to insureds on a block of business that historically has had better than expected experience;
- Desire to increase loss ratios on a product with high administrative expenses to avoid paying rebates; and
- Desire to keep premiums down on a new product with high start-up administrative costs.

The review process should be one in which the filing actuary and the reviewing actuary discuss the actuarial assumptions and methodologies. The filing actuary is expected to provide documentation for assumptions that are "supported by substantial evidence."²⁵ Open communication between actuaries is expected.

²⁵ 45 CFR 154.205

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Appendix I—State Requirements

There are considerable differences in the health rate increase filing laws and regulations among states. In some states, there are significant differences within state laws and regulations—between group and individual, small and large group, HMO and PPO, etc. As an example of the differences that exist between individual states, this appendix attempts to detail the state-specific health filing requirements for Maine and Florida.²⁶

Examples: Maine and Florida

Maine has a relatively less-populated state and a complex, multi-layered structure of health rate filing laws and regulations. The state recently has made several changes to its laws and regulations to make them consistent with the ACA.

Florida is one of the more populous states. Florida’s rate review requirements are less complex than Maine’s. Unlike Maine, Florida has made few changes to its laws and regulations to comply with the requirements of the ACA. The rate review requirements do not vary between HMO and PPO products, with the exception of individual HMO. The format of the actuarial memorandum varies between individual PPO and HMO, but all other filing requirements are identical.

The comments below are applicable to both PPO and HMO business.

Large groups (51 or more eligible employees)

Maine: These rates are filed for informational purposes only. The rates do not require approval by the Bureau of Insurance (BOI).

Florida: The Florida Office of Insurance Regulation (OIR) does not require the filing of rates or rate increases.

Small groups (50 or fewer eligible employees)

Maine: If a carrier’s block of small group business covers enough members to be considered fully or partially credible under the ACA, then it is considered credible by Maine and is subject to the MLR requirement. In this case, a carrier must file rates, including all formulas and factors that adjust rates, for informational purposes only. In addition, the carrier either must demonstrate that a proposed rate change is not potentially “unreasonable” or submit the ACA preliminary justification Parts I and II. If the carrier’s small group block is considered credible, then it must pay rebates to members if its actual loss ratio, as determined by the ACA-specified calculation, is less than an MLR of 80 percent.

Maine law previously allowed a carrier with 1,000 or more members to choose whether it would be subject to a loss ratio of 78 percent. As with the new law, the earlier law waived prior approval of rate filings subject to the loss ratio.

²⁶ Florida Administrative Code 690: 149.002 – 149.006, 149.037, 191.054, and 191.055; Florida statute Sections 627.410, 627.411, 627.6699, 641.31. Maine Revised Statutes Title 24-A.

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If the carrier's block of Maine small group business does not insure enough members to be considered fully or partially credible according to the ACA, then the carrier must file rates and receive approval from the BOI before using them. The carrier must demonstrate in the filing that the proposed rates will return to policyholders an anticipated loss ratio of 75 percent or more, both in the future and over the lifetime of the policies (past and future). In addition, the filing must contain sufficient supporting documentation to demonstrate that the rates are not excessive, inadequate, or unfairly discriminatory. The information required includes past Maine and, if applicable, national experience, rating formulas, trend, morbidity basis and assumptions, marketing method, underwriting (and its impact on claims by duration), premium classes, and the average premium. If the rate filing is a revision, it also must include a history of prior rate changes.

All small group rate change filings, whether subject to prior approval, must include the average and maximum rate increase percentages. In addition, all filings must include an actuarial certification that the rates comply with Maine laws and regulations. The maximum rate increase includes both trend and changes in rates and rating factors, assuming no change in the covered population. Rates must be filed no less frequently than annually.

Florida: Florida requires small group carriers to file rates and rate changes for approval on at least an annual basis. For rate increase purposes, Florida uses a state-specific credibility adjustment based on insured count—500 insured is considered 0 percent credible and 2,000 insured is considered 100 percent credible. Linear interpolation is used for counts between 500 and 2,000 subscribers.

Carriers must file their complete rating methodology, including all applicable rating factors that may affect the final premium, for approval. This includes a full justification of future premium trend assumptions and a complete actuarial analysis of any changes to the existing approved rating factors.

