AMERICAN ACADEMY *of* ACTUARIES

Feb. 22, 2011

Center for Consumer Information and Insurance Oversight (CCIIO)
Department of Health and Human Services
Attention: OCIIO-9999-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Rate Increase Disclosure and Review Proposed Regulations

To Whom It May Concern:

The American Academy of Actuaries'[1] Premium Review Work Group appreciates the opportunity to provide comments to the Department of Health and Human Services (HHS) on the proposed regulations implementing Section 2794 of the Public Health Service Act as enacted by the Affordable Care Act (ACA) regarding the disclosure and review of "unreasonable" premium increases. This letter includes responses to your solicitation of comments on specific provisions, as well as general comments and our requests for clarification on aspects of the regulation.

In addition to the specific, more technical comments included in this letter, the work group offers the following general comments:

- As a result of concentrating only on "unreasonable" rate increases, HHS appropriately leaves a significant portion of other state rate regulation to the states. State regulations are intended not only to protect the consumer from excessive rates, but also to protect the consumer by imposing capital requirements, which maintains the insurer's ongoing financial viability. We trust this would not result in dual reviews of rate increases or delay the approval process for reasonable rate increases.
- Actuaries working on behalf of insurers are familiar with each state's rate filing requirements. This includes when to use national data in cases in which the state's data standing alone are not credible, implications of the results of prior rate changes, and the coordination of rate requests for certain policy forms in comparison to rate changes for other somewhat similar policy forms. While approaches to addressing these issues may vary from state to state, due to unique circumstances within each state, the transition from state review to HHS review could create disruption when moving from a variety of approaches to one approach. HHS should consider the implications of such a change in the manner of review.

For ease of review, our comments are organized by section of the proposed regulations as published in the Federal Register on Dec. 23, 2010.

[1] The American Academy of Actuaries ("Academy") 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.

II. Provisions of the Rule

A. Introduction and Overview

Is 10 percent a reasonable threshold to apply in determining which rate increases will be subject to review (Page 81006)?

Regardless of the chosen percentage, a specific numerical benchmark will facilitate understanding and administration. The 10 percent threshold, however, might be in place only for a period of six months or less in 2011, at which point the proposed regulations anticipate state-specific thresholds to be developed. Given the higher rate increases in the individual market compared to the small group market, we suggest having market segment-specific thresholds (higher in the individual market than small group market) in addition to the state-specific thresholds.

In the future, if rate increases in the large group market were subject to a review process under Section 2794, should that process differ from the process provided in the proposed regulation for the individual and small group markets (Page 81006)?

We believe rate increases in the large group market should not be subject to rate review.[2] Furthermore, the proposed process for the individual and small group markets would not be appropriate for the large group market. Few states currently review large group rate increases.

Are there alternative approaches that HHS should consider in lieu of deferring to the definitions of individual, small group and large group markets employed in state rate filings (Page 81007)?

HHS should defer to the state definitions of individual, small group, and large group markets rather than implementing an alternative approach because it would be less disruptive and less likely to increase approval timelines.

We believe Code of Federal Regulations (CFR) Section 154 will significantly affect current state regulatory review practices—especially for the small group market because currently there is no state review in most states. Rate reviews will involve the review of actuarial assumptions for future periods. This will involve both the actuary for the company and the actuary for the state; the public review could necessitate additional actuarial resources.

Should the public's ability to comment on unreasonable rate increases during the review process be considered as one criterion for an effective rate review program (Page 81007)?

The primary goal of a premium review process is to ensure a full and effective actuarial review of the reasonableness of proposed premium rate increases. If public comments or hearings are encouraged, a process should be developed to ensure that comments are considered in an expeditious manner; otherwise, delays could occur.

[2] The appropriateness for excluding large groups is explained in the Academy's Oct. 29 letter to HHS on potential methods for defining unreasonable rate increases (see page 7): http://www.actuary.org/issues/pdf/AAA%20on%20premium%20increases%20102910%20final.pdf.

B. Definitions

What factors, other than those addressed in the proposed regulation, may be viewed as affecting the reasonableness of a rate and should be considered in determining whether a rate increase is unreasonable (Page 81009)?

CFR Section 154 contains many of the standard industry factors that are considered in rate review programs. There are also other pertinent factors that can affect the rate schedule and the reasonableness of the resulting increase from the existing rate schedule. Some of these are broad, environmental factors that affect many, if not all, health insurance issuers; others are state, issuer, and product specific. Some of these factors have been addressed in CFR Section 158, *Health insurance issuers implementing medical loss ratio requirements (MLR) under the Patient Protection and Affordable Care Act.* The following factors may be considered when reviewing an issuer's premium rate increase.

