May 2, 2011

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attn: CMS-10379
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for comments regarding the disclosure forms associated with the review process for unreasonable rate increases

To Whom It May Concern:

On behalf of the American Academy of Actuaries'[1] Premium Review Work Group, I appreciate the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the request for information related to the forms associated with the disclosure and review of "unreasonable" premium increases under the Affordable Care Act (ACA). This letter includes both general and specific comments on the preliminary justification form and instructions as well as the disclosure form designed to inform consumers about a health insurance issuer's rate increase.

The following are general comments we have about the preliminary justification form/instructions and the consumer disclosure form:

- *Purpose of forms:* We encourage HHS to clarify the purpose of each of the required forms. Because of the simplified nature of Parts I (rate summary worksheet) and II (explanation of the rate increase) of the preliminary justification form, it appears to us that the information provided on that form is intended solely to populate the consumer disclosure form and not to evaluate actual rate increases. If this is the purpose, HHS should make that clear in the forms' instructions. If the purpose is to support a rate review and approval process, we believe the forms would require significant modification. Table 1 addresses our concerns with the consumer disclosure form, including consistency between the consumer form and the rate summary worksheet. As noted, our primary comments assume that Parts I and II are not used for the review of rate increases. In the event that our assumption is incorrect, we have included Tables 2 through 4 outlining our more significant concerns with the preliminary justification form, specifically the values reflected in the rate summary worksheet and the instructions for completing all parts of the form.

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and 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.

- *Values in the consumer disclosure form:* The values currently reflected in the form do not represent how any particular issuer would develop its future rates and increases. In addition, according to HHS' proposed rule on rate increase disclosure and review, this information does not represent any particular premium or premium increase percentage that might be experienced by a given individual or small group employer. It is meant, instead, to reflect averages across all products included within a filing and on a rate table basis.[2] Aging of an individual into a new age band, for example, would not be reflected in the information provided in the rate summary worksheet, so it would not be reflected in the disclosure form. The information available for the disclosure form, therefore, would not match the percentage increase in a renewal notice for any particular consumer, except in a few circumstances (e.g., a community-rating approach using a single-rate basis).

- *Difference between premium and rate increases:* Many of the numbers included in the disclosure form are taken directly from the values in the rate summary worksheet. Given our concerns with the rate summary worksheet, we believe that this information could be misleading to consumers. For example, based on the language used in the form, consumers might expect their premium increases to be within the range provided, which may not be the case. This is because, as drafted, the range provided on the form is for the rate increase, not the premium increase. This could be confusing to the consumer.

- *Medical loss ratio (MLR) reporting:* Based on our understanding of the purpose of the form, we do not believe it is necessary for the values included in Parts I and II of the preliminary justification form, as well as those used in the consumer disclosure form, to be consistent with the values included in MLR reporting. The adjustments to the claims (numerator) and premium (denominator) that are made when developing the MLR report should not be reflected in these values. We recommend that HHS put a disclaimer on Parts I and II, as well as the consumer disclosure form, stating that the values presented in the forms are not meant to be consistent with MLR reporting. In addition, the instructions should state that adjustments that are part of MLR reporting should not be made in the values presented in Parts I and II. This could mitigate confusion by the users of the forms if they attempt to compare loss ratios presented in these forms with the federal MLR standards.

- *Rating changes in 2014:* A number of regulatory changes that will affect premiums are scheduled to be implemented in 2014. We encourage HHS to consider updates to these forms that could be necessary due to the effect of some of those changes. For example, some policyholders may experience rate changes due to age compression, elimination of gender rating, etc., that may not be associated with a rate increase. It may be necessary to communicate this to consumers.

- *Calculation of rate increases:* In response to the proposed rule for rate increase disclosure and review, our work group proposed a revision to the way in which rate increases are determined for Section 154.200.[3] The following is an excerpt from the letter:[4]

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[2] See page 81009 of the proposed rule on rate increase disclosure and review: http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf. (Dec. 23, 2010)

[3] See proposed rule on rate increase disclosure and review: http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf. (Dec. 23, 2010)

> "We suggest the average rate increase be calculated differently. The rate increase should be equal to new revenue divided by old revenue minus 1.0. Old revenue refers to the sum of all current premiums for each insured person affected by a rate increase filing; new revenue refers to the sum of all new premiums over the same population.
>
> We recommend that the composite rate increase be determined by calculating the percentage increase in revenues resulting from the proposed rate increase (or cumulative 12-month increase when appropriate) on an aggregate basis, all segments combined. The enrollment population included in the rate filings should be used in calculating revenues before and after the rate increase. The definition of 'rate increase' in CFR Section 154.103 should be revised accordingly, as well as the discussion in the preamble."

