A PUBLIC POLICY PRACTICE NOTE

Exposure Draft

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

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Developed by the Rate Review Practice Note Work Group
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EXPOSURE DRAFT
Addendum to Practice Note on Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act

This addendum to the original 2012 practice note, *Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act*, was developed by the Rate Review Practice Note Work Group organized by the Health Practice Council of the American Academy of Actuaries. This document is intended to provide updated information to actuaries preparing, reviewing, or commenting on rate filings in accordance with Section 2794 of the Public Health Service Act, as amended by the Affordable Care Act (ACA) for the 2014 filings provided in 2013. Section 2794 requires the U.S. Department of Health and Human Services (HHS) Secretary to work with states to establish an annual review of "unreasonable" rate increases. All rate changes, above and below the "unreasonable" threshold, are discussed in this practice note.

This addendum to the practice note is intended for use as a reference tool only and is not a substitute for any legal analysis or interpretation of the regulations or statutes. This practice note is not a promulgation of the Actuarial Standards Board, is not an actuarial standard of practice, is not binding upon any actuary and is not a definitive statement as to what constitutes appropriate practice or generally accepted practice in the area under discussion. Events occurring subsequent to this publication of this addendum to practice note may make the practices described in this addendum to the practice note irrelevant or obsolete. It is expected that the Unified Rate Review Template will be updated after the 2014 qualified health plan and rate filings have been completed. Therefore, guidance in this practice note addendum may need to be updated before the April 30, 2014 filing for 2015 rates.

This addendum to the practice note is not an official or comprehensive interpretation of the ACA. However, this addendum to the practice note does address a number of issues that were not addressed in the original practice note because official HHS guidance had not be finalized at that time (e.g., essential health benefits, actuarial value, reinsurance, risk adjustment, etc.). Even with this addendum, the actuary should review state and federal regulations and related material continuously as HHS and states may revise regulations and interpretations periodically.

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

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

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Introduction

This is an addendum to the original 2012 practice note, *Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act*. Since the original practice note was published, the Preliminary Justification Parts I, II, and III that were created by U.S. Department of Health and Human Services (HHS) regulation implementing Section 2794 of the Public Health Service Act, as amended by the Affordable Care Act (ACA), have been replaced with a new set of requirements to be used for filing with states and HHS when applying for qualified health plan (QHP) status and when a plan or product has an increase.[1]

The section on *Recommendations for Completing HHS Required Documentation* in the October 2012 practice note will be replaced by this addendum. The other sections in the original October 2012 practice note are still relevant and may give readers additional guidance in filing rate information. Given timing considerations, the work group updating the practice note opted to provide this addendum immediately; however, a revised version of the full practice note (including this addendum) is planned for future publication.

New Requirements—General

Any mention of the effect of the ACA in this document refers to the newly effective requirements that affect products, plans, and rating requirements beginning in 2014. There are many other ACA regulations that were and are becoming effective prior to 2014 that are not discussed in this addendum.

The new rate review and disclosure requirements include Parts I, II, and III. Part I is the Unified Rate Review Template (URRT)—an Excel spreadsheet that includes information for all products and plans in a market (i.e., individual, small group, or combined), which is essentially the single risk pool of products and plans. There are two worksheets in Part I: Worksheet 1 includes aggregate information across the entire risk pool, and Worksheet 2 includes information by product and plan within product.

Part II includes a summary description of the rate changes and is filed whenever a rate increase is greater than the threshold for rate review.

Part III is the actuarial memorandum that describes and supports the development of the information provided in Part I. Both Parts I and III are filed when a non-grandfathered individual, small group, or combined product or plan has an increase. These two parts also must be filed for federally facilitated exchange (FFE) QHP applications. These forms do not apply to grandfathered business. However, if grandfathered business experience is needed for credibility purposes, the actuary can include that experience in the credibility manual columns. In addition, these forms are filed for all FFE QHP applications and for compliance with applicable state law.

[1] Federal Register—Health Insurance Market Rules; Rate Review (Feb. 27 final rule): http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

The new URRT (Part I) does not necessarily align with actuarial information, techniques, or computations typically used in the development of rates or rate table increases that, in turn, form the basis of states' departments of insurance (DOI) rate submissions. As an example, on Worksheet 2 of Part I, the rate change percent and the cumulative rate change percent over the 12 months prior are inputs and not derived directly from other information on the form. Rate increase percentages should be determined based on the projected population, which means estimating the premium rates effective one year prior to the projection period also would be based on the projected population as well as the proposed premium rates.

Part I has a different purpose, mainly tracking experience data and index rates to meet certain ACA reporting requirements. This purpose is noted in the instructions published by HHS.

However, 45 CFR Section 154.215(f) requires that Part III, the actuarial memorandum, contain "reasoning and assumptions supporting the data contained in Part I." It continues to state that "Parts I and III must be sufficient to conduct an examination satisfying the requirements of section 154.301(a)(3) and (4) and to determine whether the rate increase is an unreasonable increase."