Carriers must demonstrate that the annual anticipated loss ratio after the proposed rate change is equal to or greater than the minimum state loss ratio requirement for small group or is equal to or greater than the prior filing's loss ratio. If a carrier files for a loss ratio that is higher than the 80 percent minimum required, for example, the carrier is held to this higher loss ratio for the life of the policy. Any changes to this target loss ratio must be justified fully, including a full expense analysis to support the changes in administrative expenses.

As in Maine, the filing must contain sufficient supporting documentation to demonstrate that the rates are not excessive, inadequate, or unfairly discriminatory. The information includes past Florida experience,²⁷ rating formulas, trend, morbidity basis and assumptions, marketing method, underwriting (and its impact on claims by duration), premium classes, and the average premium. If the rate filing is a revision, it also must include a three-year history of prior rate changes. The filing itself consists of a cover letter, the universal data letter, the actuarial memorandum, and an electronic submission of the rates via the state's I-file system. The universal data letter contains basic information regarding the filing, including number of insureds, average annual premium before and after the rate change, and anticipated loss ratio before and after the rate

²⁷ Florida does not accept national small group experience as a proxy for Florida small group experience.

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change. The actuarial memo consists of a detailed 28-item document that includes a certification from a qualified, credentialed actuary.

Although Florida has issued informational bulletins outlining the effects of the ACA, including the new 80 percent MLR, it has not made any changes to existing state rules and regulations for rate filings. As in Maine, carriers must pay rebates to members if their actual loss ratio is less than 80 percent.

Individual

Maine: If a carrier's block of Maine individual business covers enough members to be considered fully or partially credible according to the ACA, the carrier can *choose* to file rates either under a loss ratio option or under the traditional file-with-prior-approval option. The difference from small group is that a carrier with a fully or partially credible small group block of business must use the loss ratio filing for small group. If the individual carrier chooses the loss ratio option, the carrier must still file rates, including all formulas and factors that adjust rates, but no prior BOI approval is required (unless a rate review for a potentially unreasonable rate change is required by the ACA). The carrier must demonstrate that a proposed rate change is not potentially "unreasonable," as defined by the ACA, or submit the ACA preliminary justification Parts I and II.

If a carrier's block of Maine individual business does not insure enough members to be considered fully or partially credible, or if a carrier with a credible block chooses not to use the loss ratio option, then the carrier must file rates and receive approval from the BOI before using them. The carrier must demonstrate in the filing that the proposed rates will return an anticipated loss ratio of 65 percent or more, both in the future and over the lifetime of the policies (past and future). In addition, the filing must contain sufficient supporting documentation to demonstrate that the rates are not excessive, inadequate, or unfairly discriminatory. The information includes past Maine and, if applicable, national experience, rating formulas, trend, morbidity basis and assumptions, marketing method, underwriting (and its impact on claims by duration), premium classes (tiers), and the average premium. If the rate filing is a revision, it also must include a history of prior rate changes.

All individual policy rate changes, whether subject to prior approval, must include an actuarial certification that the rates comply with Maine laws and regulations.

Florida: The rate filing requirements are nearly identical for individual and small group business, as are the credibility standards. The format of the cover letter, universal data letter, and the actuarial memorandum are identical for small group and individual. Individual rate filings, whether initial rates or rate changes, must be filed for approval on at least an annual basis.

The differences are as follows:

- The requirements for carriers to file rates electronically via the Florida I-File system do not exist for individual carriers;
- Unlike the annual loss ratio requirement for small group, individual carriers must include a demonstration that the individual plans will meet or exceed the lifetime loss ratio of 80 percent.

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HMO

Maine: HMOs have an additional requirement that rate filings must include a certification by a qualified actuary that the rates are not excessive, inadequate, or unfairly discriminatory, and with adequate supporting information. It is not clear how this differs from the requirements cited above for small group and individual plans, or what constitutes “adequate supporting information.”

Florida: Small group HMO rate filing and rate increase requirements are identical to the small group PPO rate filing requirements. The format of the individual HMO actuarial memo is slightly different than the format of the individual PPO actuarial memo; otherwise, the file and approve requirements are identical.