The rate increase definition we suggested in our letter is consistent with the rate increase proposals typically submitted to states, as well as those anticipated to be submitted to HHS. Any other means of calculating the average rate increase would not be consistent with the rate increase filing and would yield a result different from the rate increase submitted.

- *Glossary:* We encourage HHS to develop a glossary to help consumers understand the terminology used throughout the disclosure form. We would be happy to assist the HHS in developing such a glossary of relevant terms.

If the information in the rate summary worksheet is corrected to reflect appropriate values (see our comments in Tables 2 through 4), then the comments in Table 1, specific to the consumer disclosure form, will enhance the understandability and usefulness of the form for consumers.

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

Sincerely,

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

[4] American Academy of Actuaries' Premium Review Work Group's comment letter on the HHS proposed rules related to rate increase disclosure and review: http://www.actuary.org/pdf/health/AAA%20comments%20on%20rate%20review%20prop%20regs%20022211%20final.pdf. (Feb. 22, 2011)

Table 1: Consumer Disclosure Form

Page/Section	Issue	Recommendation
Page 1, third bullet	The following statement is incorrect: "The law requires a review of these proposed rate increases by States, or if as State does not review insurance rates, by the federal government, to determine if the proposed increase is unreasonable."	We suggest the following modification to the statement: "The law requires a review of these proposed rate increases. If a state is determined by HHS to have an effective rate review program, the state will determine whether the proposed rate increase is actuarially justified. If not, [the federal government] will make the determination."
Page 2, second bullet under *How will this rate increase affect the premiums people pay?* "The 11.8% is an average increase for all policyholders. The insurance company has stated that the minimum premium increase any of its customers will receive will be 5% and the maximum is 13.6%. The new premiums people will pay will be in that range."	In the first bullet under this section, the terms "rate" and "premium" are defined but then used incorrectly in the second bullet. The minimum and maximum "premium increase" as listed should be the minimum and maximum "rate increase." The rate may be within the specified range, but the actual premium could be different.	The language in the second bullet should be modified to, "The 11.8% is an average *rate table change* for all policyholders. The insurance company has stated that the minimum rate increase any of its customers will receive *as a result of rate table changes* will be 5% and the maximum 13.6%." The last sentence should be dropped because it is incorrect.
	The increases included in this form are meant to reflect individual rating cell changes or how the rates in the rate table have changed. If a plan member ages into another age band or changes family status, region, or product chosen, the maximum rate change would not necessarily be reflected in the maximum calculation, and, therefore, cannot explain a particular individual's or small group's actual rate change.	HHS should state clearly that the increase percentages reflected in the form are changes to the rate table only. For example, the percentages do not reflect an increase that specific individuals or groups may see because they age, change family status, move into a different rating tier, move to a new region, or choose a different product.
	For small group plans, if the employer changes the premium contribution amount for members, the actual increase in contributions may have nothing to do with the premium increases reflected in Part I of the preliminary justification form.	Separate forms for the individual and small group markets should be created. The language on the small group form should indicate that the form reflects increases the employer is expected to see and not necessarily the premium contributions that are made by employees.
Page 2, *When will this take effect?*	The disclosure form identifies only one date when rates will become effective. Many rate schedule changes take effect on renewals and new policies first delivered for effective dates on or after some specified date. A single date is misleading.	The language should be modified to reflect that the rate schedule changes take effect on anniversary dates or renewal dates between the first date of the effective period and the last date of the effective period. In addition, language could be added to prompt consumers to contact the issuer if they have questions about when