45 CFR 154.301(a) lists the items a state must include in its review of rates to be considered as having an "effective rate review program." Subsection (a)(3) includes reasonableness, past projections versus actual experience, reinsurance and risk adjustment program effects, the market-wide single risk pool, essential health benefits, actuarial values, and other market reforms. Subsection (a)(4) includes the itemized list of factors a state must review. Not all of the listed items in either Subsections (a)(3) or (4) are included in Part I (see list below).

Information in Parts I and III, which is not identified by the carrier and deemed by HHS as proprietary information, will be made publicly available on HHS's web site. Actuaries should check state rules and regulations regarding filing requirements and confidentiality to determine what is optional to include in Part III compared to what needs to be included in the state filing memorandum.

In developing the actuarial memorandum (Part III), it will be important to provide documentation that supports the information in Part I. In addition, information supporting specific elements listed in 45 CFR 154.301(a)(3) and (4) that are not included in Part I may need to be included in the actuarial memorandum, particularly when HHS is performing the review.

If a state does not have an effective rate review program and the rate increase is subject to review (the increase is greater than the threshold), then HHS will use Parts I and III to determine whether the rate increase is "unreasonable." Therefore, it also will be important to provide more typical actuarial rate filing or increase information related to the development of rates or rate table increases that support the rate increase percentages in Part I, Worksheet 2. If the material in Parts I and III does not provide enough information for HHS to determine whether the rate increase is "unreasonable," HHS may ask for more information.

If a state has an effective rate review program, it also may have its own requirements for filing information to support the rate increase requested. A separate actuarial memorandum supporting the rate filing as required by each state is appropriate to use. The actuarial memorandum (Part

III) supporting the information included in Part I and 45 CFR 154.301(a)(3) and (4) may be requested by the state. The filing actuary will need to stay abreast of changes to state requirements, as some states have been adopting the standardized data template for use in their respective states.

The actuarial memorandum(s) should identify the Actuarial Standards of Practice (ASOPs) used by the actuary and, per ASOP No. 41, *Actuarial Communications*, disclose any deviation(s) from guidance contained in such ASOPs.

The Part III instructions provide guidance regarding the language to include in the actuarial certification. However, some states have specific language and mandatory references to law that may be required. In such instances, state-specified language should be followed.

Items in 45 CFR 154.301(a)(3) or (4) not included in Part I but included in Part III

As noted above, there are items noted specifically in the rule (154.215(f)) that are listed as "necessary to satisfy requirements of 154.301(a)(3) and (4) and to determine whether the rate increase is an unreasonable rate increase," which are not included in Part I. Therefore, information on the following items should be included in Part III and also may need to be included in any state filing as required by the state.

- Subsection (a)(3)(ii)—The health insurance issuer's data related to past projections and actual experience.
- Subsection (a)(4)(iii)—The impact of cost-sharing changes by major service categories, including actuarial values. Part I does not have a specific section for cost-sharing changes by service category. This would be included in the "Other" column on Part I, Worksheet 1, along with other items, and explained separately in Part III.
- Subsection (a)(4)(v)—The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use. Part I, Worksheet 1 does include input for population risk morbidity. However, if rating limitations require that modifications be made to achieve revenue neutrality, there is not a place to include the back up for the change in Part I. Therefore, it may be necessary to reflect these changes in Part III. If the rating limitation modifications are not revenue neutral, the results would be included in the population risk morbidity column and documentation on the effect of the change would then be included in Part III.
- Subsection (a)(4)(vi)—The impact of any overestimation or underestimation of medical trend for prior year periods related to the rate increase.
- Subsection (a)(4)(vii)—The impact of changes in reserves required.
- Subsection (a)(4)(viii)—The impact of changes in administrative costs related to programs that improve health care quality.
- Subsection (a)(4)(ix)—The impact of changes in other administrative costs. Part I includes input on changes to total administrative costs, but not broken out by health care quality improvement costs and other administrative costs, so these will need to be provided in Part III.
- Subsection (a)(4)(xi)—Medical loss ratio (MLR). Part I does not include input on the ACA MLR; therefore, discussion on MLR will need to be included in Part III.
- Subsection (a)(4)(xii)—Insurer capital and surplus.
- Subsection (a)(4)(xiii)—The impact of geographic factors and variations.

All of these items not included in Part I but required by 45 CFR 154.215(f), which references 45 CFR 154.301(a)(3) and (4), should be included in the actuarial memorandum (Part III) particularly when the state does not have effective review and HHS would be performing the review.

In particular, the actuarial memorandum instructions (page 15) state: "There are elements of an effective rate review for which the data needed to perform the review is not explicitly shown on the Part I Unified Rate Review Template, e.g., the health insurance issuer's capital and surplus. Issuers may optionally provide additional information to facilitate an effective review of the submitted rate increase(s). While this information is optional, it is noted that providing the information with the initial submission reduces the likelihood of the reviewer requesting supplemental information during the course of the rate review."