Summary

As shown above, Maine and Florida have substantial differences in filing laws and regulations. It is common to have significant differences between states. In addition, state laws and regulations are modified frequently. As a result, actuaries involved in rate filings will need to be knowledgeable of state rules and regulations in which the filing is being submitted.

In addition to the state-specific rate filing requirement, actuaries must be knowledgeable on the federal rate filing requirements. The federal requirements currently are found on the Center for Consumer Information and Insurance Oversight (CCIIO) website at <http://cciio.cms.gov/>.

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Appendix II—Rate Increase Questions and Examples

This appendix is a reproduction of the technical FAQs published by CCIIO as part of the agency's overall rate review training resources. The following are questions related to rate filings to which CCIIO responded. The full FAQs can be found on the CCIIO website at http://cciio.cms.gov/resources/files/rate_review_training.html (Aug. 1, 2011) and http://cciio.cms.gov/resources/training/rate_review_faq.html (Oct. 24, 2011)

Technical FAQ – Set 1 (Aug. 1, 2011)

32. Pooling of products: A company has in its small group line of business four products: A, B, C and D. The experience for the four products is pooled to get a rate increase for the pool. There is another process that sets the benefit relativities between products. This means annual average rate increases for each product can be different from both other products and the pool. For example, one might see:

-A pool increase of 12%

-An annual product increases after a change in benefit relativity: Product A increases 14%, Product B increases 10%, Product C increases 11%, and Product D increases 13%

Would this company be required to submit one Preliminary Justification at the 12% level or four Preliminary Justifications (one for each product)?

Since the rate increases are different on each of the four products, four different Preliminary Justifications are needed, one for each of the four products.

33. Some carriers have had historical experience that justifies assuming trend factors much greater than those for most of the other carriers, resulting in requested increases greater than 10%. The carrier is aware that its experience is unusual and is investigating, but does not yet have an explanation. Should the requested increase be considered reasonable?

State law and State standards as to what is unreasonable or not unreasonable should continue to be applied in States that have effective rate review programs. In States where CMS is performing the review, the standard used to make an unreasonable determination is the three-pronged excessive, unjustified, and unfairly discriminatory standard, as articulated in the federal rate review regulation. States with an effective rate review program should continue to apply their standard using all the facts of the case.

34. A carrier has consistently filed significant rate increases on a block of business over several years. As a result of this history, the healthy insureds have tended to terminate their coverage leaving the unhealthy insureds trapped in a "death spiral." The current large increase is seemingly justified based on recent historical loss ratios. Should the requested increase be considered reasonable?

The answer is the same as the preceding question. State law and State standards as to what is unreasonable or not unreasonable should be applied in States that have effective rate review programs. In States where CMS is performing the review, the standard used to make an

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unreasonable determination is the three-pronged excessive, unjustified, and unfairly discriminatory standard, as articulated in the federal rate review regulation.

35. Does the 10% rate increase threshold that triggers review apply only to the weighted average increase or are minimum and maximum increases considered as well?

The threshold test trigger uses the weighted average premium rate increase to determine if a given increase is subject to review. The maximum increase and minimum increase are not used in the threshold test.

36. The final regulation requires issuers to file a Preliminary Justification at the product level. Some States focus their review at the filing level. Thus, States may review multiple Preliminary Justifications per rate filing. How does CMS envision the State's review process to operate in this case?

If a filing includes more than one product, a State with an effective review process should conduct the review of the filing in the manner in which it normally conducts such reviews. The regulation should not cause any State with an effective rate review program to change the manner in which it reviews rate filings. However, a separate result will have to be entered for each Preliminary Justification record that appears in the HIOS system.

In the case where a filing contains several products that are pooled for one Preliminary Justification submission, the result of the review would be entered into the HIOS system just one time for the pooled record.

37. Would the determination for all Preliminary Justifications described in item 36 be identical?

The determination for each product need not be identical.

38. Would there ever be a case in which different products within one rate filing received different determinations?

Yes, it is conceivable that the same proposed rate increase would be unreasonable for one product in the filing and not unreasonable for another.

