



# AMERICAN ACADEMY *of* ACTUARIES

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Oct. 29, 2010

Steven B. Larsen  
Director, Office of Oversight  
Office of Consumer Information and Insurer Oversight  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Mr. Larsen:

Section 2794 of the Public Health Service Act (PHSA), added via the enactment of the Affordable Care Act (ACA), requires the secretary of Health and Human Services (HHS) to work with states to establish an annual review of unreasonable rate increases, to monitor premium increases, and to award grants to states to carry out their rate review process. As HHS considers how to implement this provision, the American Academy of Actuaries' Premium Review Work Group offers an evaluation of a few of the potential methods for defining or measuring "unreasonable" rate increases for your consideration.

Under ACA, the increase from a prior premium rate to a proposed premium rate will be compared to an applicable definition(s) of "unreasonable." If a rate increase meets the applicable definition of "unreasonable," the company must disclose and submit justification for the rate increase to the HHS secretary and the states in which the company operates prior to the implementation of the increase. A pattern of excessive or unreasonable rate increases can be used as a factor in determining a plan's eligibility for participation in an exchange marketplace.

Although "unreasonable" is the term used in ACA to identify a premium rate increase that requires justification and disclosure of information, it is important to recognize that such an increase could be appropriate. In particular, health insurance premiums needed to maintain the insuring entity's solvency could be appropriate. It is important to note that health insurance premiums would be subject to a required actuarial attestation that premiums are reasonable in relation to benefits provided.

## **Premium Development**

When actuaries develop premium rate structures, they typically do not start by calculating the premium increase itself. Instead, actuaries project claims and administrative expenses to determine the premium income required to cover these costs. Factors that are considered when determining an adequate premium rate structure include claim costs (which in turn reflect provider prices, utilization, and enrollee demographics and health status); administrative costs; and some combination of risk charge, contribution to surplus, and profit.

Private health insurance premium rate structures typically change annually due to anticipated changes in claims costs. Numerous factors affect how average claim costs for a particular plan and insurer might change from year to year; how those changes in claim costs are factored into a plan's premiums can vary from insurer to insurer. Factors currently affecting premium changes include not only those directly related to increased health spending—such as the per-unit cost of health services and increases in utilization—but also those specific to insured plans, including policy duration, changes in enrollment mix, the leveraging effect of the deductible, and correction of prior estimates.<sup>1</sup>

## **Current Rate-Filing Process**

Most states have processes in place to review and approve premium rate structures for some benefit plans, primarily in the individual market. For individual business, in states that review rate filings, most reviews are prospective in nature. Many states require approval prior to the insurer implementing the new rates. Other states have a process called “file and use” under which companies may file premium rate increases and implement them prior to the state's review of the increases.

Premium rate structures for fully insured employer group policies are subject to less review, ranging from complete prior approval (almost exclusively for small groups), some type of file and use (primarily small groups), or no filings at all (some small and almost all large groups). Many states require that an actuary employed (or contracted) by companies certify that small group premium rate structures comply with state law. Self-funded benefit plans meeting the criteria under ERISA are not subject to state insurance regulation. They set their own funding levels and have no “premiums,” per se.

## **What rate increase measure should be compared to the benchmark?**

Regulation should specify what premium increase measure is compared to the benchmark for determining whether an increase is “unreasonable.” The current state submission and approval processes focus on the premium rate structures used to determine premium rates charged to customers. For the individual market, the customer is the individual policyholder. For small and large group markets, however, the customer is the employer or group policyholder, as opposed to the individual employees. The premium increase comparison, therefore, should reflect total premiums, not the employee premium contributions. The changes in employee premium contributions typically are not correlated with the changes in total premiums and are determined by the employer, not the insurer.

The rate increase measure ideally would reflect changes in the premium rate structure charged to the consumer, and would control for any changes that are outside of the control of the insurer. For example, the increase measure should not include premium changes that result from adding or removing a dependent, moving to a different geographic location, or election of a different benefit design. (See Appendix 1 for more detail on the types of changes that are in the insurer's control and those that are outside of the insurer's control.)