In addition, in states without effective rate review and for which HHS is performing the rate review, it might be important to include the age, geographic area, and smoking status factors in the actuarial memorandum. There also may be some of this additional information in the other QHP rating template and business rules template that may provide what the reviewers need.

Index Rate

Section 1312(c) of the ACA requires insurers to combine all non-grandfathered business into a single risk pool. The experience period and projected period index rates are the mechanisms that implement the single risk pool. They are developed by combining the allowed claims experience of the enrollees in all non-grandfathered plans of an insurer in the individual or small group market (or combined, if required by state law). Such plans are those that provide essential health benefits. Excepted benefits (e.g., dental, vision, and short-term policies) are not subject to the single risk pool requirement. All rates for an insurer's non-grandfathered business effective Jan. 1, 2014, will be developed from the index rate.

It should be noted that the allowed claims experience should include only those essential health benefits that were in existence during the experience period, without any estimation of non-existent benefits. For example, if maternity coverage in the individual market did not exist during the experience period, no adjustment for maternity should be made in the index rate. Such adjustment should be made in the projection section of the URRT Worksheet 1. In addition, any benefits that are not considered essential health benefits, but were included in the experience period, must be removed from the calculation of the experience period index rate.

The projection period index rate also only includes projected allowed claims experience for essential health benefits and should not include any benefits in excess of the essential health benefits. In addition, it is important to project allowed claims assuming any projected membership for the cost-sharing reduction (CSR) variations, which would not be at the standard plan level but potentially at the higher projected allowed claims level for those CSR members (reflecting benefit richness).

The definition of allowed claims in the instructions to Part I includes all cost-share payments, whether from the member or from HHS, due to the CSR amounts. Since allowed claims may,

thus, reflect higher utilization assumptions for those CSR members, premium rate development will need to adjust out the value of the CSR variations in order to develop rates that are appropriate for the standard plan level only.

Rates are required to be shown to meet the new rating requirement of single risk pool rate development. This requirement identifies the starting point as the projected index rate and then three market-wide adjustments are made. The premium rate for any given plan cannot vary from the resulting adjusted market-wide index rate, except for the five plan-specific modifiers that are allowed. This approach may not be how the plan base rates are actually developed, but the actuary is required to show this approach in the actuarial memorandum. The discussion below highlights issues the actuary might need to consider.

Once the projection period index rate is set, a market-wide adjustment is made to the index rate based on the total expected market-wide payments and charges under the risk adjustment and transitional reinsurance programs in a state and the carriers' estimated user exchange fees for projected members expected to purchase on an exchange in the market. In this way, risk adjustment, reinsurance, and exchange user fees are spread across all products and plans in a market. Note that "market-wide" here means the carrier's market (i.e., individual, small group, or combined).

The resulting market-wide adjusted index rate is then used to develop premium rates, utilizing only the following factors:

- The actuarial value cost-sharing design of the plan.
- The plan's provider network and delivery system characteristics, as well as utilization management practices.
- Plan benefits in addition to the essential health benefits—the additional benefits must be pooled with similar benefits provided in other plans to determine the allowable rate variation for plans that offer these benefits.
- Administrative costs, excluding user fees.
- With respect to catastrophic plans, the expected impact of the specific eligibility categories for these plans.

The index rate, the market-wide adjustment, and the variations mentioned above must all be actuarially justified and implemented by insurers in a transparent fashion. The resulting calculations will produce average rates for all plans offered by an insurer in a state's market. The plan rates then will be adjusted by the following allowable factors, if applicable—age, geography, tobacco use, and family composition.

There are three different "actuarial value" terms used in the URRT and the actuarial memorandum. They are as follows:

- Metal-level actuarial value (AV)—defined by the standard population federally-designed AV calculator (referred to as "metallic AV" in this document).
- AV pricing value—defined in the instructions to the URRT as representing "the cost to the issuer of providing coverage under (each) plan (i.e., incurred claims and administrative costs) as a percentage of the cost of providing coverage for a fixed reference plan" (chosen by the actuary and identified in the actuarial memorandum).

- Actuarial value and cost-share design of the plan—defined as one of the allowed modifiers to move from the index rate to the base plan rate (referred to as the "AV modifier" in this document).

There is a distinction between the actuarial value produced by the AV calculator (the metallic AV), and the more traditional actuarial value used in pricing (a portion of the AV modifier). The AV calculator is not a pricing tool; it is a tool used to compare the relative generosity of benefits among plans and compliance with actuarial value requirements established under Section 1302(d) by the ACA (the metallic AV). It does not take into consideration anything specific to a particular insurer, most notably an insurer's provider reimbursement arrangements and utilization management practices. Also, the AV calculator does not account for all benefits (essential or non-essential health benefits) offered within a plan, and therefore will not adjust when cost-sharing differs by these benefits. Pricing using actuarial values developed independently of the AV calculator (AV modifier) are those that are specific to each insurer and should account for all benefits and cost-sharing variations offered. Therefore, AV modifiers should be used to develop plan-specific rates.

