AMERICAN ACADEMY of ACTUARIES

Nov. 5, 2010

Commissioner Sandy Praeger
Chairperson, Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

Re: Rate Filing Disclosure Form

Dear Commissioner Praeger:

On behalf of the American Academy of Actuaries' Premium Review Work Group, I would like to resubmit the comments expressed in the work group's July 14 letter to the National Association of Insurance Commissioners' (NAIC) Speed to Market (EX) Task Force. Based on a review of the revised disclosure form, we believe there are several significant issues that could lead to misunderstandings by insurers and individuals.

Section 1—Part B
Parts B5 and B6 in the revised disclosure form refer to the minimum and maximum rate increases for any individual. Instructions contained in the disclosure form read: "*The 'Minimum/Maximum Rate Increase for any Individual' is to capture the minimum/maximum premium increase for any individual within this block of business*." This instruction is not specific enough because it does not address the following questions:

- If an individual changes his or her benefit option, should this be included in the minimum/maximum? An insurer may not know of this in advance of the bill being mailed to the insured.
- How should a move to a different geographic location be handled?
- How should the aging of the individual be treated?
- What does the term "any individual" mean—a specific insured or the policyholder or employee?

In our original letter (Page 4), we recommended alternative language for the footnote: "*The minimum/maximum rate increase for any individual represents the range of increases consistent with proposed changes in the rate table/manual*." We also would suggest that the term "any individual" be defined as "any policyholder" throughout the form. This alternative instruction would address the questions listed above.

Section 1—Part C
Part C requires information on the components of the average rate increase (decrease). In our original letter (Pages 5 and 6), we listed nine points requiring interpretations or explanations of various rate increase components to complete the form. We recognize a change was made in the revised form—the first two components in the original form were combined and are now presented simply as "medical utilization changes." None of the remaining issues we identified in those points, however, have been addressed adequately in the revised disclosure form and its

instructions. The work group would like to offer our assistance in any further work to clarify the instructions with respect to data to be included in the final form.

Section 3
Section 3 contains significantly more information than is currently required in most rate filings in the majority of states. We believe that some of this information could be considered proprietary by companies and consulting actuaries. In addition, the usefulness of such information at the policy form level is unclear for smaller companies. This section was not presented formally to the NAIC's Actuarial Work Group. Given the actuarial nature of the information contained in this section, we would be pleased to work with the NAIC to determine the appropriate level of information that should be included.

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These comments are intended to provide additional specificity to the instructions for this form and to mitigate the potential for significant variation in insurers' interpretation. As noted, the Academy is willing to assist the NAIC with the potential interpretations of the various components included in this form, to better encourage consistency among insurers.

We would encourage you to review our original comments (attached) on the disclosure form for a more detailed discussion of these and other concerns. If you have any questions, please contact Heather Jerbi, the Academy's senior health policy analyst, at 202.785.7869 or Jerbi@actuary.org.

Sincerely,

Michael S. Abroe, MAAA, FSA
Chairperson, Premium Review Work Group
American Academy of Actuaries

Enclosure

AMERICAN ACADEMY *of* ACTUARIES

July 14, 2010

To: Theresa D. Miller
Chair, Speed to Market (EX) Task Force
National Association of Insurance Commissioners

Sandy Praeger
Chair, Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

From: Mike Abroe
Chair, Premium Review Work Group
American Academy of Actuaries

Re: Draft Rate-Filing Disclosure Form

The American Academy of Actuaries' [1] Premium Review Work Group has reviewed the NAIC's exposure draft Rate-Filing Disclosure Form, which is intended to facilitate the reporting of unreasonable rate increases to the Department of Health and Human Services as required by the Sec. 2794 of the *Public Health Service Act* (PHSA) that was created by *Patient Protection and Affordable Care Act* (PPACA). We appreciate the opportunity to provide the following general and section-specific questions and comments. We also offer our assistance in developing separate forms for individual, small-group and large-group rate increases consistent with our comments below.

General Comments
At this point, the test for "unreasonable" rate increases under Sec. 2794 has not been developed. As drafted, the form requires significant information, but it is unclear what information is appropriate after a rate increase has been approved by the state and meets the state's definition of an "unreasonable" rate increase.

It should be noted that rate increases apply to existing rate tables and do not necessarily reflect effective rate increases on a policy-by-policy, individual, or group basis. Thus, changes in covered lives, rate bands, or other demographic changes would not be reflected in the "unreasonable" rate increase.