39. Does CMS have guidance in the event of the situation described in item 38?

CMS does not have additional guidance at this time. States with effective rate review programs should follow their State law and State standards in making any determination as to whether a particular product increase is unreasonable or not.

40. There is a group health insurance carrier in a State which does not have an effective rate review process. The carrier's rates are effective 10/1/2011, but renewal notices will go out to members beginning on 8/1/2011.

Does the Carrier have to file with CMS before "implementation" of the rates? Is implementation the date the renewal letters go out, or the effective date of the rate increase?

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Yes. For States with a filing requirement, filings submitted on or after September 1, 2011 are subject to the rate review regulation. For States where there is no filing requirement (i.e., no effective rate review program), increases with an effective date on or after September 1, 2011 are subject to the rate review regulation and must file all three parts of the Preliminary Justification with CMS.

The implementation date is the effective date of the rate increase. The renewal letter has no bearing on the timing of the Preliminary Justification submission to CMS.

41. If a filing includes a requested rate increases of 7%, 12% and 14% for three different products, how many preliminary justifications would be required for this filing?

The most granular level of submission for the Preliminary Justification is the product level. Two or more products can be submitted together in one “pooled” Preliminary Justification submission if the product’s experience is combined or pooled for the purposes of rate making AND the products submitted together have the same increase. If the experience for two or more products was not combined or pooled for rate making purposes, a Preliminary Justification must be submitted for each product.

42. For the same filing mentioned in item 41 above, rather than 3 different increases, the filer decided to request the same increase of 11% for all 3 products, and the increase was based on the combined experience of the products. In this case, would the filer be required to submit just one preliminary justification?

The filer may combine the three products into one Preliminary Justification, but is not required to do so.

43. For the same filing mentioned in item 41 above, the filer pooled the experience from all three products but decided to allocate different increases to each product. The total of all the increases was equivalent to the overall increase based on the combined experience. Would you consider the increases unreasonable?

State law and State standards as to what is unreasonable or not unreasonable should continue to be applied in States that have effective rate review programs. In States where CMS is performing the review, the standard used to make an unreasonable determination is the three-pronged excessive, unjustified, and unfairly discriminatory standard, as articulated in the federal rate review regulation.

Technical FAQ – Set 2 (Oct. 24, 2011)

41. Do the instructions for meeting the subject to review threshold include any language that addresses the 10% limit as an “annual” limit? If not, is there anything that indicates previous filings for the year should be included to pass the 10% threshold?

Rate increases for the 12-month period preceding the rate increase effective date must be aggregated to determine whether the specified threshold is met or exceeded.

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42. Please clarify the following example as to whether it is an increase over the 10% threshold. This example is about a State-mandated Open Enrollment plan in the individual market. The State mandates that in 2012 rates have a limit of 1.5 times the lowest comparable plan new business rate. In 2011 the limit was 2.0 times the lowest comparable plan new business rate. Medical trend caused an increase in the lowest comparable plan new business rate of 14% for all ages. Below are simple numbers for illustration of just one age band. Note the 14% increase is applicable to all age bands.

For example, for one age band the 2011 lowest comparable plan rate was \$1,000. The 2.0 times limit allowed an Open Enrollment plan rate of \$2,000 for this age band. Trend caused the increase in the lowest comparable plan rate to 1.14 times \$1,000 or \$1,140, for 2012. The 2012 year's 1.5 times limit allowed an Open Enrollment plan rate of \$1,710. Has the threshold been breached for this example?

If the example cited is the only business in this filing, and if the maximum allowable Open Enrollment limits are being used, then the 2011 rate of \$2,000 is actually being reduced to a 2012 rate of \$1,710, so the 10% increase threshold has not been breached. In a setting such as this, the fact that trend alone exceeds 10% is not dispositive regarding the breaching of the threshold. It is the final rate that matters.

The average rate increase over the entire filing will be reviewed. For example, suppose that an issuer was employing a 1.5 cap in 2011, despite the ability to cap at 2.0. Presumably if the 1.5 cap is retained in 2012, and 14% trend applies without further modifications by other elements, then the threshold would be breached because, as we understand the assumption, all rates would rise by 14% over a one year period.