Because the projected index rate is reflective of the expected membership of a carrier, it does not reflect the aggregate base rate information. For example, if a carrier expects only to have 45-year-old members, the index rate would reflect that average age. If the "average age 45" index rate is then used to develop product and plan rates, applying the age 45 rating factor to the index rate would result in premiums that are too high, since the age 45 rating factor does not equal 1.0. The age 21 rating factor is 1.0. Similarly, the index rate is reflective of the average geographic area and smoking status of the projected population. Therefore, normalization for demographics (age), geographic area, and tobacco status will need to occur in the development of the AV modifier. Through communication with representatives of the Center for Consumer Information and Insurance Oversight (CCIIO), the work group understands that these adjustments must be made at the market-wide level—meaning the same normalization factor should be used for every plan in the development of the AV modifier.

In addition, as noted above, the projected index rate also will include the higher utilization expected for cost sharing reduction members. However, rates for CSR members must be the same rate as for a standard plan level member. Therefore, another adjustment needs to be included in the development of the AV modifier for each plan to decrease the effect of the higher utilization included in the index rate. Without this adjustment, standard plan rates would be too high.

Timing

There will be non-grandfathered policies that renew in 2013 with rates that will be effective through 2014. Rates for these groups will not follow the new ACA rating rules until their 2014 renewal date. The rules that they are exempt from include:[2]

- Essential health benefits;
- Actuarial value;

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule, Vol 77 No. 236 Part II, Published December 7, 2012

- Risk adjustment;
- Guaranteed availability;
- Guaranteed renewability;
- Modified community rating (unless already required by the state);
- Single risk pool;
- Risk adjustment;
- Risk corridors; and
- Reinsurance.

These policies will be subject to reinsurance and risk adjustment at the time of renewal in 2014, although there is state flexibility as to when these policies would be subject to the risk mitigation mechanisms in ACA, and the states may subject policies to the mechanisms prior to their renewal in 2014. However, these policies will have to begin paying for the reinsurance assessment beginning Jan. 1, 2014.

Rates are required to be filed for the individual and combined markets by April 30 of the preceding calendar year for the FFE. In addition, rates for the small group market for a FFE also must be filed by April 30, 2013, for use in the first two quarters of 2014 (at a minimum), until such time as HHS can accept additional quarterly rate filings for small group (expected no sooner than third quarter). State-based exchanges may have different filing timeline requirements.

Individual and combined markets are required to use calendar year experience from two years prior to the projection period. For example, 2014 individual rates would use calendar year 2012 experience.

In the development of rates effective in 2014 and 2015, there will be no base year experience available for the metal plans. There may be some plans that are already ACA compliant and have the appropriate actuarial value (metallic AV), but they are rare. Actuaries will need to use the base experience for non-metal plans and make adjustments to convert benefits to be ACA compliant.

The base experience available for rates effective in 2016 will consist of experience from metal plans with policy years starting in 2014 and non-metal plans experience with 2013 effective dates renewing in 2014. Again, actuaries will need to use the base experience for non-metal plans and make complicated adjustments to convert benefits to be ACA compliant. In addition, with 2014 being the first year for the metal plans, the first month or two may include artificially low claims as policyholders may not be able to set up routine medical examinations and other doctors' appointments due to switching to a new physician, slow issuance of an identification card, or other reasons. Adjusting for seasonality may be complicated since one or more months of experience may not be credible and because seasonality factors vary by plan of benefits and no experience yet exists for calculating seasonality for these benefits.

In the development of the 2017 rates the experience used will be the 2015 metal plan experience and, therefore, will be the first year that the experience used for rating will be completely from experience that is ACA compliant.

Given the timing issues stated above, there will be information required in Worksheet 2, Section 3 that will be difficult to complete until the experience period fully reflects experience under the ACA, most likely in calendar year 2015. This type of information includes separating the experience into EHB, state mandates, and other categories.

Uniform Rate Review Template (URRT)

There are numerous issues through which the actuary must navigate as he or she fills out the URRT (Part I).