		any rate increase will take effect.
Page 3, *Section 1: What is Causing the Proposed 11.8% Rate Increase* Factors Impacting Proposed Rate Increase—Profit or Retained Earnings	The values presented in the rate summary worksheet, from which this form is populated, use the term "underwriting gain/loss." That is not the correct terminology. The value is not profit nor retained earnings and should be labeled appropriately—the value is the margin remaining after claims and certain expenses.	The term "margin" should be used instead of "profit or retained earnings" as the values do not represent either profit or retained earnings but imputed margin.
Page 4, *Section 2: Rates and Medical Costs*	The categories listed on the disclosure form do not match the categories in Part I (the rate summary worksheet).	The same categories should be included on both the consumer disclosure form and the rate summary worksheet.
	The footnote includes a description of items that are included in "other costs." If the same categories are used on this form as are used on the rate summary worksheet, then "capitation" would be listed on a separate line (not combined with "other"). In addition, "ancillary services" is not included in the rate summary worksheet.	The footnote should be modified to describe the appropriate items included under "other."
Page 5, *Section 3: New Rate*	With respect to "profit or retained earnings," the values presented in the rate summary worksheet, from which this form is populated, use the term "underwriting gain/loss." That is not the correct terminology. The value is not profit nor retained earnings and should be labeled appropriately. The value is merely the margin remaining after claims and certain expenses.	The term "margin" should be used instead of "profit or retained earnings" as the values do not represent either profit or retained earnings but imputed margin.
	The breakdown of medical costs into hospital inpatient, outpatient facility, professional services, prescription drugs, ancillary services, and other, are not the same categories used in the rate summary worksheet. The percentages are not actually calculated on the rate summary worksheet.	The same categories should be included on both the rate summary worksheet and the consumer disclosure form. In addition, the percentages of the medical services should be calculated on the rate summary worksheet so that no additional calculations would need to be made for the purposes of consumer disclosure.
Page 6, *Section 4: Past Rate Increases*	In cases in which issuers are providing a rate filing for the first time (filings and/or approvals have not been required) or the history is less than three years, it should be acceptable to leave the "increase the company asked for" blank or blank for prior periods that did not exist.	HHS should clarify whether, in situations in which previous history does not exist, leaving the section blank or stating "no prior increase" is appropriate.

Page 7, *Section 5: Other Information for Consumers*	The identifying information should be consistent with the information provided through the HHS portals.	HHS should ensure that the identifying information used here is the same as the information provided in the portals.

Table 2: HHS Preliminary Justification Form: Rate Summary Worksheet (Part I)

Page/Section	Issue	Recommendation
Section A: Base Period Data	The form instructions request the inclusion of an estimate of unpaid claims by service category, which few health plans will have. Estimates of unpaid claims are based on historical data that generally will be in different categories and vary widely by company. Unpaid claims estimates are also on a paid basis, not necessarily on an allowed basis. This would require an adjustment to the incurred but not paid (IBNP) claims to be used with allowed dollars. In addition, the instructions for Parts I and II are not clear on whether provider incentives are to be included in allowed and net, along with expenditures to improve quality.	The instructions should allow for an adjustment as appropriate for unpaid claims. They also should note that the adjustments for unpaid claims are estimates.
Section B1 and B2: Claim Projections	Capitation is separated from other service categories. The sample does not reflect cost shares for capitation, yet there are often copayments associated with capitated services. Sometimes encounter data (e.g., number of office visits) are not collected completely for capitated services. If cost shares of capitated services are reflected in the service category related to capitation (e.g., copayments for professional services for primary care capitation), there is the potential that the value of member cost shares for capitation would be understated due to incomplete encounter data reporting.	The instructions should identify this as a potential issue and the issuer should be asked to include in Part II an explanation of its expectation of whether the value is understated or complete.
Section C: Components of Current and Future Rate Increases	In the *Prior Estimate of Current Rate,* the instructions state that per member per month (PMPMs) should be input based on the pricing assumptions in an earlier rate filing for the current rate. For comparisons of PMPMs to be valid, the population (mix of demographics and products) should be the same for each period's	The instructions should be modified to reflect that a single population—the one used to develop the future rates—be used in Sections B1, B2, and C. For Section C, specifically, the current rate table should be applied to the single population identified.

	calculation. If the previous rate filing net claims are used without adjusting for the population that is being used to develop the future rates, then the change in claims from "prior" to "future" also will reflect a different demographic and product mix than was used in the last filing. In addition, the change in demographics and product mix would flow through into Section D, Line 8, *Correction of Prior Net Claims Estimate.*	
	There is what could be considered a loss ratio calculation in this section (percent net claims over total rate) for both future and current rates. As the four parts to the MLR will change over time, the loss ratio per the instructions will bear no relation to the MLR that will be the focus of premiums in the future.	HHS should include in the instructions a disclaimer that the values here are not meant to be consistent with MLR reporting.
	Line 5, *Overall Rate Increase,* is calculated automatically. Without the rate summary worksheet provided as a working spreadsheet, it is unclear how the overall rate increase is calculated.	HHS should release a working spreadsheet, and the instructions should be expanded to discuss how to reflect all prior rate increases that have occurred within the past 12 months. The instructions also should include a discussion of how to reflect prior rate increases that have not occurred 12 months apart. As noted earlier, we recommend HHS revisit the rate increase calculation to be consistent with the actual rate increase submitted to the state or HHS.[5]
	In the instructions, under Section C, the second sentence states, "The administrative and underwriting gain/loss components should be reported consistently with how terms are determined for state rate filings and financial reporting and should adhere to Generally Accepted Accounting Principles (GAAP)." Most rate filings are not based on items calculated under GAAP. Most states assume statutory financial reporting consistency in the approach to calculating values for rates. For example, for products such as individual medical in which first-	The language should be modified to "The administrative and underwriting components of the margin should be reported consistently with how terms are determined for state rate filings."