Environmental factors

Cost shifting: If Medicare and Medicaid provider reimbursement levels increase at a slower rate than medical CPI, or even stay flat or decrease, some providers may need to make up the difference in these lower reimbursements by charging the commercial plans (as regulated under CFR Section 154) a higher rate. This cost shifting could result in increased claims trend producing health insurance rate increases higher than expected. This has been experienced in the past, and has been included in historical rate increases.

Provider negotiation leverage: In some locations the providers have stronger negotiating leverage than the issuers. The provider may be the only one in the area; it may have formed specialty groups to which all patients requiring that specialty care in an area would go. In these situations, the providers could decide not to contract with a particular issuer or all issuers, potentially leaving members covered by those issuers without access to needed care. As providers have more control of the reimbursement level for services, the level of premium rate increases in an area could be affected.

State-specific laws affecting reimbursement levels: Laws exists in some states that may limit the discounts for reimbursement levels providers and insurers can negotiate. There may be a specific minimum percentage of billed charge levels that is affected by what the providers charge overall. A change to existing law, such as disallowing "most favored nation" clauses in provider contracts with issuers, could result in a particular issuer's reimbursement levels changing more than expected. These factors, which might be outside the control of the issuer, could result in varied levels of premium rate increases.

Economic impacts: As the economy changes, there are factors that affect the demand for health care services, particularly in the group insurance business. For example, during the early stages of a downturn, as employees face the potential for layoffs, utilization might increase as members of employer-provided plans seek to obtain health care services before they lose their jobs and coverage. Layoffs may result in a higher probability that high-risk employees will request COBRA coverage. COBRA coverage tends to have higher utilization patterns than plans for employed individuals. This creates higher claim costs for the group plan, which has the potential of expediting premium level increases.

Underwriting cycle: Competition and shifting demand can affect the underwriting cycle. After margins in the rates are driven competitively downward and become smaller or negative, issuers may need to adjust their premium rates to a higher level to cover future expected costs more adequately.

Health Insurance Issuer Factors

Membership (life years in CFR Section 158): The credibility of an issuer's product line may be too low if its membership, or covered life years, is low. Adjustments are considered under CFR Section 158 for calculating the medical loss ratio. While different, adjustments for credibility in premium-rate calculations also should be considered under CFR Section 154. Credibility, as defined in CFR Section 158, is only for claim fluctuation. But, there are other uncertainties within a rate schedule that vary by size of the block (e.g., smaller blocks may use a national medical trend value while larger blocks may be able to determine an area-specific medical trend). We would be happy to discuss this issue with HHS in more detail.

Start-ups: During a new health insurance company's first few years, appropriate levels of risk-based capital and amortization of start-up costs may need to be considered.

Payer of last resort (until 2014): In some states, there are health insurance issuers that also are identified as "payers of last resort." The membership and claims experience of these issuers may not be controllable by the payer. Their experience, therefore, should be considered when determining whether a proposed rate increase is reasonable.

Changes to administrative costs that improve health care quality: Many quality improvement efforts take time to reflect positive results, such as decreased costs, unnecessary claim payments, higher patient satisfaction, and higher quality of care. Initial investments, therefore, can be expected to increase costs.

Pilots for new provider delivery practices and reimbursement strategies: ACA includes pilots to encourage development of accountable care organizations (ACOs) and patient-centered medical homes. To support these types of programs, additional investment in health care technology or other process improvement investments can be necessary. In some cases, issuers may provide additional payments for these programs. In other cases, providers may negotiate for higher reimbursement levels to cover these costs.

Product Factors

Deductible leveraging factors: High-deductible products require higher rate increases to cover both greater variability in claims experience (as noted in CFR Section 158) and deductible leveraging due to the deductible portion of the claims remaining fixed. Depending on the mix of products sold in a market or particular to an issuer, the resulting rate increase could be higher than for issuers with lower deductible levels. The effect of the deductible leveraging, therefore, should be considered in reviewing proposed rate increases.

State or Federal Factors

Changes via legislation causing increases in cost: Changes in state or federal laws often can increase the cost of health insurance coverage faster than the trend would suggest. New reporting requirements that add to administrative costs, coverage of newly mandated benefits, increases in taxes or other fees, costs to implement ICD-10 or other mandated technology changes, are all examples of potential additional costs that could affect premium levels.

D. Rate Increases Subject to Review (Section 154.200)

CFR Section 154.200 applies to rate increases *filed* in a state on or after July 1, 2011, if the state requires rate increases to be filed. If states do not require rate increases to be filed, then CFR Section 154.200 applies to rate increases *effective* on or after July 1, 2011. The definition of "effective" is unclear. We believe the effective date is best determined based on the insurer's new rate table.