Part I, Worksheet 1, Section 1

Part I, Worksheet 1, Section 1 only allows for one year of actual experience for the legal entity, state, and market segment (i.e., single risk pool) being filed. For the individual or combined market, the instructions state that the effective date must be January 1 and the experience period must be a calendar year period. For the small group market, the first date of the experience period must be the first date of a calendar quarter (i.e., January 1, April 1, July 1, or October 1). As also stated in the instructions, the actual experience for the experience period should be entered in the template, regardless of the credibility level. If a carrier would like to use more than one year of data in its projection, then this will need to be handled in the "Credibility Manual" part of Worksheet 1, Section 2. For example, smaller carriers with less credible experience may choose to use two years of data and perhaps weight the more recent annual period (Year N) more heavily than the less recent year (Year N-1). In this case, a carrier may enter the experience for Year N in Section 1 and enter the projected Year N-1 experience as the "Credibility Manual" in Section 2. Alternatively, the carrier may choose to use a manual rate to blend with the actual experience from the current year. In either case, the carrier will need to explain its methodology and the data source for the manual rate as part of the actuarial memorandum.

Part I, Worksheet 1, Section 2

Part I, Worksheet 1, Section 2 allows for four types of adjustments to the experience period data: population risk morbidity, other, cost, and utilization. The "Population Risk Morbidity" factor is applied to the utilization data while the "other" factor is applied to the cost per service data. These two factors are not annualized and are not "trended." They are applied directly to the experience data. Whereas, the "utilization" and "cost" factors are input as an annualized trend factor, trended by the calculated number of months from the experience period to the projection period, and then applied to the experience data.

The instructions are specific as to the type of changes that should be included in each of the adjustment factors. For example, the instructions state that changes in mix of services or changes in product mix should be included in the utilization trend, while changes in cost related to a change in the distribution of services across network providers should be included in the cost trend. The instructions also state that utilization trend would include changes in induced demand related to product mix and any effects of selection, and the "other" factor would include changes in the average utilization of services due to differences in average cost sharing requirements between the experience period and the projection period.

In the small-group market, employers historically have chosen a single carrier (or possibly two) with a handful of plans to offer their employees. Participation and contribution requirements helped to limit potential adverse selection across the group's members. The ACA has set a minimum participation rate of 70 percent. A carrier still can have a contribution rate. Effective 2014, small groups that do not meet the participation requirements can now enroll during a short open enrollment period from Nov. 15 through Dec. 15, potentially creating additional adverse selection to a carrier's small group line of business. This selection effect could be included in the "utilization" trend factor, and would result in being applied to the entire small-group market products (as is required by ACA).

Currently, the population morbidity, other, cost, and utilization columns do not accept factors that are less than 1.0. If a factor of less than 1.0 is necessary, the work group understands that there are two options:

- That the "Credibility Manual" section could be used to adjust to the appropriate result.
- That an input of less than 1.0 be used, and the error that results during validation be ignored when finalizing the template. The actuary would need to test that the input is used appropriately in the calculations in this instance.

The number of months of trend is automatically calculated in cell T21 of Worksheet 1. Note that it appears there may be an error in how the number of months is calculated in cases in which the experience period is three or more years prior to the rate effective date. However, since it is required that the most recent calendar year of experience be used for the individual and combined markets (i.e., for rates effective Jan. 1, 2014, the experience period must be CY 2012), the months of trend will be calculated as 24, which is accurate for the trended calculations.

We understand that the formula will be changed in future versions of the URRT so that the time period does not create any issues. (Please note that through communication with CCIIO the work group understands that experience period data cannot be older than 24 months. So this example is provided only to illustrate how the number of months is calculated.)

Population risk morbidity is further discussed under the section on *Enrollee Risk Profile Considerations.*

Given the standardization built into the federal forms, there will be many instances in which a carrier will have to modify the results of their rate development to fit the data required in these federal forms. It is recommended that in these cases, the carrier use the actuarial memorandum to clearly state the assumptions that were needed to "cross-walk" a carrier's rate development to the federal forms. The actuarial memorandum instructions also state the following:

> "The actuary may qualify the opinion, if desired, to state that the Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers."

Part I, Worksheet 2, Section 2

Part I, Worksheet 2, Section 2 requests the components of the premium increase separated by type of service categories in addition to administrative costs, taxes and fees, and risk and profit charges. Many carriers do not typically develop rates using a "bottom-up" approach that would allow them to detail the premium increase by these types of service categories. In these cases, one approach would be to determine the amount of total premium rate increase related to medical claims and to then allocate by type of service category using a projected distribution of claims by type of service. It is expected that a carrier will be able to isolate the component of the premium increase related to administrative costs, taxes and fees, and risk and profit charges.

Note that taxes and fees on Worksheet 2, Section 2 would include the reinsurance assessment and the risk adjustment fee, whereas on Part I, Worksheet 1, the reinsurance assessment is netted out of reinsurance recoveries and, thus, not included in the taxes and fees. The risk adjustment value is also net of the risk adjustment fee.