43. How should the cumulative "threshold rate increase" be calculated? In the examples provided, it appears the multiple rate changes over a 12-month period are just being summed. However, the subsequent rate changes would be applied on top of the previous rate changes, creating a slightly higher 12-month cumulative. For example, if a company files quarterly rate changes of 3%, the second quarter rate increase would be a 3% increase on the rates that had already undergone a 3% increase 3 months prior. If rates started at \$100, the increasing rates would be as follows: \$103, \$106.09, \$109.27, \$112.55; resulting in a 12.55% increase, rather than a 12% increase. Which method of calculation should be used?

For any increase, the rate of change should be determined by the actual increase in the premium rate. If the method used for each increase is multiplicative rather than additive, then indeed the compounding would result in the \$100 premium reaching \$112.55, as is the case in the example presented, and the threshold rate increase used in the test would be 12.55%, which is the difference of the \$112.55 and the \$100 (or \$12.55), divided by the \$100. Generally, to evaluate any particular increase, one has to include any impacts to premium from other increases that have occurred within a year of elapsed time measured from the effective date of the rate increase being evaluated. Thus, a single cliff increase (with no other increase within a year) is evaluated on its own. Regular quarterly increases would require one to include the impact of the previous three quarters. With the proposed increase being evaluated in this example, the compound increase effect is 12.55%. If the premium instead rose by an even \$3 every quarter (from \$100, to \$103, \$106, and \$112 respectively the additive model) then the threshold rate increase would be 12% not 12.55%.

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44. How do issuers handle the situation in those States for which they file an annual rate increase as of a given date and a maximum annual trend, which may be applied to the rates for subsequent effective dates? For example, consider the illustrative case where an issuer files an annual rate increase effective January 1 of 9.5% and a maximum annual trend of 12% (which implies a maximum increase in the rate of approximately 0.949% per month).

The threshold testing should be based on the maximum increases that the issuer could apply. This is true both at the date of the filing that first addressed the maximum possible increase, and at the date of any subsequent filing covering a period for which part of the initially requested and approved maximum trend can still be implemented.

45. How and when are benefit changes considered for the threshold test? In particular, are distinctions made between:

- a. legally required benefit changes;***
- b. benefit changes that the issuer is choosing to make that will affect all policyholders;***
- c. benefit changes that will only impact new issues; and***
- d. optional benefit changes that the policyholder may elect (or reject)***

All benefit changes, including those legally required and those the issuer chooses to make are included in the threshold test. Benefit changes that will only impact newly insured individuals are not included in the threshold test. Optional benefit changes that the policyholder may elect (or reject) are changes in premium, not rates, and are not included in the threshold test.

46. Consider the below scenario: In one filing an issuer is proposing the following rate increases:

<i>Quarter</i>	<i>Quarterly increase</i>	<i>Annual rate increase</i>
<i>01/01/2012</i>	<i>3.00%</i>	<i>0.08</i>
<i>04/01/2012</i>	<i>3.00%</i>	<i>0.11</i>
<i>07/01/2012</i>	<i>3.00%</i>	<i>0.09</i>
<i>10/01/2012</i>	<i>3.00%</i>	<i>0.13</i>

a) Given that two of the annual increases are greater than the 10% threshold, is the issuer required to submit two Preliminary Justifications for this filing?

Slide 12 of the Subject to Review Threshold Test training module states: "If a filing has periodic increases with multiple effective dates for its component increases, the greatest threshold rate increase for the filings should be used for the threshold rate increase." In this example, we have a 3% increase that is implemented quarterly. This is a periodic increase that constitutes a 13% threshold rate increase. The issuer need not submit two Preliminary Justification data sets; it only needs to submit one for the entire filing.

b) In general, in a filing that has periodic increases with multiple effective dates, is the issuer required to justify any annual rate increase above the 10% threshold within a Preliminary Justification?

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Yes. In this example, we have a 3% increase implemented quarterly. This is a periodic increase that constitutes a 13% threshold rate increase. The issuer must justify any increase that is part of a Preliminary Justification that triggers the threshold.

c) The answer given for (a) above was that the issuer is only required to submit one Preliminary Justification (triggered by the 13% annual rate increase). Should the 11% annual increase, effective 4/1/2012, also be justified/supported in the Preliminary Justification?