According to the discussion in CFR Section 154.200 (Page 81009), HHS states, "As explained previously, while section 2794 of the PHS Act directs the Secretary 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." We interpret this to mean new changes in underlying rates (i.e., rate tables as filed on or after July 1, 2011).

There are several implications stemming from this interpretation: first, it stands independent of state regulations; second, built-in durational or inflationary adjustments to a rate do not imply a change in rates. It is unclear how long such durational or inflationary adjustments can continue without being considered a change in the rate schedule.

Insurers often implement rates for new business and renewals for a 12-month period commencing on or after a specified date. It is likely this 12-month period will surround July 1, 2011. In situations in which an insurer does not need to file rates, an internally designated effective date would be comparable to a state-approved date. Consistent with the HHS language referenced, we believe CFR Section 154.200 applies only to changes in rates on or after July 1, 2011.

As stated on Page 81011, the average rate increase is calculated based on the "weighted average increases for all enrollees subject to the rate increase." The weighted average is determined by using the enrollees for each subcategory as weights. It is unclear what elements of an "increase" are included in the calculation of the weighted average proposed rate increase as stated in the proposed rule. The proposed rule does not use "new revenue divided by old revenue." Rather, it looks only at the rate increase percentage and weights it by rating subcategory.

We suggest the average rate increase be calculated differently. The rate increase should be equal to new revenue divided by old revenue minus 1.0. Old revenue refers to the sum of all current premiums for each insured person affected by a rate increase filing; new revenue refers to the sum of all new premiums over the same population.

We recommend that the composite rate increase be determined by calculating the percentage increase in revenues resulting from the proposed rate increase (or cumulative 12-month increase when appropriate) on an aggregate basis, all segments combined. The enrollment population included in the rate filing should be used in calculating revenues before and after the rate increase. The definition of "rate increase" in CFR Section 154.103 should be revised accordingly, as well as the discussion in the preamble.

E. Review of Rate Increases Subject to Review by a State or by HHS (Section 154.210)

We have several questions related to the determination of states meeting the requirements for an effective rate review process. Those are presented in more detail in our comments on CFR Section 154.301.

There should be clear timeframes as part of the entire review process. Delays in reviewing and processing rate increase requests could delay implementation; even while medical trend continues. As a result, a delay in a rate increase may result in the next request for increase being adjusted for the period of the delay. Some states have "deemer clauses" so that the review process can adjust to a high or low volume of rate increase requests (or rates for new policy forms). There typically is a review that focuses on the completeness of the filing, as well as the assumptions behind the rate increase request. If these are consistent with other rate filings, the review may not need to address all items in the requirements for an effective rate review process. In cases in which there are issues or questions, states request further information or even may suggest a modification to some assumptions that change the amount of the rate increase.

F. Effective Rate Review Program (Section 154.301)

For purposes of our analysis, we have made the assumption that insurers would follow state rate review regulations whether or not HHS determines that the state has an effective rate review process.

We view the HHS criteria set forth in (a) as a set of elements of a state's rate review process; but we anticipate the state would exercise judgment and rely on experience when applying such elements of the process. We also assume that an actuary preparing a filing for an established insurer would have different rating and documentation issues compared to an actuary preparing a rate filing for a start-up company. All of the HHS rating criteria should not be expected to apply to every rate increase—for example, an insurer with substantial data history may not have the data available for each criterion, while a start-up operation would have no history.

There are many additional elements of a state's rate review process not identified in the proposed regulations that also should be considered:

- *Premiums rely on projections.* Health insurance premiums are a product of assumptions, estimates and projections and are not necessarily calculated on fully credible data.
- *Interaction between actuaries.* State actuaries work with insurer pricing actuaries to arrive at a mutually agreed set of appropriate actuarial assumptions and resulting rates and rate increases. Without this type of interaction, the implementation of the increase could be delayed.
- *A timely and prudent review process*. A lengthy process delays implementation and could result in additional trend make-up at the next rate increase. The number of insurers and start-up operations in a state can place an undue burden on state actuaries. Some states may need additional staff/consultants to handle the rate review process.
- *Identifying inadequate rates*. An insurer may set aggressive rates to build market share. This could result in higher rate increases, especially for start-up operations. States often track rates and rate increases for comparative purposes.

We also have a number of specific comments and questions that require clarification under this section:

- "Major service categories" needs to be defined.
- Trend and utilization by major service category is defined inconsistent with the NAIC Rate Filing Disclosure Form, which we anticipate will be the basis for the HHS Rate Filing Disclosure Form.
- When will HHS's evaluation of the states be completed? How often will the evaluation be updated (e.g., quarterly or annually)? The regulations should establish rules for handling rate increases that already have been filed with HHS but have not been finalized. Transition rules are needed to address rate increase requests at various stages of the rate review process.

