AMERICAN ACADEMY of ACTUARIES

May 14, 2010

Department of Health and Human Services
Attention: DHHS–2010–PRR
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Premium Review—Request for Comments Regarding Section 2794 of the Public Health Service Act

Dear Ms. Arnold -

On behalf of the American Academy of Actuaries'[1] (Academy) Premium Review Work Group, I appreciate this opportunity to provide comments in response to the recent request for comments on the new Section 2794 of the *Public Health Service Act* (PHSA) that was added to that statute via the enactment of the *Patient Protection and Affordable Care Act* (PPACA). Section 2794 of PHSA requires the Health and Human Services (HHS) Secretary 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.

These provisions could have a significant impact on the structure of the health insurance industry and consequently on consumers. Over the next several years, the way in which Section 2794 is implemented could affect such items as: the number of insurers that remain active in the health insurance market, the market segments those insurers choose to service, the premium levels charged by insurers for their products, the manner in which those products are distributed, the administrative practices of insurers, and the willingness of providers of capital to invest in the health insurance industry. In addition, the way in which Section 2794 is implemented could have a significant impact on actuarial professionals who generally have been responsible for preparing rate increase filings.

The Academy's Health Practice Council has a long history of providing objective technical advice on areas that affect health insurance regulation, leveraging our members' professional expertise and familiarity with health insurance from a variety of perspectives. As such, our aim in responding to the request for comments is not to advocate for a particular regulatory outcome, but to explore different alternatives and provide our professional insights on the pros and cons of those alternatives. The work group that developed this response includes actuaries who work, either directly or indirectly, as consultants in state insurance regulation, the health insurance industry, and public accounting firms. Our intent in this response is to provide a balanced

[1] The American Academy of Actuaries is a 16,000-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.

perspective on these important issues, in the hopes of contributing to the development of technically sound rulemaking regarding Section 2794.

Because the critical aspect is that premium rates are appropriate, not excessive or inadequate, the majority of our comments will focus on the manner in which appropriate premiums are determined—rather than the rate increases that result. Similarly, state regulations generally focus on premium adequacy—not rate increases.

In the remainder of this document, we provide responses to most, but not all, of the questions posed in the request for comments. We have chosen not to respond to several questions for which we believed that the work group did not have unique expertise to offer and for which other respondents were likely in a better position to provide salient input. We would welcome the opportunity to discuss further any or all of our responses with interested regulators.

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1. Rate Filings and Review of Rate Increases

1. The Act requires the Secretary, in conjunction with States, to establish a process for the annual review of unreasonable increases in health insurance premiums. A justification for an unreasonable premium increases is also required

A rate increase is the difference between two consecutive premiums. In order to review premium increases, one first must determine if the two premiums determining the rate increase are sound. The following is a relevant excerpt from a recent Academy policy statement.[2]

> **Principles for Premium Oversight**
> Effective premium-oversight mechanisms should be based on actuarial principles. The principles outlined below highlight the criteria for a viable, sustainable, and competitive insurance market.
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> *Health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges.* A fundamental actuarial principle is that premiums must be adequate to pay projected expenditures, and that these expenditures depend on many factors, including the underlying medical costs of the enrollee population. It is important to understand the reasons for the increases in claims and expenses. Claims can increase due to many factors, including increases in provider payment levels, increases in utilization, and the introduction of new technologies.
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> *Premium oversight should be done in conjunction with insurer solvency oversight.* Premium oversight that focuses solely on the goal of limiting premium increases has the potential to ignore premium adequacy. If premiums or premium increases are held to levels at which health plans are unable to fully meet their commitments for claim payments, necessary administrative expenses, and reserve and capital funding, solvency

[2] American Academy of Actuaries, *Critical Issues in Health Reform: Premium Setting in the Individual Market*, March 2010.

problems could arise and plans could be forced to leave the market. Premium oversight mechanisms that incorporate insurer solvency considerations will help ensure that premiums are adequate and plan solvency is maintained.

Premium oversight requires strong actuarial representation. Actuaries and actuarial principles have key roles both in the premium-development process and in current regulatory oversight. Participation by actuaries in a formalized manner in any new regulatory oversight mechanisms will help ensure adherence to actuarial principles. In particular, actuaries have expertise in evaluating pricing risks as well as in identifying the potential volatility of such risks.

Appropriate risk-based capital (RBC) levels must be in place. Current RBC formulas would need to be modified to recognize any additional risks brought about by a universal premium setting regulation. Currently, RBC requirements for health insurance business subject to state premium review are higher than for business not subject to premium review (generally, individual versus group business). This difference reflects the inability to secure state approval of adequate premiums on a timely basis in the individual market. If all individual and small-group business premiums are to be subject to review, RBC should be modified to reflect the increased risks borne by insurers due to delayed premium approval.