Yes. When justifying a rate filing with multiple increases that trigger the threshold, the issuer must justify each rate increase. The same holds true if the rate increases were filed separately.

47. Below is an example of a rate increase request filing for either individual or small group policies renewing in 2012:

a. 1st quarter 2012 renewing business rate increase request is 10.5%

b. 2nd quarter 2012 renewing business rate increase request is 10.1%

c. 3rd quarter 2012 renewing business rate increase request is 9.7%

d. 4th quarter 2012 renewing business rate increase request is 9.2%

The weighted average aggregate rate increase request is 9.8% for 2012. In this example, would the subject to review threshold test be met or not?

No. This does not trigger the subject to review threshold. The threshold is based on a weighted average, and in this example, it does not exceed 10%.

48. Please clarify the treatment of changes in demographic, geographic and benefit factors (not changes in the actual demographics or elections). Should these changes be included in the calculation of the threshold rate increase (e.g., if benefit factors increase to adjust for deductible leveraging)? Should these changes be included in the calculation of the minimum and maximum rate increases (e.g., if a change in age factor increases rates an additional 5% for a given cohort, would that factor into the calculation of a maximum rate increase)?

First, when discussing changes in factors, and not changes in individuals or cohorts of individuals that arise solely due to the application of the factors, and not discussing changes to those factors, the impact of changes to the underlying rate factors for demographic, geographic, and electoral factors are changes in the rate structure and would be included in the threshold rate increase test. Such changes would indeed also be included in the minimum and maximum rate increases as well.

Second, when discussing factors that are not being changed, but cause premium changes due to individuals aging (under an issue age rated product), moving across geographic rating areas, or making elective changes in benefits, the changes in premiums are not considered to be changes in the rate structure and do not impact either the threshold rate increase test or the minimum and maximum rate increases.

49. On the Rate Summary Worksheet (Part I of Preliminary Justification), should the minimum and maximum percent increases align with the effective date of the threshold rate increase and the effective date of the overall rate increase, or should they be based on

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increases that are effective at any point during the approval period (assuming rolling increases are pre-approved)? Using Example 3A from the training, if the issuer filed an 8% increase on January 1 and an additional 4% increase on July 1 and increases were consistent across all plans and policyholders for each given effective date, would the minimum increase be 8% and would the maximum increase be 12%? If not, what would they be?

In this example, it appears that all policyholders will get a 12% increase in the aggregate across the board so the minimum, maximum and average increases are the same. In cases where they differ, information for Part I of the Preliminary Justification should be entered using the effective date of the rate increase.

50. Please clarify whether the minimum and maximum increases in the Part I Preliminary Justification should be based on hypothetical or actual enrollees. In other words, should the maximum increase be calculated as the maximum increase across the current population, or the highest possible increase, even if it doesn't apply to any actual enrollees?

The minimum and maximum rate increase should be based upon actual enrollees, except in the case where there is a rate increase (not an initial rate filing) and there are no enrollees, then the highest possible should be used.

51. For the cumulative threshold test, are increases effective in the 12 months prior to September 1, 2011 considered for filings effective September 1, 2011 and after? For example, a filing was made November 1, 2011, effective January 1, 2012, for 9%, and there is a prior approved increase that was filed in June 2011 and effective August 1, 2011 for 9%. Should the cumulative effect of both 9% increases be considered for the threshold test?

Yes. The 9% increase should be considered when calculating the threshold test.

52. If changes made in the underwriting manual or methodology are implemented, would the effect of these changes be included in the threshold test?

Any impact or changes in the underlying rate structure should be included in the threshold rate increase test.

53. In the case where rates are filed for a given time period, for example, First Quarter, 2012, and proposed trend factors for the rest of the year are filed, yet issuers have the ability to reevaluate the rates and file new rates each quarter, is the weighting necessary to determine the threshold? Or, would the increase subject to the threshold be based purely on the annual increase effective with January 1, 2012? For example, if January 2012 proposed rates correspond to an annual increase of 9.7%, yet application of the proposed trend factors would lead to an increase over 10% in September 2012, would an issuer need to consider the September increase in determining the threshold? Or would the issuer not need to file a Preliminary Justification with the First Quarter filing and instead need to file one with the Third Quarter filing if rates needed were producing an increase over 10%?