[5] American Academy of Actuaries' Premium Review Work Group's comment letter on the HHS proposed rules related to rate increase disclosure and review: http://www.actuary.org/pdf/health/AAA%20comments%20on%20rate%20review%20prop%20regs%20022211%20final.pdf. (Feb. 22, 2011)

	year commissions differ from renewal commissions, the administrative expenses should be net of deferred policy acquisition cost (DPAC). Companies preparing only statutory financial statements probably are not currently calculating any DPAC balances.	
Section F: Range and Scope of Proposed Increase	It is unclear what values are required for the number of covered individuals and policyholders in Section F, *Range and Scope of Proposed Increase.*	The number of covered individuals and policyholders included in the single population used to develop the future rates should be indicated.
	According to the instructions for the minimum and maximum current and proposed premiums, the values to be entered are the lowest and highest "premiums," which may not correspond to the lowest and highest "rate increases." In fact, it is likely that the two are different.	The instructions should require values that reflect the minimum and maximum rate increase percentages from the rating table.
	The proposed rule on rate review and disclosure states that the rate increases being reviewed are "…the underlying rates and methods that are the subject of the actuarial review…" The information provided in Parts I and II of the preliminary justification form, therefore, is based on rate table changes, not premium changes. As a result, the effect of an individual changing rating areas, aging, or changing family status, duration, or health status is not reflected in the values presented in the form. Such changes should not be included in the calculation, and the increase reflected in Section F should be calculated from one (current) rating cell to the same (proposed) rating cell.	The instructions should clarify how the increase is to be calculated. HHS could consider language similar to that on the NAIC Rate Filing Disclosure Form—"The minimum/maximum rate increase represents the range of increases consistent with proposed changes in the rate table/manual." We interpret this language as applying to a person of the same age before and after the rate increase.
	The information in Section F (minimum and maximum current and proposed premiums) seems to be used in the consumer disclosure form only to identify a range of potential increases. This section was not discussed in the proposed rule. We have some concern with how this range could be used, as the maximum percent change is likely to be more than the threshold and more than the average used to determine whether a proposed rate	HHS should clarify the intended purpose for this information, as well as indicate that the range is not used to compare to the threshold to determine whether a proposed rate increase needs to be filed using these forms.

	increase needs to be filed under the proposed rule.	
General Concerns	There appear to be discrepancies as a result of rounding in the worksheet.	A disclaimer explaining that values may not match due to rounding should be included.
	It will be important that issuers reflect the value of coordination of benefits (COB) appropriately in Parts I and II of the preliminary justification form. If the value of COB is not removed from *Allowed Claims*, it would by default be included in *Member's Cost Sharing* and, thus, overstate the cost-sharing amount. If COB is added back to *Net Claims*, that would not reflect the true paid claim amount. If COB is removed from *Allowed Claims*, the values would be more meaningful.	The instructions should remove COB from the development of *Allowed Claims.*

Table 3: HHS Preliminary Justification Form: Written Explanation of Rate Increase (Part II)

Page/Section	Issue	Recommendation
Financial experience of the product	It is likely that attempts at comparisons to the federal MLR standards will be made. If a disclaimer that the items are not meant to be consistent with the MLR standards is not included, then the instructions should include a request that issuers provide a discussion of the difference in Section 2. In addition, there are states that have regulations requiring loss ratios that are different from the federal MLR standards.	The instructions should request that issuers provide an explanation of the differences in the loss ratios reflected on the rate summary worksheet from the MLR standards, as well as identify whether state requirements related to loss ratios result in further differences.