Premiums should be self supporting and not subsidized by other lines of business. Requiring or expecting other lines of business to subsidize health insurance business would result in other policyholders subsidizing the medical costs of those with health insurance. It may also put an insurer that operates in only one market at a competitive disadvantage since it would not have another line of business from which to obtain subsidies.

The premium-review process should be transparent and equitable for all insurers. Regardless of whether regulatory oversight is conducted at a federal or state level, insurers competing for the same participants must be subject to the same oversight process and rules. Deviation from such consistency would result in a less competitive marketplace.

The premium-review process should allow for adequate premiums that appropriately reflect past experience. If medical trend is larger than expected, then premiums for the coming year would need to be increased to reflect not only expected medical trend in the next year, but also any understatement of trend up to that point. If the prior year's premiums proved too conservative, then the premium increase would be less than it would be otherwise. If insurers are not allowed to incorporate these kinds of adjustments, they will set premiums more conservatively.

The premium-review process needs to be coordinated between state and federal regulatory entities. In most circumstances, premiums in the individual market are filed for "approval" purposes and premiums in the group market are filed for "informational" purposes. Requiring full state and federal review and approval of all individual and small

group premiums would significantly increase a state's workload. The resulting premium-review process must accommodate timely implementation of appropriate premium increases. The timing of an approval is critical, since premium calculations are based on an expected effective date; if approval is delayed a premium shortfall will develop. If states become backlogged, a process should be established whereby after a certain period of time, premiums are deemed to be approved. Furthermore, it would be inefficient to have an insurer's request for a premium increase subject to both a state and federal approval process. Procedures should be put in place to clarify which regulatory entity has approval authority and the extent of that authority.

The lag between the observation of the basic data and the effective date of the premium increase should be kept short. Premium setting usually requires the projection of past experience into the future. The longer the time spanned, the greater the statistical uncertainty introduced. Greater uncertainty causes more variance in results for the period in which the premium rates were intended. The size of future increases also will be more volatile.

1.a. To what extent do States currently have processes in place to review premium rates and rate increases?

Almost all, if not all, states have processes to review and approve premium rates for some benefit plans and not for others. Premium rates for Medicare supplement policies issued to individuals are reviewed and approved by most, if not all, states. Premium rates for individual market policies similarly are reviewed and approved by a large number of states. There are some states, however, that do not review rates for individual medical products.

Review of premium rates for employer group policies are subject to less review, ranging from complete prior approval, some sort of file and use, or even no filings at all. Many states require that an actuary employed (or contracted) by companies certify that small group premium rates comply with state law. Most states do not review premium rates for insured large groups. Self-funded benefit plans meeting the criteria under the *Employee Retirement Income Security Act* (ERISA) are not subject to state insurance regulation. They set their own funding levels and have no "premiums" per se.

1.a.1 What kinds of methodologies are used by States to determine whether or not to approve or modify a rate or a rate increase? What are the pros and cons of these differing methodologies?

The work group's response to this question will be given in the context of an individual market policy form or rate submission to a state. We believe our comments translate well to other insured medical markets.

Rate and form submissions

At this time, not all changes to premium rates are subject to professional review by an actuary for a state. However, we outline a suggested process for such a review.

For a new policy form, the approval process would involve approval of the product language, including benefit provisions and the premium rates proposed. This process would include an interactive review and approval process by personnel in a state's forms department. Applications, outlines of coverage, and marketing information often would also need approval by the state.

Once this process is concluded, the filing is then typically forwarded (sometimes concurrent review takes place) to a state's rates department, where a similar interactive process is involved in securing approval of rates.

This is a more involved process than approving updated rates for an existing policy form. This rate filing most often includes an analysis of emerging experience that forms the basis for the rate filing.

The work group takes no stance on "file and use," "pre-approval," or "deemer" provisions. Our major concern is that the process chosen will result in timely approval of forms and other materials, as well as premium rates.

Criteria for judging premium rates

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 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.

A formal actuarial memorandum is generally included, and would reference specific ASOPs followed in setting premium rates. These would typically include any or all of 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*

We suggest that the regulations require that an actuary who is qualified under the U.S. qualification standards provide an attestation, and that the attestation indicate the filing and premium rates comply with applicable federal and state statutes and requirements.

The rate review process should ensure premiums for health insurance policies in the individual market 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. Moreover, 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 are appropriate—neither being too high nor too low.