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<sup>1</sup> For more information on the factors influencing premium growth, see the Academy's paper *Critical Issues in Health Reform: Premium Setting in the Individual Market*, available at: [http://www.actuary.org/pdf/health/premiums\\_mar10.pdf](http://www.actuary.org/pdf/health/premiums_mar10.pdf).

An appropriate method of reflecting the rate increase would be to apply the new and old premium rate structures to a plan's insured population as of a certain date. For plans in the individual market, this would be a straightforward application of the old and new premium rate structures. For plans in the group market, this would entail applying the base rate along with any applicable rate factors, such as those that reflect demographics and health status (note that even if the factors change between the old and the new rates, they would apply to the same population).

Such comparisons typically are designed to exclude the impact of the population aging. An additional comparison, however, could be done to include the impact of aging one year. Even if population aging is incorporated, it is important to recognize that the average rate increase measures would not necessarily reflect the increase applicable to any particular individual or employer. Rate increases applicable to any particular individual or group also would incorporate changes based on actions of the individuals and employers. As a result, an insurer's consumer-directed communication materials focusing on the premium increase threshold and premium increase breakdowns would need to highlight that their particular premium increase may differ from that used in the comparison.

How the benchmark is applied will need to vary by whether rate approval is required in the state. When rate approval is required in a state, the "unreasonable" rate increase benchmark should be applied to the rates approved by the state, not to any preliminary rate filings. It should be the responsibility of the insuring entity to identify an "unreasonable" rate increase according to the HHS benchmark and in advance of implementing such a rate increase. Actuarial memoranda submitted to the state approval authority for adjustments to currently approved rating tables typically would include a calculation of the resulting composite rate increase as well as a history of prior rate increases and dates.

When rate approval is not required in a state, it may be appropriate to determine the rate increase that is compared to the "unreasonable" rate increase benchmark, and prepare and maintain internal work papers and documentation used to support such determination. The Actuarial Standards of Practice, particularly ASOP 41, applicable through the Code of Professional Conduct generally require actuaries to cause to be maintained documentation and other work papers supporting their actuarial communication, such as an actuarial rate change memorandum which is used when rate increases are filed with state regulators. For large group rate increases, the underwriter and/or actuary responsible for the rate development would similarly need to prepare and cause to be maintained appropriate documentation and work papers supporting the final rates and rate action.

## **Potential Options for Defining the "Unreasonable" Rate Threshold**

To evaluate the various options for defining or measuring "unreasonable" rate increases, the work group developed the following set of criteria:

- Is the approach feasible? (e.g., Can it be self-reported by the carrier? Can it be measured easily? Can it be used and understood easily by regulators?)
- Does the approach make sense from an actuarial/empirical perspective? (e.g., does it reflect changes in health spending and other factors influencing premiums?)

- Does the approach make sense from a policy perspective? (e.g., is it understandable by consumers?)

In its May 12, 2010, letter to HHS, the National Association of Insurance Commissioners (NAIC) put forward several options for defining a potentially unreasonable increase:<sup>2</sup>

- The actuarial reasons and data provided are incorrect or incomplete;
- The average increase is higher than X percent for a one-year period;
- The largest increase for any individual is higher than X percent for a one-year period;
- The average increase is higher than the medical CPI plus X percent for a one-year period;
- The average increase is higher than the average of other rate increases in the market plus X percent;
- It is likely to result in a loss ratio below the 80 percent or 85 percent medical loss ratio (MLR) requirements;
- It does not appropriately reflect benefit changes;
- The resulting rates are unprofitable “loss leaders” for the company and might force other carriers out of the market, followed by large rate increases;
- The rates include provision for excessive administrative expenses or profit;
- The rates include provision for unreasonable or wasteful administrative expenses;
- It results in significant part from egregious conduct by the insurer, such as providing false information in prior rate filings, failing to provide required annual filings, or purposefully charging inadequate rates.