Part I, Worksheet 2, Section 2 also requests projected membership by plan within each metal tier. This will be an important assumption, as the weighted average components of the rate increase will be weighted by this membership and the average current rate PMPM to determine the overall rate increase for the product or plan. Note that in the case of a new plan, there will be no rate change to enter. (The carrier should review the instructions for specific direction on what to enter in the rate change fields for new plans.) It may be very difficult for a carrier to project membership by plan in 2014 with any amount of precision, especially for carriers that are intending to file new plans or products and especially in the individual market in which, in most states, there is expected to be an increase in membership to this population. There are many aspects that a carrier will want to consider in their membership projections, including the following:[3]

- Whether or not the state is expanding its Medicaid coverage.
- Whether or not the state will introduce a Basic Health Plan.
- The size and income distribution of the uninsured population in the carrier's market.
- Whether or not the state is maintaining its high risk pool.
- Any available information on whether small employer groups are planning to stop offering health plan coverage in the carrier's market.
- Any available competitor information on new products being marketed and potential price points for these products.

Part 1, Worksheet 2, Sections 3 and 4

In the 2014 rate filings and possibly the 2015 rate filings, many carriers may close current products or plans and offer new products or plans. In the case of a new product or plan, there will be no information completed in Worksheet 2, Section 3 "Experience Period Information," but there will be information completed in Worksheet 2, Section 4 "Projected Period Information." In the case of a closed product or plan, it is expected that there will be no information completed

[3] Except for the last item, the other items are primarily impacts to the individual market or combined market, rather than the small group market.

in Worksheet 2, Section 4 "Projected Period Information," but there will be information completed in Worksheet 2, Section 3 "Experience Period Information."

Part I, Worksheet 2, Columns A and B calculate or reference values from Worksheet 1 that are meant to be compared to comparable values from Worksheet 2. "Warning" messages are generated in Column A if the difference between these values are outside of a +/-2 percent range. HHS has indicated that these warnings are to provide guidance to the actuary completing Part I, but a warning does not necessarily mean that the Part I cannot be validated and uploaded into Health Insurance Oversight System (HIOS). In fact, there are specific instances in which a warning message will be generated. For example, it is likely that a warning will be generated in cell A86 in many cases given the differences in how reinsurance and risk adjustment are treated in each of the Part I worksheets. If there is a warning generated in Column A of Worksheet 2, the actuary should provide an explanation in the actuarial memorandum.

Other Technical Issues

There are other technical issues with the URRT and missing guidance, for which the work group can offer some information based on communication with representatives from CCIIO. For example, if a carrier is filling out the form for the small-group market, Part I, Worksheet 1 does not allow any input in the reinsurance recoveries net of reinsurance contributions line. In this instance, the reinsurance contributions should be included in the taxes and fees line.

If a carrier is a brand new carrier with no previous experience, Part I, Worksheet 1 does not allow zeros to be used for the experience. We understand that it is appropriate to use values very close to 0 (e.g., 0.0000001) in this situation.

On Part I, Worksheet 2, if too many products are added, the ones that are not needed cannot be deleted. Instead, the actuary would need to start over with the input process.

On Worksheet 2, for terminating products, a zero can be used for the metallic AV, and a near-zero value (e.g., 0.0000001) can be used for the AV pricing value.

On Worksheet 2, the instructions indicate for new plans that the historical rate increase lines need to be left blank. However, if the lines are left blank, the actuary would get an error when trying to validate input. Therefore, zeros can be used in these lines.

On Worksheet 2, for terminating products, zeros can be used for the rate change percentage (over prior filing) and for the cumulative rate change percentage (over prior 12 months).

On Worksheet 2, Section 2, for both terminating and new plans, in the lines for the components of rate increase by service category, it is recommended to use zeros in these lines.

On Worksheet 2, the net amount of reinsurance is only recoveries and is not net of reinsurance premium, as it is on Worksheet 1. We understand that it may be appropriate to include the reinsurance assessment in the taxes and fees in Section 2, components of rate increase, in situations in which products are being modified. But for new products, there would be no place on Worksheet 2 to reflect the reinsurance assessment, since the components of rate increase should be input as zeros. This should be explained in the actuarial memorandum.

On Worksheet 2, the "net amount of risk adjustment" has not been corrected to be able to accept negative values. It is suggested for products being modified to include any negative risk adjustment values in the taxes and fees line of Section 2, components of rate increase. For new products, the risk adjustment is not needed to be reflected by plan, so no input is required. However, the actuary would need to explain this in the actuarial memorandum.

Enrollee Risk Profile Considerations

Overview

The actuary should estimate incurred claims before considering adjustments related to risk adjustment and reinsurance transfers based on the population expected to be enrolled during the rating period. The actuary should separately estimate risk adjustment and reinsurance transfers for the rating period. These separate, but related estimates may share common components, but usually will not be completely consistent.

This section discusses each of these primary steps separately.

Issuer Risk Profile (Morbidity)

The final rule states that HHS will conduct rate review using the same kind of criteria that states with an effective rate review process follow. Among other important items, effective rate review takes into account the impact of changes in morbidity. As such, Part II (in cases in which morbidity changes are a key driver of a rate increase) and Part III should include commentary of enrollee risk profile changes.