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

It is our understanding that the form is to be used for increases that are scheduled to be implemented and have been deemed as "unreasonable." If prior approval is required, this form should be submitted and disclosed on the company website after approval has been secured. As such, terms and phrases like "proposed," "rate request," and "if…approved" would need to be removed from the form and summary document.

The form does not require any information concerning credibility, although some information may be inferred based on the number of enrollees. Smaller volume business is subject to more volatility and such volatility may result in rate increases that are consistent with the state experience yet are deemed unreasonable, depending on the criteria ultimately used.

We also recommend that the final product from the NAIC be more than just the summary document. It should include instructions for preparers of the form as well as examples and definitions to help users interpret the form appropriately. The form may also need some further wording to explain what information each section is intended (and not intended) to convey to the public.

Part A: Issuer Information and Type of Plan

We recommend the creation of separate forms for the individual, small-group, and large-group markets. While the draft rate-filing disclosure form is intended for use in the individual, small-group, and large-group markets, its design is more relevant to the individual market. As such, it would require adjustments for application to small and large groups. For example, many states do not currently require filings for small-group rates except for an annual certification that the rates comply with existing small-employer rate requirements (if present in that state). In addition, almost no states require filings for ERISA large-group business.

Part B: Rate Request

Following is the current draft (6/11/2010) version of Part B of the form.

1. Proposed Effective Date	
2. Number of Enrollees Impacted in this State	
3. Number of Lives Covered Under this Plan Nationwide	
4. Proposed Average Rate Increase/Decrease* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	% Increase/decrease from PMPM to PMPM
5. Minimum Rate Increase/Decrease for any Individual* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	% Increase/decrease from PMPM to

	PMPM
6. Maximum Rate Increase/Decrease for any Individual* [show as % and Average Per Member Per Month (PMPM) increase/decrease from one year earlier]	%
	Increase/decrease from PMPM to PMPM

***The average rate does not mean that the premium will increase/decrease by this amount. Premiums are affected by many factors, including ages of the people covered, whether family members are covered and the date the policy renews. The "Minimum/Maximum Rate Increase for any Individual" is to capture the minimum/maximum premium increase for any individual within this block of business.*

Premium rates for an insured can increase or decrease for many reasons, a number of which are part of general rating characteristics in a rate table/manual (e.g., age and family status) and beyond the scope of a rate filing. The following outlines reasons for these types of change:

- **Trend factors** and **durational factors** approved as part of the premium rate structure;
- **Attained-age increases** (typically annual for individual plans and quinquennial for group plans);
- **Family status changes** such as adding or removing a spouse or a dependent child;
- Changes in **covered benefits** (usually at the request of the individual but some benefits added involuntarily may have a premium associated);
- Change in residence or **area;**
- **Modes of payment**—quarterly premium rates will be approximately three times monthly premium rates;
- **Change in risk class** (e.g., changing from non-smoker to smoker)—renewing and being re-underwritten to a higher or lower rate class.

The following outlines illustrative examples of rate-table/manual changes that could be included as part of a rate filing:

- Rate-table changes for experience and anticipated trend,
- Changes to area factors in the rate manual,
- Changes in the attained age slope (e.g., 4 percent per year to 3 percent per year), and
- Changes in rate relativities for different benefit plans (i.e., a $1,000 deductible plan was 10 percent lower than a $500 deductible plan, but now is 15 percent lower).

We believe it is important to distinguish between premium rate changes that are part of the normal course of business (e.g., individuals moving, adding dependent children, etc.) and those that are related to the proposed rate increase. However, we also appreciate the desire to understand the potential magnitude of rate changes when known course-of-business changes occur concurrently with additional rate changes. To account for these concurrent changes, one option for defining current and proposed rates to be used in the calculation of the minimum and maximum rate change for any one insured is as follows:

- The **current rate** (i.e., the denominator) is the rate charged as of the last premium bill and is based on the insured's benefit plan option and demographics as of the bill's premium effective date.

- The **proposed rate** (i.e., the numerator) is the rate to be charged to the insured at the time the filed rate increase is implemented. Depending on the carrier's billing cycles, this timing could vary (e.g., the next bill due date after approval, a group's renewal date, or the next policy anniversary).

- The proposed rate would be based on the same plan and demographics as the current rate. However, any additional premium change resulting from a rating characteristic change that is known to occur as of the proposed implementation date also would be included. This could include attained-age increases; durational increases; changes due to demographic mix since the last renewal (for composite rated groups); and changes that would be unknown at the time of the calculation (and therefore not included) such as elected benefit changes, geographic area changes, and changes in family status.