If the September increase that brought the initial increase of 9.7% was effective within 12 months of the earlier increase, the effects of the two increases would be combined for the purpose of the threshold test for the September increase. If the two increases were filed

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separately, the earlier increase of 9.7% would not trigger the threshold or be subject to review, but the later incremental increase that brought the aggregate effect within one year over the threshold value would. If filed together, the compound increase filing would become subject to review. If any incremental increase in a filing made within a year of an earlier increase(s) triggers the threshold, the entire filing becomes subject to review. The effects of increase to rates from base increases as well as trend increases are both included in the threshold rate increase test.

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Appendix III—List of Effective Rate Review Programs

This appendix is a reproduction of the list of effective rate review programs as published by CCIIO. The table indicates whether a state has an effective rate review program or whether HHS will have responsibility for review of proposed insurance rate increases. This information also can be found on the CCIIO website at

http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

This list is up-to-date as of Feb. 16, 2012.²⁸

State	Individual Market	Small Group Market	Individual & Small Group Effective Rate Review Program	Individual Association Products	Small Group Association Products
Alabama	Federal	Federal	No	Federal	Federal
Alaska [‡]	State	State	Yes	State	State
Arizona	Federal	Federal	No	Federal	Federal
Arkansas	State	State	Yes	State	State
California	State	State	Yes	State	State
Colorado	State	State	Yes	State	State
Connecticut	State	State	Yes	State	State
Delaware	State	State	Yes	State	State
District of Columbia	State	State	Yes	State	State
Florida	State	State	Yes (Associations: Partial)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)
Georgia	State	State	Yes	State	State
Hawaii [‡]	State	State	Yes (Associations: No)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)
Idaho [‡]	State	State	Yes (Associations: No)	Federal	Federal
Illinois	State	State	Yes	State	State
Indiana	State	State	Yes	State	State
Iowa [‡]	State	State	Yes	State	State
Kansas	State	State	Yes	State	State
Kentucky	State	State	Yes (Associations: Partial)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)

²⁸ http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

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Louisiana	Federal	Federal	No	Federal	Federal
Maine	State	State	Yes	State	State
Maryland	State	State	Yes	State	State
Massachusetts	State	State	Yes	State	State
Michigan	State	State	Yes	State	State
Minnesota	State	State	Yes	State	State
Mississippi	State	State	Yes (Associations: Partial)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)
Missouri	Federal	Federal	No	Federal	Federal
Montana	Federal	Federal	No	Federal	Federal
Nebraska	State	State	Yes (Associations: Partial)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)
Nevada	State	State	Yes	State	State
New Hampshire	State	State	Yes	State	State
New Jersey	State	State	Yes	State	State
New Mexico	State	State	Yes	State	State
New York	State	State	Yes	State	State
North Carolina	State	State	Yes (Associations: Partial)	Federal	State
North Dakota	State	State	Yes	State	State
Ohio	State	State	Yes	State	State
Oklahoma	State	State	Yes	State	State
<u>Oregon*</u>	State	State	Yes (Associations: Partial)	Federal	State (Non- exempt plans) Federal (Exempt plans)
<u>Pennsylvania**</u>	State	State	Yes (Associations: Partial)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)
Rhode Island	State	State	Yes (Associations: Partial)	State (Sitused) Federal (Non-Sitused)	State (Sitused) Federal (Non-Sitused)
South Carolina	State	State	Yes	State	State
South Dakota	State	State	Yes	State	State
Tennessee	State	State	Yes	State	State
Texas	State	State	Yes	State	State
Utah	State	State	Yes	State	State
<u>Vermont***</u>	State	State	Yes (Associations: Partial)	State (Non- exempt plans) Federal (Exempt plans)	State (Non- exempt plans) Federal (Exempt plans)