Although each of these measures may be considered by the regulator when reviewing a rate increase, many do not meet our evaluation criteria. In particular, many of these are not self-reported or easily measured. Therefore, we focus on the four approaches that meet our criteria:

- Approach 1: The average increase is higher than X percent for a one-year period;
- Approach 2: The largest increase for any individual is higher than X percent for a one-year period;
- Approach 3: The average increase is higher than the medical CPI plus X percent for a one-year period;
- Approach 4: It is likely to result in a loss ratio below the 80 percent or 85 percent MLR requirements.<sup>3</sup>

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<sup>2</sup> See NAIC response to the HHS request for comments regarding Section 2794 of the Public Health Service Act (May 12, 2010): [http://www.naic.org/documents/committees\\_e\\_hrsi\\_hhs\\_response\\_rr\\_adopted.pdf](http://www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf)

<sup>3</sup> Thresholds for particular carriers may differ due to credibility adjustments and/or other adjustments.

Approaches 1 through 3 would compare a rate increase measure to a threshold. Setting the value for “X” in these approaches would require considering its impact on the share of rate increases that would be classified as “unreasonable” and therefore need additional justification. A lower value for “X” would result in relatively more rate increases being classified as “unreasonable;” a higher value would result in relatively fewer. Having too few or too many rate increases classified as “unreasonable” would limit the effectiveness of the benchmark. In contrast to approaches 1 through 3, approach 4 would assess whether rate increases are unreasonable by using information on MLRs. This approach would be more consistent with how states typically assess the appropriateness of insurer rate filings. It should be noted that, primarily for the individual market, there are two major differences between the MLR regulation and current rate filings: the level of aggregation and the time period measured.

Table 1 examines the four approaches according to our evaluation criteria.

Approach	Is the approach feasible? Can it be self-reported, measured easily, and used/ by regulators?	Does the approach make sense from an actuarial/empirical perspective?	Does the approach make sense from a policy perspective? Can it be understood by consumers?
<p><b>Approach 1:</b> Average increase is greater than X percent for one-year period</p>	<p>Could be easily measured (based on lives covered as of a certain date) and self-reported by plans, and easily used and understood by regulators.</p>	<p>The threshold is unlikely to reflect the factors associated with premium increases, including health spending growth. Even if the threshold is set based on a historical average of annual premium growth, the threshold may not reflect premium growth factors for any given year.</p>	<p>Could be understood by consumers.</p> <p>Rate increase measure will not reflect the actual increase faced by any particular consumer.</p>
<p><b>Approach 2:</b> Largest increase is greater than X percent for one-year period</p>	<p>Could be easily measured (based on lives covered as of a certain date) and self-reported by plans, and easily used and understood by regulators.</p>	<p>Similar concerns as Approach 1.</p>	<p>Could be understood by consumers. Could cause confusion if actual increase exceeds the largest increase due to aging one year or changes in small group demographics.</p> <p>Rate increase measure will not reflect the actual increase faced by any particular consumer.</p>
<p><b>Approach 3:</b> Average increase is greater than medical CPI plus X percent for one-year period</p>	<p>Could be easily measured (based on lives covered as of a certain date) and self-reported by plans, and easily used and understood by regulators.</p>	<p>Basing the threshold on medical CPI could help align the threshold with increases in premiums due to the increase in medical prices, and to some extent for other factors increasing health spending growth, depending on how X is set. Medical CPI is retrospective rather than prospective, however, and does not fully reflect expected future price changes due to utilization mix changes. In addition, the threshold would not reflect other factors that can affect premium growth, such as policy duration, changes in enrollment mix, the leveraging effect of the deductible, and correction of prior estimates.</p>	<p>Could be understood by consumers.</p> <p>Rate increase measure will not reflect the actual increase faced by any particular consumer.</p>
<p><b>Approach 4:</b> Likely to result in MLR below 80 percent/85 percent thresholds in ACA</p>	<p>Could be easily measured and self-reported by plans, and easily used and understood by regulators.</p>	<p>This approach is more closely aligned with the factors associated with premium rate development.</p>	<p>Relative to comparing a rate increase to a threshold, it may be more difficult for consumers to understand.</p> <p>The MLR for the plan is not applicable at the individual consumer level.</p>

## Other Considerations

Regardless of which approach is used to identify “unreasonable” rate increases, several issues need to be considered:

- The appropriateness of varying “unreasonable” rate increase benchmarks by market (e.g., individual, small group, and large group), at least temporarily.