With that said, we note that depending on the carrier's billing cycle and anticipated rate-increase implementation date, the results of the information provided in Part B may vary by company. This would result in less comparative value of the information provided in Part B. Attachment A provides illustrative examples of this concept. For this reason, we recommend that the committee consider limiting the information to be provided in the form to specifically address the proposed changes in the rate table/manual. Changes that occur independent of the proposed table change could be addressed separately as part of educational materials on rate changes in the normal course of business that may apply. This recommendation would allow a more consistent measure of information across carriers.

The following is our recommended rewording of the footnote to the table consistent with our recommendations:

Premium rates for an individual insured can increase or decrease for many reasons, many of which are part of general rating characteristics in an existing rate table/manual (e.g., age, family status, etc.) and beyond the scope of a filing. The minimum/maximum rate increase for any individual represents the range of increases consistent with proposed changes in the rate table/manual.

A rate increase to a given "individual" in a group should reflect the total premium charged for a group member, as opposed to the employee portion of the premium. To the extent that an employer changes its premium contributions, this will be felt as a rate change to an individual, but is independent of the scope of changes made by an insurer.

Another recommendation is for Part B to provide only percentage comparisons as the inclusion of per member per month (PMPM) changes may result in inappropriate comparisons. The following offers a couple of hypothetical examples under which the PMPM comparison does not appropriately illustrate the impact of the rate increase:

- The largest percentage change is not always the largest PMPM change (e.g., a younger insured has a 20 percent rate increase on a $100 premium, resulting in a $20 change, while an older insured has a 5 percent increase in premium on a $500 premium, which is a $25 change). The illustration of percentages only provides a consistent basis for comparison.

- If a carrier has rates that differ monthly by trend, a group with a rate effective date of March 2011 would have a base rate that differs by one month from that for a group with a rate effective date of February 2011. If a carrier implements a 10 percent increase, each group gets a 10 percent increase, but the PMPM dollar amounts would not be the same. Again, the illustration of percentages provides a consistent measure of relative value.

Part C: Components of the Average Rate Increase/Decrease and Basis for Rate Request

Following is the current (6/11/2010) version of Part C of the form.

> Break down the "Proposed Average Rate Increase/Decrease" into the following components of rate changes (in percentage):
>
> | | |
> |---|---|
> | 1. Medical** Utilization Change - Population | % |
> | 2. Medical** Utilization Change - Other | % |
> | 3. Medical** Price Changes | % |
> | 4. Medical** Benefit Changes Required by Law | % |
> | 5. Medical** Benefit Changes Not Required by Law | % |
> | 6. Changes to Administration Costs | % |
> | 7. Insufficiency of Prior Rates (continuing losses that need to be covered by additional rate – not a recovery of previous losses, but a projection of continued shortfall from target) | % |
> | 8. Other Reasons for the Rate Request | % |
> | 9. Provide a Simple Calculation of how the Average Rate Increase/Decrease is derived based on the above components of rate changes | |
>
> ***Medical includes Prescription Drug*

Our concerns about this part are numerous. Following are our specific comments:

- It should be made clear this part refers to the increases being applied to the current rate tables, and will not necessarily reflect the actual increase any policyholder may receive.

- The breakdown of the rate increase in Section C is detailed and somewhat arbitrary. Many factors go into determining a rate increase that overlaps these categories. For example, if a

benefit change (Line 5) was intended to modify utilization, is it only a benefit change, is it utilization, or both? Alternatively, if general utilization increases by more than anticipated in the last filing, does that go to insufficiency in prior rates or is that general utilization trend? Conversely, a plan with small enrollment may experience actual utilization less than expected. Is this a negative insufficiency to be reported in Line 7?

- Given that a policy form may have many benefit variations (levels of network participation, relative proportions of hospital versus medical versus drug benefits), and cost-sharing variations (co-pays, deductibles, etc.), it is unlikely that the components of "trend" for Lines 1 through 3 will break down into easily prepared numbers for the proposed report. In most situations, the amount of data will only be sufficient for broad "trend" development. Most likely the aggregate trend would be developed and two of the three lines would be estimates. The third line would become a balancing line.

- Unless the increase is on a plan with a very large enrollment, credibility will be an issue.

- The "other" category (Line 8) is likely to be the result of the interaction of numerous factors. One alternative would be to allow for free form lines whereby the insurer can better select from a predetermined list what applies for the specified unreasonable rate increase.

- The work group believes that it will be important to have clear instructions so that the trend values reported from one company to another can be consistent and that differences are the result of different assumptions and not because of the placement of various aspects of a rate increase into the reported components. We offer our assistance to the NAIC in developing instructions to accomplish this.