The review process should be one in which the pricing actuary, as well as the actuary performing the state review, agree with resulting actuarial assumptions and methodologies. While we realize resources may be an issue in some states, we recommend that the state review and any resulting public statement of actuarial opinion be prepared by or under the direction of an actuary who is qualified under the U.S. qualification standards and is a member of the American Academy of Actuaries.

Pros and cons

Although the work group has not done any formal analysis of pros and cons of current state approval methodologies, we have some concerns if states are to implement a thorough review process for all health products that fall under Section 2794. Such a process not only will be quite costly, but some states also will need to develop expertise in order to process rate increases internally.

Our major concern, however, relates to the ability of states to approve rates on a timely basis. Delays in implementing rate increases could result in an inadequate premium being charged. This most likely would result in higher subsequent rate increases.

The work group suggests that any review of state methodologies concentrate on the timeliness of disposition of rate increase submissions. An ongoing survey of time, from date of submission to date of resolution, is suggested.

1.a.2. Are special considerations needed for certain kinds of plans (for example, HMOs, high deductible health plans, new policies, and closed blocks of business)? If so, what special considerations are typically employed and under what circumstances?

Special considerations certainly will arise as conditions and external forces affecting medical claims—both positive and negative—arise. The unpredictability of future cost pressures will certainly result in special considerations as they are identified and measured.

Special considerations are warranted whenever solvency concerns affect the level of premium rates.

Changes in rules could require a transition period. In brief, here are a few specific cases that PPACA might affect: treatment of grandfathered plans and new rating restrictions might require a transition period in some states; in the individual market, shifting from pricing on a lifetime basis to an annual basis might require a transition period; interplay with medical loss ratio requirements might also require a transition.

Certain rate increases could be considered subject to special circumstances. Here are a few examples:

- Health plans, such as HMOs, which may have multi-year provider contracts, may show relatively low trends until the provider contracts expire and have to be renegotiated.

- Various models of insurance carriers (e.g., staff model HMOs, HMOs and PPOs) will have differing trends based on how increasing costs of medical services are reflected through the models.

- Products through which a significant share of medical services is delivered by non-contracted providers will typically show relatively high trends, as providers have historically increased their charges at rates that exceed the rates at which negotiated payments increase.

1.b. Where applicable, do health insurance issuers currently provide actuarial memorandums and supporting documentation relating to premium rate calculations, such as trend assumptions, for all premium rates and rate increases that are submitted, and/or for all premium rates and rate increases that are reviewed?

Actuarial memoranda are generally included with rate filings that are submitted and/or reviewed. Supporting documentation requirements vary by state and include some, or all, of the following:

- Experience exhibits showing the historical earned premium, incurred claims, loss ratio, etc.
- Experience projections to provide support for the requested rate increase.
- Detailed explanation of the proposed changes, including support for changes.
- Explanation and support for all significant actuarial methods and assumptions (i.e., trend, lapse rates, etc), as applicable.
- Rate tables and factors.
- 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.

Although requirements for filing documentation vary by state and product type, in all cases we recommend the documents should be prepared in accordance with ASOPs and contain an attestation signed by a member of the American Academy of Actuaries.

Much of the information listed above is appropriate for all or most rate filings. To the extent that the types of information and formats can be reasonably standardized, it may simplify both the preparation of filings and the review of those filings.

1.b.1. How is medical trend typically calculated?

Premiums for plans in the individual health insurance market typically increase every year due to increases in claim costs. The sum of all factors is considered claims trend. The following excerpt from a recent Academy policy statement[3] outlines the major component parts of historical claims trend.

[3] *Ibid.*

External factors driving medical-cost increases
These factors, which are common to all health insurance markets, are those that reflect increases in the per-unit cost of health services (e.g., the price for a given physician visit) as well as increases in utilization.

Policy duration (for medically underwritten business)
Medical costs can be relatively low during the first year of a policy, in part due to the application of medical underwriting. However, they are likely to increase annually after the year of issue as individuals develop health conditions and incur more claims. Insurers can spread these increases over all premiums for the length of time a typical policy will be in force (including the initial premiums) or they can set the initial premiums low and impose higher premium increases to reflect expected increases each year.

Policyholder lapses/changes in enrollment mix
Adverse selection concerns arise not only at issue, but also at renewal. If a healthier individual can purchase a new policy at a lower premium compared to the renewal premium, then the average medical costs and premiums of the individuals retaining coverage would increase over time.

Leveraging effect of deductible
When total health spending increases but the deductible level is held constant, the deductible each year represents a smaller share of claims. Therefore, the plan's claims will increase more on a percentage basis than the increase in total spending. This increase in claims, and the associated increase in premiums, is referred to as deductible leveraging and the higher the deductible, the greater the leveraging effect will be, all other things being equal. Higher deductible plans, however, typically attract individuals with lower expected claims, including those who increase their deductible levels in order to reduce their premium increase. This can offset the increases resulting from deductible leveraging of higher deductible plans.