Table 4: HHS Preliminary Justification Form: Rate Filing Documentation (Part III)

Page/Section	Issue	Recommendation
General Comments	When will HHS complete the state determination on rate review effectiveness? How much lead time will states have to adjust their process to meet the requirements prior to HHS having to review rate filings? How much lead time will insurers have when providing rate increase requests to HHS? While companies have experience with existing state requirements, it will take several months of lead time for insurers to prepare HHS	We recommend that the effective date be delayed appropriately. This would allow states to respond to issues related to effectiveness of rate review, and would provide insurers with sufficient time to incorporate and implement changes into their rate filing process.

	filings and work with HHS to finalize and implement an increase.	
Instructions, second paragraph, *Reporting elements*	There are a number of items on the required reporting elements list that do not seem to make sense for individual and small group health insurance.	The instructions should be modified so that a company needs to include only those elements that are relevant to a rate increase.
List of Part III Reporting Requirements	There are no definitions of any of the reporting requirement items.	Definitions should be provided. as appropriate.
Item 1.l.vi, *Premium Classifications*	What is required under *Premium Classifications*? Is this intended to reflect rate tiers as they pertain to health status (e.g., standard and sub-standard)?	HHS should clarify what *Premium Classifications* means.
Item 3, *Average annual premium per policy, before and after rate increase*	For comparisons to be appropriate, the same set of covered lives and elected plans should be used for calculating the "before" and "after" average rates.	Issuers should be instructed to use the same set of covered lives and elected plans when calculating the "before" and "after" averages and that this population should be the same as the population used to develop the future rates.
Item 4.d, *Evaluation Period, Experience Period, Projection Period*	What is the "evaluation period"? Is that different from "experience period"?	The definition should be clarified or the term should be removed from the list.
Item 4.g, *Incurred But Not Reported (IBNR) Claims*	It is unclear how much detail HHS requires in this section.	HHS should clarify the detail it would like to see for this item.
Item 5.a.i, *Profit and Contingency*	It is unclear how much detail HHS requires in this section.	HHS should clarify in the instructions that this item should reflect target risk and contingency. In addition, an explanation on the level assumed should be requested.
Item 5.c, *Overall Premium Impact of Proposed Increase*	This item seems redundant after considering what is required in Item 3, *Average annual premium per policy, before and after rate increase*.	This item should be removed.
Item 5.e.iii, *Trend Assumptions*	It seems that the trend assumptions are required under Items 5.e.i.1 and 2.	HHS should clarify that trend assumptions should be included in the descriptions under Items 5.e.i.1 and 2 and remove this as a separate item.
Item 5.e.iv, *Interest Rate Assumptions*	An interest rate assumption may not be relevant to the determination of the rate increase. For example, rates developed for the next calendar year often are calculated without an interest rate assumption.	The instructions should note that if an interest rate assumption is not used in the rate increase calculation, it should be disclosed.

Item 5.e.v, *Other Assumptions, including Morbidity, Mortality and Persistency*	Mortality assumptions typically are not relevant unless premiums are projected over a period greater than one year. This section, however, allows the opportunity to include discussion on items such as change in risk mix (expected with new exchange members), persistency, and other contributing factors.	This section should be described as *Other assumptions, including impact of changes in persistency, risk, and product mix.* In addition, insurers should be allowed to identify which assumptions are not relevant for the proposed rate increase.
Item 5.f, *Company Financial Condition—Risk Based Capital and Company Surplus*	These items should not be considered as part of a rate review process. In particular, the NAIC RBC for Health Organizations Model Act specifically states in Section 8(F) that RBC reports "shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance."	These items should be removed from the list.
Item 7, *The projected future loss ratio and a description of how it was calculated*	This should be assumed to be the projected loss ratio over the coming rating period for which the rates are being proposed.	HHS should provide a definition of future loss ratio to include the projected loss ratio over the coming rating period for which the rates are being proposed.
Item 7.a, *Loss Ratio Exhibit*	This item appears to be the same as Item 8.	The description should be modified to exclude Item 7.a.
Item 9.a.i, *Anticipated loss ratio presumed reasonable according to the guidelines including adjustment for credibility if applicable*	Some states require loss ratios different from the federal MLR requirement, and the rate increase filing should demonstrate that the market-based federal MLR standard also is expected to be met.	HHS should provide instructions related to this item, reflecting that the federal MLR standard is a market-based standard that applies to an entire line of business. Filings for products may reflect loss ratios higher or lower than the federal MLR standard. If the future anticipated loss ratio for a particular filing is below the federal standard, that alone is not a reason to consider the increase unreasonable. In addition, state regulations or other guidelines could be more appropriate for a particular filing as opposed to the federal MLR requirement.