- For individual and small-group business, often rate increases are intended to maintain business at minimum loss ratio standards and any expense loadings or margins for contingencies or profits are considered balancing items. For many companies, the administrative-expense assumptions will not be state-specific—unlike medical-cost information, administrative-expense information often is captured only very broadly.

- Large-group rates are commonly associated with custom benefits, and a rating formula capable of building up claims costs for a wide variety of plan designs is common. Other parts of the formula provide for administrative expenses and margins. As such, there is not a simple premium rate manual for large group. In addition, aggregate claims experience figures prominently in large-group rates and is frequently the exclusive basis on which future premiums are determined. The work group recommends, for large-group business, the form be abbreviated for this segment so that it includes only the trend element.

- Item 9 will not balance to any actual increase a policyholder may receive, other than by coincidence. Aging or demographic changes are not reflected in this part. This needs to be clear so the information provided is not misused or the reader misinformed.

Part D: Earned Premiums, Incurred Claims, and Profit/Loss for the 12-Month Period from this State and Nationwide

It appears that Part D of the disclosure form incorporates some aspects of medical loss ratio reporting. These elements are not applicable on a policy-form basis. In addition, at the policy-form level, credibility would likely be an issue.

We recommend that values in this section be on a state basis, consistent with current filing requirements. Policy forms are not always used across state lines. As such, nationwide values would not be meaningful to present on this form. We do understand that the materials used by the regulators in evaluating rate increase requests may need national information, as well as state experience. This does not mean the insurance company has unreasonable rate increases in every state, nor is it necessarily filing rate increases in every state at the same time. These comments also apply to Sections E and F.

Part E: Projected Results of the Proposed Rates

At a policy-form level, this section is meaningless. The change in the proportion of the rates arising from each component should result from the comparison of the expected proportions in the proposed rates with the percentages assumed in the current rates at the time they were set, not the proportions derived from experience reported in Part D. It seems that the goal is to illuminate large swings in rating assumptions and require them to be explained. This should be part of the rate review before it is implemented. Such explanations will not fit easily into a prescribed form.

Part F: Average Annual Rate Increases Implemented in the Past Three Calendar Years

While several years of historical information may add some insight, we question how this information by itself would be useful when the form applies only to "unreasonable" rate increases. Would it be useful to show the initial filed request and the actual rate increase implemented over these three years? In those situations in which actual rate increases in prior years were not equal to what was initially requested, this may lead to a better understanding of a larger rate increase in a single year.

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We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Attachment A
Illustrative Example of Minimum/Maximum Rate Changes

Small Group Information from Last Bill (07/01/10)

Employee 1—single, age 25, premium $100 PMPM
Employee 2—family, age 39, premium $470 PMPM
Employee 3—couple, age 30, premium $206 PMPM

Renewal date is Jan. 1, 2011

Company ABC Rate Manual Information

- Small groups are not experience rated, and rates are based on the small group rate manual. Groups with less than 15 lives are rated individually (not composite).
- Proposed rate manual changes are typically implemented at a group's renewal, but under certain circumstances changes are implemented on the next bill due date.
- Attained age increases are also implemented at a group's renewal (5-year age bands reflective of 3 percent aging per year).
- Company ABC is proposing a 10 percent flat increase to all rates in the rate manual.

Scenario #1: Rate increase is effective at the group's renewal, 01/01/11, based on plan information as of 7/1/10

- All persons get a 10 percent increase for the renewal
- Employee 2 turns age 40, so receives an additional increase of 15.9 percent
- Minimum increase—10 percent
- Maximum increase—1.10 * 1.159 - 1 = 27.5 percent

Scenario #2: Rate increase is effective at the group's renewal, 01/01/11. ABC was notified on Nov. 15, 2010 that effective Jan. 1, 2011, Employee 1 will change to family coverage.

- All persons get a 10 percent increase for the renewal
- Employee 2 turns age 40, so receives an additional increase of 15.9 percent
- Employee 1 changes to family coverage. Family rates are 3.5 times the single rate (250 percent). The total rate increase for Employee 1 is 285 percent (1.10 * 2.50 – 1).
- The family status change was unknown at the time, therefore was not included in the rate disclosure form.
- Minimum increase—10.0 percent
- Maximum increase—27.5 percent

Scenario #3: Rate increase is effective on the next bill due date, which is 10/01/10.

- All persons get a 10 percent increase for the renewal
- Employee 2 turns age 40 during the plan year, but will not receive the increase until the group's renewal, so the rate increase is 10 percent.
- Minimum increase—10.0 percent
- Maximum increase—10.0 percent