Correction of prior estimates
As data on actual medical spending emerge, premiums may need to be adjusted up or down to correct for any under- or over-estimates of medical trend. Setting premiums too low has a compounding effect when the next premium increase is calculated. Premium increases for the coming year reflect not only expected medical trend in the next year, but also any understatement of trend up to that point.

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.

Additional analyses should include one or more of the following:

- Experience exhibits showing the historical earned premium, incurred claims, loss ratio, etc.
- Changes in provider reimbursement agreements (e.g., hospital contracts, physician fee schedules).
- General inflation.
- Use of usual and customary language that may dampen trends.
- Cost-shifting from government programs.
- Regulatory changes, such as mandated benefits.
- Increased use of expensive modern technology or newly developed drugs.
- Changes in the mix or intensity of services. These could be the result of new technology or the implementation of medical management programs.
- Changes in medical practice, such as services shifted to the outpatient setting or the introduction of new drugs or technologies.
- Implementation of medical management programs.
- Changes in supply of services, such as number of hospital beds or number of physicians (increase in supply can lead to increased utilization and vice versa).
- Changes in demographic mix of the insured block.
- Epidemics or catastrophic events (e.g., higher than normal flu season).
- Benefit plan design (i.e., plans with little cost sharing tend to experience more intensive use of services).
- Improvements in morbidity due to preventive activities.
- Anticipated loss or reduction of benefits leading to increased utilization.
- Changes in the demographic or geographic distribution or a change in benefits.
- Selection, favorable or unfavorable, as the morbidity of the enrolled lives changes.
- Benefit structure (e.g., a deductible and/or out-of-pocket maximum has a leveraging effect on trends).

An analysis reconciling aggregate annual historical trend into its component pieces is suggested. Once this is done, then the actuary can estimate or project future expected trends as needed. Please note that as future trends are based on judgment, they are not guaranteed, but expected 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 is typically part of the process.

We should note many analyses need homogeneous data and such data are not likely to be available at the discrete level of most rate filings.

1.b.2. Are specific exhibits, worksheets or other documents typically required? If so, are these documents generally submitted to the State Insurance Department directly, and if so, in what format?

At this time, there is some consistency between states as to what documentation should be included with a rate increase request. This is often dependent upon the existing, applicable laws

and regulations of each state. Resources available within a particular state government or insurance department also affect their requirements.

Most states have developed the capability to allow for electronic submission of forms and rates, increasing the efficiency of the review process. The insurance industry and the states collaborated to create the System for Electronic Rate and Form Filing (SERFF), which is now widely used to facilitate filings.

Documentation typically falls into a number of categories and is provided in the actuarial memorandum and supporting exhibits:

- Descriptive information;
- Historical information;
- Proposed rates; and
- Reason for proposed rate increase

Descriptive information includes the company, policy forms included in the request (along with a brief description of the benefits), whether or not the block is open or closed, the rating basis, proposed effective date of the new rates, and overall rate increase percentage. Ranges of increases and a demographic analysis of the distribution of increases often may be necessary to accurately describe the changes in rates being proposed.

Historical information includes past rate increase history, past claims, and premium history with accompanying loss ratios, enrollment history, and history of past rates.

Proposed rates include the rates by rating classification and policy form, as well as the rate increase percentage for each rating classification. Rating factors are sometimes presented in lieu of actual rates for such items as smoker, age, etc.

Reasons for proposed rate increase include the rating assumptions and methodology used to determine the required rate increase. These include the medical trend, administrative cost trends, new business, persistency, and interest rate assumptions. Medical trend may be segregated by its components of service type, utilization, and cost per service. Adjustments also may be made for changes in severity of service mix, risk factor of the projected population, and benefit changes. Support should be provided for all assumptions.

The state reviewer often may ask for supporting work papers or spreadsheets or more information.

1.b.3. To what extent do issuers use the following categories to develop justifications for rate increases: cost-sharing, enrollee population including health risk status, utilization increases, provider prices, administrative costs, medical loss ratios, reserves, and surplus levels? Are there other factors that are considered?

Insurers implement premium rate increases in response to changing conditions with the goal of arriving at rates that are sufficient to allow the insurer to continue to fund the cost of claims;

provide for the cost of administration; and provide for some combination of risk charge, contribution to surplus, and profit. A rate increase should generally be considered reasonable if it resulted in premiums that were reasonable in relation to the benefits provided, and if it resulted in an expected loss ratio that exceeded any applicable statutory minimum loss ratio requirement.