Although the work group is not aware of any empirical studies that track differences in average annual rate increases by market, rate increases have varied across markets. Individual market plans likely have the largest rate increases, and large group plans the lowest. We expect that these differences are likely to continue through at least 2015.

- The appropriateness of varying “unreasonable” rate increase benchmarks by state, at least temporarily.

Premium increases likely will vary across states as they implement ACA benefit, coverage, and rating provisions, based on the extent to which the ACA requirements are more rigorous than a state’s current requirements. Premium increases could be dramatic in states that currently impose rules less restrictive than those in ACA. Plans in the individual market could be particularly sensitive to the implementation of more restrictive provisions.

- The appropriateness of excluding certain large group business from the “unreasonable” benchmark tests.

Rate increases for very large fully-insured groups typically will reflect significant negotiations with the plan sponsor as well as benefit changes that are directed by the plan sponsor. In addition, these large fully insured groups may have the following characteristics:

- A. Experience-rated business, such that the primary determinant of rate change is the actual past and projected experience of the group. Such experience rating also may involve more than a single year of experience (i.e., the desire to use or increase any experience rating reserve amount the group has with the carrier). These groups generally will have their own contractual loss ratios and retention levels, which may not be consistent with the ACA loss ratio calculations. Thus the rate review for large groups should involve changes to the manual rates and rating factors and not to any group’s actual rate change.
- B. Multiple locations and use several carriers. In cases in which these carriers have separate but affiliated legal entities, a rate increase may be based on the group as a whole, rather than each legal entity of the carrier. The proposed MLR rebate calculations currently allow for the recognition of a blended rate applied to each group. The manner in which this could be applied to the rate increase of each legal entity is challenging.

- C. Offer options to be selected by the employee. The resulting rate may be a blend of the various options, so the rate increase is not necessarily legal-entity specific.

Not all large groups as defined by ACA (e.g., more than 50 or 100 employees) will face these issues. If a large group falls under one of these three categories, it might be appropriate to exclude them from the benchmark test.

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We would invite 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](mailto:Jerbi@actuary.org)).

Sincerely,

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



## **Appendix 1**

### **Discussion of Rate Increase Drivers**

While actions of covered individuals and employers may affect significantly the actual rate increase experienced by any particular individual or employer, they should not be part of the rate increase that the carrier must disclose and justify under the ACA. The disclosure and justification should be limited to rate changes resulting from actions by carriers.

Rate changes result from actions taken by individuals, employers, and carriers. They also result from the passage of time under some rating structures that recognize aging and duration. Since duration only makes a difference to the extent the carrier's rate manual measures that effect, such changes could be included under actions of carriers when considering the expected increase for a renewing population. In other words, rate changes due to aging and duration occur even if a carrier has not altered its rate table.

The following are lists of various actions taken by carriers, individuals, and employers that could result in changes to premium rates.

#### **Actions of Carriers**

- Change to table of rates;
- Discontinuation of plan(s) benefits;
- Modification of coverage within existing plan(s) benefits (by carrier or as required by regulatory authority);
- Change to rating structure or factors (rating tiers, etc.);
- Application of credibility/experience rating formulae, including experience refunds.

#### **Actions of Individuals**

- Election of benefit plan;
- Addition/elimination of covered dependents;
- Change in location or occupation.

#### **Actions of Employers (Group Markets)**

- Change in makeup of workforce (hiring and firing, etc.);
- Election of plan benefits;
- Change in location or industry;
- Election of multi-year rate guaranty period (increase during the guaranty period not to exceed a stated percentage), with the potential for a much larger change after the guaranty period expires.