Part III technical commentary should discuss the important considerations described below, keeping in mind this is in regards to the overall issuer's book of business and not by individual plan since health status is not allowed in pricing by plan.

- Assumptions and data sources for expected average morbidity in the experience period for the population expected to be enrolled with the issuer;

- Enrollee risk profile changes anticipated for the issuer since the experience period;

    - The issuer should reflect potential new members (including potential high risk pool members, newly insured without premium or cost sharing subsidies, newly insured with premium or cost sharing subsidies, and those coming from prior employer coverage).

      The morbidity of the previously uninsured may be very different than the current population. This will vary by state depending on the state's rating changes before and after 2014.

    - The issuer should consider the "pent up demand" effect of those previously uninsured seeking coverage and how to incorporate the potential temporary increase in utilization.

- The issuer should consider the effect of enrollee movement to products outside of the risk pool, including the Basic Health Plan and Medicaid.

The issuer should separately document how changes in enrollee risk profile contribute to the change in the projection period's utilization and average cost per service shown in Worksheet 1. This would include shifts in product mix, and related induced demand and any selection effect.

Results from several recently released studies may be useful to adjust a carrier's experience period data to the projection period. In addition, many states have conducted their own analysis of the impact of the ACA on their particular markets and many of these are publically available and can be found online. Larger carriers may have also conducted their own internal analysis simulating the impact of the ACA on their current populations. It should be noted that when using any of these kinds of studies, the actuary developing the rates needs to clearly understand the assumptions and data sources used in the study to ascertain if the results are applicable to their population and if any further adjustments are necessary.

Risk Adjustment Transfer

Transfer Formula

The HHS risk adjustment transfer formula is as follows:

HHS Transfer formula: T_i

$$= \left[\frac{PLRS_i \times IDF_i \times GCF_i}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{AV_i \times ARF_i \times IDF_i \times GCF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)}\right] \bar{P}_s$$

Where:

T_i=Transfer for plan i

$\bar{P}_s$=State Average Premium

$PLRS_i$=Plan i's plan liability risk score

IDF_i= Plan i's allowable rating factor

AV_i=Plan i's metal level AV (metallic AV)

ARF_i=Plan i's allowable rating factor (age)

GCF_i=Plan i's geographic cost factor

s_i=Plan i's share of State enrollment, and the denominator is summed across all plans in the risk pool in the market in the state

The two summary level terms in the formula are identical except the first term uses plan liability risk score (PLRS), which reflects both morbidity based risk scores and the actuarial value of the enrolled members, while the second term uses allowable rating factor (ARF), or age factor, and a separate actuarial value term (AV modifier). Other variables are included and are present to capture the interaction between variables. The actuary would need to understand the mechanics of this formula and the impact of this interaction.

The state average premium ($\bar{P}_s$) in the formula above is an important component of the formula but may be difficult to estimate. The actuary would be prudent to consider available sources of information in estimating this value, but also recognize and communicate the inherent difficulty in estimating it.

Estimating the plan liability risk score and the allowable rating factor for the issuer relative to the state/market will usually include an estimate in the experience period (if feasible, especially in 2014) and an estimate of changes between the experience period and the rating period. These analyses may parallel the estimates of an issuer's morbidity in the experience period and changes in an issuer's morbidity, although differences may exist since risk adjustment methodologies do not entirely reflect morbidity.

While Part I does not require risk adjustment values to be included for 2012 experience or for the projection period in the 2014 form, it will be a challenge to estimate the risk adjustment impact for 2014 and 2015 experience period, as the risk adjustment program for small-group and individual markets is new under the ACA, and little, if any, experience exists to estimate the impact by carrier within each risk pool. If an actuary assumes no risk adjustment payments or charges (other than the risk adjustment fee of $1 PMPY), it is important for an actuary to explain this in the actuarial memorandum.

Risk Score

Factors to consider in assessing enrollees' risk score changes for the issuer relative to the statewide market:

- The issuer should include a non-technical description of the major reasons driving a change in relativities from the experience period;

- The issuer should model the reasonable range of the risk relativity to the statewide market for the projection period and include a discussion of the financial effect on rate sufficiency when outcomes deviate from the chosen single point estimate;

- The issuer should consider the possibility of changes in coding intensity for the market versus their own pool. Consistent changes in both likely would not affect rates materially, but differences between the market and the issuer would.

A major purpose of risk adjustment is to protect issuers against potential adverse selection effects that are not already handled by permitted rating variations. Transfers should reflect health risk and not other cost differences, and funds from issuers with relatively lower-risk enrollees would go to issuers with relatively higher-risk enrollees. In applying any risk adjustment system, an actuary is expected to consult ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*.