While practices vary among companies, it is likely that each of the factors listed in the question would be considered in developing a rate increase. Other factors that might be considered include the regulatory environment and the insurer's competitive position.

Insurers' premium rate increases are generally based on a review of historical experience and assumptions regarding how that experience will change in future periods as the result of a myriad of factors. While not all premium rate increases are subject to regulatory review, many are, and those rate increases that are subject to regulatory review are covered by ASOP No. 8: *Regulatory Filings for Health Plan Entities*. This standard requires the actuary making the filing to adjust past experience for any known or expected changes to the following:

- selection of risks;
- demographic and risk characteristics of the insured population;
- policy provisions;
- business operations;
- premium rates, claim payments, expenses, and taxes;
- trends in mortality, morbidity, and lapse; and
- administrative procedures.[4]

This list is not exhaustive, but it covers many of the factors a practicing actuary would take into consideration in developing rate increases.

1.c. What level(s) of aggregation (for example, by policy form level, by plan type, by line of business, or by company) are generally used for rate filings, rate approvals, and any corrective actions? What are the pros and cons associated with each level of aggregation in these various contexts?

The extent to which a company aggregates business for setting premium rates should be applied consistently for determining initial premium rate levels, assessing experience, and subsequent filing for rate actions.

For some products, specific criteria regarding aggregation are dictated in state regulations. In lieu of specific criteria, however, the level of aggregation is usually guided by two general considerations: the characteristics or homogeneity of the business and the credibility of data. While these are broad topics that encompass a number of considerations, they provide a general benchmark from which companies proceed.

The following outlines in more detail how these considerations are generally applied to a company's health business.

[4] Actuarial Standard of Practice No. 8: Regulatory Filings for Health Plan Entities, American Academy of Actuaries.

At a minimum, companies segment products into major lines of business. Examples of major lines of business are as follows:

- Individual medical
- Small group medical
- Large group medical

The segregation of major lines of business is important given distinct markets as well as product characteristics and influences that drive experience. In addition, state regulators often determine lines of business to be unique and set regulations and offer guidance accordingly.

While a company may, at a minimum, review business by major lines of business, there are typically various products and/or business classes within each line that warrant further segmentation of the business for the purpose of setting premium rates. These are outlined in more detail below.

The level of segmentation within a line of business, for the purposes of setting premium rates, can vary greatly. The ultimate decisions, however, are driven by product characteristics and the credibility of data. This concept, though applicable to all lines of business, is well stated in the *NAIC Model Guidelines for Filing of Rates for Individual Health Insurance*:

> "…experience under forms that provide substantially similar coverage and provisions that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined for purposes of evaluating experience data in relation to premium rates and rate revisions, particularly where statistical credibility would be materially improved by the combination."

The following outlines general variations used by companies, by major lines of business.

Individual medical
Individual medical business is generally aggregated by policy form. Premium rates are set for that form to meet medical loss ratios over the projected lifetime of the business. To the extent that there are policy forms that are similar in nature, which include a variety of considerations, such as benefits provided, underwriting applied, and age of policy form, the pricing actuary may group these similar forms together to have a more credible set of data to evaluate experience and set premium rates. Some state regulations specify the level to which companies should aggregate rates for this purpose.

Small-group medical
The aggregation of business for the purposes of setting small-group premium rate levels follows state small group regulations. Product options offered in this line of business are generally similar, but a company may establish separate business classes, to the extent they are distinct segments with unique characteristics. For example, business that is marketed through a different channel or a block of business acquired from another company may be defined as a separate business class.

Companies will evaluate experience and establish the required aggregate rate level for a given class of business, and then vary premium rates within that class based on the plan benefit options and other case characteristics allowed for in state law or regulation. Examples of allowable case characteristics are age, gender, geographic area, industry, and group size. Further rate variation for a given small group for characteristics such as health status, group experience, and policy duration can be applied, but is subject to limitations of the small group state regulation. Some state laws or regulations do not allow certain case characteristics to be used (e.g., gender).

Large-group medical
The products offered in the large-group medical line of business are generally similar, but a company may establish separate business classes, as appropriate. Companies will generally set "manual" premium rates, which vary by case characteristics, based on the experience of the business class in aggregate. However, since the groups are larger and have more credible experience, the ultimate premium rate charged to a given group is developed with consideration for that group's experience. When evaluating a group's experience, companies generally remove very large claims and pool them with large claims from other large groups in the business class. The risk of large claims is then spread equally to all groups through a pooling charge.