H. Issuer Disclosure Required Under Part 154

HHS will post a disclaimer regarding the preliminary justifications for rate increases similar to "The preliminary justification is the initial summary information regarding the rate increase subject to review and does not represent a determination that the rate increase subject to review is an unreasonable rate increase." What specific language should the HHS use in this disclaimer?

Because the rate review process is based on rate increases as opposed to premium increases, the disclaimer statement included with the preliminary justification should state that premium rates may include factors that are not considered in the proposed or filed rate increase and that actual premium changes for any policyholder could be different. Inclusion of such language in the disclaimer hopefully would reduce the potential for confusion of policyholders should their premium increase differ from the rate increase disclosed in the preliminary justification.

We also recommend including a statement indicating that the rate increase included in the preliminary justification is subject to change during the review process. In some cases, multiple preliminary justifications may be required as rate increases are modified as a result of the review process. Including language with each preliminary justification should reduce consumer confusion in the event of multiple rate increases for any product.

The following is our suggested language for the disclaimer:

> "The preliminary justification is the initial summary information regarding the rate increase subject to review and does not represent a determination that the rate increase subject to review is an unreasonable rate increase. The proposed rate increase included in this preliminary justification is not final and may change as a result of the review process. The proposed rate increase does not include the effect of all rating factors; as a result, actual premium increases for a given policyholder could be higher or lower."

III. Collection of Information Requirements

B. ICRs Regarding the Rate Review Preliminary Justification Form (Section 154.215 and 154.220)

CFR Section 154.215

In the proposed regulations HHS requests comments regarding CFR Section 154, which includes descriptions of a preliminary justification form for rating filings, which has not yet been released (as of Feb. 22). In comparing the descriptions of the form with the NAIC Rate Filing Disclosure Form and NAIC Model Regulation 134, we have questions related to definitions, required time periods, redundancy between sections, and inconsistent terminology. When HHS releases the preliminary justification form, it should include detailed definitions and instructions to minimize confusion. We expect that there will be time allowed for public review and comment on the justification form when it is released.

We urge the following questions be considered regarding the description of the preliminary justification form included in CFR Section 154.215(e), (f) and (g):

- It is difficult to determine whether the information to be included in the final preliminary justification form will be in a form such that loss ratios can be calculated consistent with the

definitions of medical loss ratios in CFR Section 158, *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordability Act*. We request clarification on whether loss ratios reported on this form, as described in CFR Section 154(e)(6) and 154.215(g)(1)(vi), (vii) and (viii), should be calculated consistent with those reported for CFR Section 158.

- We recommend that the instructions clarify the periods for the reporting of various loss ratios. The federal MLR is a year-by-year determination, although rebate calculations may include averaging with recent experience. Cumulative, lifetime, and future loss ratios therefore are unlikely to be meaningful compared to the federal MLR. Historical loss ratios, consistent with the federal MLR for the prior two years would be needed for rebate calculations. A future period beyond one year should be considered only in two situations: in cases in which the insurer is offering multi-year rate guarantees, or in cases in which a state loss ratio requirement for individual coverage specifically is required for lifetime and/or future lifetime periods.
- CFR Section 154.215(i)(2)(ii) states that "HHS will make a determination as to whether to post information designated as 'confidential' under the standards and procedures set forth in 45 CFR 5.65 and will post that information only after making a determination that it is subject to disclosure as provided by 45 CFR 5.65."

CFR Section 154.220

There is a conflict in the summary description section and CFR Section 154.220(b) related to when an issuer must file the preliminary justification form in those situations in which a state does not require filing. Page 81015 of the summary description section states that "…issuers would have the option of completing the preliminary justification form at the time of implementation or prior to that time." But, CFR Section 154.220(b) states that, in these situations, the "…issuer must submit to HHS and the State justification prior to the implementation of the rate increase." These statements are in conflict with each other and need to be resolved.

C. ICRs Regarding State Determinations (Section 154.210 and 154.225)

CFR Section 154.225

Actuaries play a central role in developing a proposed rate increase for most health insurers. Members of the Academy, as well as other relevant actuarial organizations, require adherence to a strict Code of Professional Conduct and Actuarial Standards of Practice, and consequently should be designated to provide the actuarial assessment in the unreasonable rate review process.

In developing an overall premium rate proposal, the actuary may wish to consider the projected performance of the overall book of business which depends upon the historical claims experience as adjusted for any credibility assessment, changes in the underlying risk characteristics of the pool, projections for expenses, and the capital needs/financial strength of the company. Health insurance premiums are dependent on the credibility and/or limitations of the underlying data, experience differing from prior rating assumptions, and there is a range that exists as to possible future outcomes.

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

Sincerely,

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American Academy of Actuaries