Justification of Risk Adjustment Transfer Amount

Per the actuarial memorandum and certification instructions, issuers need to include the following information in their rate justification:

> "Under the single risk pool pricing requirements, issuers are required to make a market wide adjustment to the pooled market level index rate to account for federal risk adjustment and reinsurance payments and charges…issuers must explain how they developed their estimated risk adjustment revenue for all of the plans in the risk pool. Issuers are expected to explain all of their market and plan level assumptions related to the inputs of the HHS payment transfer formula (or alternative state payment transfer formula, if applicable). In other words, issuers must explain their assumptions related to plan and market level risk scores and other relevant cost factor adjustments that are used to calculate payment transfers under the risk adjustment program."

First, issuers will need to estimate the risk score for their own book of business as well as a risk score for the overall statewide business for all issuers, for the individual market and small-group market separately, or combined for states with a merged risk pool. Projection of the average (all issuers) *statewide* risk score is paramount in setting all non-grandfathered premiums. The projection needs to take into consideration all current non-grandfathered plans and new products. The projected average statewide risk score should be used consistently when estimating transfer amounts for each plan. Because the statewide average enrollee risk score will significantly impact a given plan's risk transfer, the issuer should provide as much support for the anticipated statewide average enrollee risk score as possible, particularly when little experience data is available or when enrollee composition in plans might not be stable.

Since risk scores will only be assigned to enrollees for the period they are in plans under the single risk pool rule, issuers should also take into consideration how enrollees will be phased into the market over time. This would affect both the number of enrollees in the market as well as the enrollee's risk score.

While risk adjustment transfer calculations are presented at the plan/rating area level, both the actual payment transfers and the anticipated risk adjustment transfers that are built into the index rate are performed at the issuer level. In practice, issuers will have to project which plans will receive payments and which plans will be assessed charges, and then sum them all up at the issuer level for the index rating and input an aggregate in Worksheet 1. This is an area of uncertainty for an actuary and should be articulated in the actuarial memorandum.

Issuers need to explain the assumptions behind each of the factors shown in the above risk adjustment transfer formula.

Issuers need to explain the assumption behind the derivation of the statewide average premium, taking into consideration current non-grandfathered plans and new products and the impact of enrollees phasing into the market.

Next, issuers need to explain how the risk adjustment amount is allocated by plan. As noted in the instructions to the actuarial memorandum:

> "Consistent with this adjustment, anticipated risk adjustment revenue must be allocated proportionally based on plan premiums for all plans within a risk pool by applying the risk adjustment transfer adjustment factor as a constant multiplicative factor across all plans."

The estimated risk adjustment revenue needs to be first developed for *all* of the plans in the risk pool, and allocated to individual plans. Issuers should explain the derivation of the anticipated risk adjustment transfer amount by plan that sums to the overall transfer amount, the constant multiplicative factor used for allocation, and how anticipated risk adjustment transfer revenue is allocated to plan premiums in the risk pool. Note that the anticipated risk adjustment transfer amount by plan would most likely not be the same as the allocated risk adjustment transfer amount used for rating purposes.

The overall risk adjustment transfer amount (and risk adjustment fee of $1 PMPY) would be entered in the URRT Worksheet 1, Section 3, as "Projected Risk Adjustment, PMPM." The allocated risk adjustment transfer revenue by plan would be entered in the URRT Worksheet 2, Section 4, as "Net Amount of Risk Adjustment."

Lastly, the instructions also state:

> "Issuers should explain any potential outlier assumptions that have a significant impact on transfers."

An example of an outlier assumption could include an assumption or set of assumptions that implies that the issuer is expected to receive (or pay) a significant transfer of funds. The issuer should include documentation to support the reasoning behind outlier assumptions.

Other considerations in assessing the risk adjustment transfer amount:

The "Projected Risk Adjusted PMPM" on Worksheet 1, Section 3 is incorporated into the definition of "Projected Incurred Claims." Similarly, risk adjustment transfer payments and charges are reflected in the numerator of the adjusted MLR. While this may lead one to consider the treatment of risk transfer amounts as similar to incurred claims, it is important to note that the value of actual risk adjustment payments is calibrated on premiums, not incurred claims. The issuer should consider how risk adjustment calibration by premiums rather than incurred claims plays a role in their pricing.

The issuer should consider the reasonable range of adjusted MLRs as well as the possibility of rebate payments due to incorrectly estimating the issuer's own risk profile, the statewide risk profile, as well as the relativity between the two. One approach is to contemplate the reasonable range of issuer versus statewide anticipated risk profiles, incurred claims, and premiums to understand the reasonable range of resulting risk transfers and rebates.

Conclusion

As of this writing, guidance is still being released by HHS in the form of "frequently asked questions," sub-regulatory guidance, and other forms. The actuary is encouraged to stay abreast of new information being released by HHS and by each state. It is expected that the URRT will be updated after the 2014 QHP and rate filings have been completed. Therefore, guidance in this practice note addendum may be out of date before the April 30, 2014, filing for 2015 rates.