In conclusion, how a company aggregates business for the purposes of setting premium rates ultimately follows the general principles of similar characteristics and data credibility. For any company, this can vary significantly depending on the lines of business, product offerings, marketing methods, and insured population characteristics, to name a few. Premium rates developed for a given segment ultimately need to be self-sustaining and adequately account for the various inherent risks, given that segment's unique characteristics.

1.d. What requirements do States currently have relating to medical trend and rating calculations? What are the pros and cons of these different requirements, and what additional requirements could potentially be set?

In the individual market, it is common for states to require that an actuarial memorandum be filed as part of the request for a rate increase. In the actuarial memorandum, the actuary certifies that the premium rates being filed are reasonable in relation to the benefits provided. The actuarial memorandum will include a description of how the rates were determined, including a description and source for each assumption used.

In the individual market, premiums are generally deemed reasonable in relation to the benefits provided if they result in a loss ratio that exceeds the statutory minimum loss ratio for the coverage under consideration. So, in most states, a rate increase is considered reasonable if it results in premiums that meet the minimum loss ratio test.

In the small-group market, federal law requires small group health insurance to be offered on a guaranteed issue basis. States generally regulate the extent to which insurers can vary premiums among the groups they insure, but not the level of the premium rates—instead relying on a competitive marketplace to limit premium rate increases. States generally require an actuarial

certification stating that the carrier is in compliance with the laws limiting the variability of premiums among groups and that the rates are actuarially sound.

States generally do not regulate premium rate increases in the large-group market, instead relying on competitive markets to set prices.

Some states may have limits on annual rate increases for specified markets or types of products. However, we are concerned about how these limits would apply during periods of uncertain adverse selection by policyholders. Limits that are inconsistent with actuarial principles will cause carriers to either leave the market or perhaps face insolvency.

1.d.1. Do States generally allow enrollees under the same policy form to be further subdivided for purposes of calculating medical trends and rates?

Under certain circumstances it may be necessary to study subsets of enrollees in order to properly understand what forces are at play in claims trends or to understand the claims risk. However, it is against state regulations or actuarial principles to single out specific insureds for rate increases. In addition, unless permitted under allowable rating structures, such analyses are for information purposes only explaining what is causing claims increases.

States generally allow carriers to make actuarially justified changes to rating factors such as age, gender, geography, and benefit relativity. Such changes would result in certain classes of enrollees covered under a common policy form experiencing different rate increases. An actuarially justified change would be one that reflected actual or anticipated differences in costs or risks associated with providing coverage.

We note that under PPACA, for non-grandfathered coverage issued prior to 2014, the limits on rate bands will lead to rate increases in 2014that vary substantially by age. At that time, older policyholders could see premium decreases and younger policyholders couldl see relatively large premium increases. This will most dramatically impact young males. Some transition rules may be appropriate to minimize disruption of the market.

All rate increases and rate structures must comply with state and federal requirements. We suggest an actuarial attestation be prepared to ensure this happens. At the same time, carriers generally would not be allowed to increase premiums for an individual due to that individual's health status or claims.

1.d.2. Do States generally allow enrollees under different policy forms to be grouped together for these calculations, and if so, how?

Most states allow carriers to decide how to group experience for the purposes of determining rate increases. Analyses to identify trend often look at subsets of enrollees across a number of forms as a means of achieving statistical credibility. These analyses often are used to review the appropriateness of rating factors, such as those for geographic adjustments, smokers or the costs of benefit changes.

Proper application of ASOPs often leads to specific and detailed analyses that are needed to understand the various factors that cause claims to increase.

No matter how an analysis is performed on any subset of an insured's enrolled population, resulting rates must comply with applicable state and federal rating requirements.

2. Defining Unreasonable Premium Rate Increases

2. The Act provides that the initial and continuing rate review process under Section 2794 is only to be undertaken for unreasonable premium rate increases.

The following is an excerpt from a May 8 Academy letter to the NAIC and presents the Academy's proposed approach for handling unreasonable rate increases.