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Virginia	State (Non-HMO) Federal (HMO)	Federal (HMO & All Small Group)	Partial (Associations: No)	Federal	Federal
Washington	State	State	Yes (Associations: No)	Federal	Federal
West Virginia	State	State	Yes	State	State
Wisconsin	State	State	Yes (Associations: Partial)	Federal	State
Wyoming	Federal	Federal	No	Federal	Federal
Territories					
American Samoa	Federal	Federal	No	Federal	Federal
Guam [‡]	State	State	Yes	State	State
Northern Marianas Islands	Federal	Federal	No	Federal	Federal
Puerto Rico [‡]	State	State	Yes	State	State
Virgin Islands	State	State	Yes	State	State

Source: Center for Consumer Information and Insurance Oversight

* Oregon State law exempts from rate review association plans that retain 95% or greater of their employer groups (ORS 743.734)

** Pennsylvania will have effective rate review authority for the non-association commercial small group market effective March 21, 2012 per newly enacted legislation (Act 134 (renumbered) of 2011). Until that date, CMS will review Pennsylvania non-association commercial small group products while the State will continue to review rates for all other non-association products. As for the association rates, effective March 21, 2012, Pennsylvania will begin reviewing rates for small group associations situated in Pennsylvania along with the rates for individual associations situated in the State that it is already reviewing. CMS will continue to review the rates for individual and small group associations that are not situated in Pennsylvania.

*** In Vermont, non-situated plans are exempt from filing with the State under the following circumstances (8 V.S.A. § 3368):

- A. the master policy was lawfully issued and delivered in a State in which the insurer was authorized to do insurance business (and thus regulated by the State of issue)
- B. (i) no more than 25 of the certificate holders are Vermont residents; or (ii) the master policy covers one or more certificate holders who reside in Vermont, are employed at a workplace located outside Vermont and have obtained insurance coverage through the workplace;

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- C. The person or entity holding the master policy exists primarily for purposes other than to procure insurance, is not a Vermont corporation or resident, and does not have its principal office in Vermont; and
- D. The policy is not offered for sale by an agent or broker licensed in Vermont, offered by mail to a Vermont resident, or marketed in Vermont in a similar manner.

Note: In this chart, the term “situated” refers to the State where the policy (not the individual certificate) is issued; the Situs State is the State that has the primary jurisdiction and whose laws, rules, and regulations govern the policy. Additionally, for the purposes of this chart, an “exempt” plan is one that is exempt under State law from State rate review requirements.

‡ Status Updates:

- Following the release of August 15, 2011 Bulletin 11-06 from the Iowa Insurance Division, Iowa now has effective rate review in both the individual and small group market.
- Following August 22, 2011 correspondence from the Idaho Department of Insurance confirming its intent to comply with the rate review regulation (45 CFR Part 145), Idaho now has effective rate review in both the individual and small group market.
- Based on information received from the Guam Department of Insurance, Guam now has effective rate review in both the individual and small group markets.
- Following issuance of July, 2011 Ruling Letter from the Puerto Rico Department of Insurance, Puerto Rico now has effective rate review in both the individual and small group markets.
- As of November 2011, Hawaii is reviewing all rates for association plans situated in Hawaii.
- As of January 1, 2012, Alaska has rate review authority in all markets per State statute.

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Appendix IV—Suggested Reference Materials for the Individual Medical Market

Critical Issues in Health Reform: Premium Setting in the Individual Market

American Academy of Actuaries, March 2010 issue brief

“Cumulative Antiselection Theory”

William F. Bluhm, *Transactions of the Society of Actuaries* Vol. 34, p215, 1982

Critical Issues in Health Reform: Transitioning to new Market Rules

American Academy of Actuaries, August 2009 issue brief

“Individual Medical Expense Insurance”

Society of Actuaries, *Professional Actuarial Specialty Guide*, October 2003

The Individual Medical Insurance Market: A Guide for Policymakers

American Academy of Actuaries, October 2008 issue brief

Individual Major Medical Business

American Academy of Actuaries, August 2005 practice note

Individual Health Insurance

Edited by Francis T. O’Grady, Society of Actuaries, 1988

Guidelines for Filing of Rates for Individual Health Insurance Business

NAIC Model Regulation 134, 2000