> ***Proposed Approach for Reasonable/Unreasonable Rate Increases***
> We propose an approach whereby a reasonable increase in premiums is defined as "the change in actuarially sound premiums." An actuarially sound premium is one in which the rate-setting process is consistent with Actuarial Standards of Practice (ASOPs), the Code of Conduct promulgated by the Academy and adopted by the five U.S. actuarial organizations, and/or applicable law. All assumptions underlying the determination of premiums would be identified, and documentation would be available for the state actuary to review. The state and company actuaries should agree on assumptions; however, the NAIC may want to consider ways to address situations in which the two actuaries are not able to reach an agreement quickly. It should be noted that actuarially sound premiums, and the resulting increases, may vary between companies based on the companies' underlying assumptions.
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> Experience subsequent to that used in developing the current actuarially sound premium is likely to differ from that which was assumed. Regardless, such experience would be used in developing the new premiums. However, the rate increase would be still deemed reasonable as it would be based on the increase in two actuarially sound premiums; therefore, the definition of an unreasonable rate increase should not be a simple percentage.
>
> We would expect states to have a process for rate review that allows for the timely use of new actuarially sound premiums, within which increases based on such actuarially sound premiums would not be considered unreasonable.
>
> Some increases to reasonable rates will be larger than others. Variations in deductibles and other components of the benefits will produce different medical cost trends for different products, yet those would still be reasonable under this approach if both prior and current rates are actuarially sound. And, certain plan designs may result in increased favorable or unfavorable selection, impacting the observed trend in claim costs.
>
> Delays in implementing actuarially sound premiums will result in larger rate increases at future filing dates. The process for the annual review involving the Secretary should not

delay any rate approval process. The manner in which the Secretary could monitor premium increases could focus on the maintenance of actuarially sound premiums from period to period. The amount or percentage of premium increases across a wide range of companies analyzed as part of this monitoring could focus on the critical connection between premium rates and the underlying increases in medical costs.

We note that CMS uses an annual schedule for rate setting for Medicare Advantage and Part D plans so that all filings are required to be submitted on the same schedule. This type of scheduling would be inappropriate and unmanageable for the private market, and consideration should be given to approaches that spread the rate review workload throughout the year. Currently, carriers are allowed to file rates on whatever schedule is appropriate to their block of business.

To assist consumers and help in the rate review process, we suggest developing categories of rate increases such as:

- Reasonable, without additional justification;
- Reasonable, based on additional solvency requirements;
- Reasonable, based on other justifiable factors; or
- Unreasonable, not justified.

If the above approach is to be implemented, or another approach used, we see a number of questions that will need to be addressed. Below we outline some of these and comment on a solution consistent with our suggested approach.

- Will the unreasonable rate increase standard be published so insurers and consumers will have the information to understand what the parameters are and how the process will work?

- Will the basis that is to be used to determine that an increase is unreasonable be clear so that the insurer will know in advance of filing? Or will it be a determination made by the state during the review? Or will the determination be made at some later date? We believe it would be in the best interests of all parties that there be a definition of “reasonable” consistent with our approach, in which case “unreasonable” does not need to be defined but would instead be regarded as increases that do not move from one actuarially sound rate to another. Otherwise, the term “unreasonable” should be clearly defined in advance so that filings can be categorized based on the level of increase the company is seeking.

- While the focus of Section 2794 relates to unreasonable increases, it may not be necessary for all increases to be reviewed. For example, if an insurer continues to operate at a medical loss ratio significantly in excess of the minimum and the regulator is not concerned from a solvency perspective, is a less frequent than annual review of rate increases possible?

- An actuarially sound premium rate schedule may involve different amounts of increase for differently situated individuals or groups to maintain its soundness. We believe that the regulations should allow for these variations without a determination that a portion of the rate increase is an unreasonable increase at the individual or group health level. For instance, in

cases in which the increase meets our proposed definition of reasonable but is different for different benefit types, the unreasonable label would not be applied to subsets.

- We believe that the concept of unreasonable premium increase should be limited to renewing business. New business premiums, where subject to rate review, should be reviewed for actuarial soundness without regard to the current rate schedule applicable to new issues.

- It is possible that solvency concerns will need to be a necessary consideration for the approval of an unreasonable rate increase. It should be noted that, especially during the transition period until 2014, the announcement of solvency concerns could lead to further deterioration of the block as insureds considered "healthy lives" leave the block. In these situations, however, significant rate increases might be the only alternative to insolvency.

- The concept of actuarially sound rates means that the regulator must be certain that the rate is not inadequate. Inadequate, low rates—while initially seen as in the public interest—actually lead to a need for carriers to request larger increase. Regulations should address the situation in which existing inadequate rates are the basis for an unreasonable rate increase.

- When a state review determines that an increase is unreasonable, a justification for the public will be prepared. Will the justification be reviewed by the state? In cases in which reasonable or unreasonable have been defined so that an insurer knows a justification is going to be needed, can this be filed with the requested increase? Will it require review from forms experts or rate experts alone? How long will it take to get approval for public release?

- Will there need to be state rules specifically around notification and approval of an unreasonable premium change? We believe that timely review and communication of all rate changes will continue to be necessary. It wouldn't make sense for companies to have to delay implementation of approved rates while preparing and obtaining approval of the website justification.

2.a. In States that currently have rate review processes, are all rates or rate increases generally reviewed? If so, for what markets and/or products? If not, what criteria do these States typically use when determining which rates or rate increases will be reviewed? To what extent do States require that these reviews take place before the proposed rate increases can be implemented?

Only a few states have prospective rate reviews in place for all individual and small group business. We are not aware of any state reviewing ERISA business.

At this time, most states rely on small group annual certifications that are retrospective. The actuary is vested with the responsibility of certifying that rates and rate increases over the prior twelve months are in compliance with state requirements. The actuary performs compliance tests, identifying any outliers, and notifying the state of such outliers. The states generally rely on the annual certification prepared for the insurer.

For individual business, for which states review rate filings, most are prospective in nature. The 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.

It is our understanding that the NAIC will be providing state-specific information addressing this question.

3. Public Disclosure

3. The Act requires that health insurance issuers prominently post the justification for an unreasonable premium increase on their Internet websites prior to implementation of the increase.

Rate memorandum and appropriate supporting attachments could be made available on the insurer's website.

3.a. To what extent is information on premium rates and premium rate increases, and related justifications, currently made available to the public?

Most states currently allow public access to individual market rate filings, if requested in person at the insurance department. Several states post rate memoranda and attachments on the insurance department website. Many states allow insurers to block certain proprietary company information. Existing state disclosure laws and regulations often dictate particular policies and procedures within a state.

3.a.1. To what extent are annual summaries of premium rate increases currently made available to the public on State or consumer websites, and/or made available by request? Where available, to what extent is this information generally provided by policy form, type of product, line of business, or some other grouping?

We are aware that several states produce a listing of approved individual market rate increases. We understand, however, these are average or composite increases. Reliance on such information can be as misleading as useful. Again, states do have to respond to Freedom of Information requests, which often allow for inspection of rates. Some states place certain rates for particular products on their websites.

3.a.2. To what extent are rate filings with actuarial justification and supporting documentation generally made available to the public? In what format(s) are rate filings currently made available to the public? What format(s) would be most useful to the public?

Most states currently allow public access to individual medical rate filings, if requested in person at the insurance department. Several states post rate memoranda and attachments on the insurance department website. Many states allow insurers to block certain proprietary or trade secret company information, which are often the underlying experience data.

We are aware of consumer guidelines for medical insurance prepared by several states. These guidelines are intended to inform consumers. Benefit options and sample rates for licensed insurers are typically shown.

We are not aware of any consumer guidelines prepared for employer group insurance.

3.a.3. What kinds of supporting documentation are necessary for consumers to interpret these kinds of information?

We interpret this question to relate to the individual market only. Premiums for group business are based on the demographic information of many people and are we assume outside the scope of this question.

Rate tables used by insurers have several component segments. To provide this type of information only would mean the consumer would need to calculate every rate. An alternative is to use rate quoting software commonly found on the internet. A consumer could enter certain vital information and the software calculates a range of premiums for the benefit options selected by the consumer. The more sophisticated software also produces benefit outlines.

We refer to consumer guidelines mentioned above. These may need to be updated and prepared by all states.

3.b. What kinds of information relating to justification for an unreasonable premium increase could potentially be made available?

We suggest the actuarial memorandum and appropriate supporting exhibits be made available. Historical claims and premium experience and discussions of assumptions and methodologies forming the basis for the premium should be provided. This information needs to be sufficient for another actuary qualified to practice in the same field to evaluate the work.

4. Exclusion from Exchange

4. For plan years beginning in 2014, States receiving grants in support of the rate review process must make recommendations, as appropriate, to the State Exchange about whether particular insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

4.a. To what extent have States developed definitions of what constitutes an excessive or unjustified premium rate increase and/or a pattern or practice of such increases? How could a pattern or practice of excessive unjustified premium increases be defined in this context, and what are some of the pros and cons of the various approaches that are available?

We are not sure what "excessive or unjustified" rate increases means given that insurers need to post justification for all unreasonable increases. Currently, to the extent that states require a filing of a rate increase, actuarial support is required. Moreover, state market conduct oversight has the ability to identify and address proper rate setting.

4.b. What criteria could be established to determine whether insurers have engaged in a pattern or practice of excessive or unjustified premium increases?

We are unsure how a pattern of "unjustified premium increases" could occur given the need for unreasonable increases to be justified. If, after the regulations clearly identify situations that define unreasonable increases, we would be happy to assist in further clarification of issues surrounding this legislative language.

* * * * *

Thank you again for allowing us to provide input into this critically important rulemaking initiative. We would be delighted to engage in further discussions about this topic. If you have any questions, please contact Heather Jerbi, the Academy's senior federal health policy analyst, at jerbi@actuary.org or 202.785.7869.

Sincerely,

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Chairperson, Premium Review Work Group
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