



AMERICAN ACADEMY of ACTUARIES

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September 22, 2015

Ms. Kimberly Cones
Acting Director, Rate Review Division
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

Re: Suggested Changes to the Unified Rate Review Template (URRT) and Rating Methodology

Dear Ms. Cones:

On behalf of the American Academy of Actuaries'¹ Premium Review Work Group, I would like to outline a number of suggested changes to the Unified Rate Review Template (URRT) and rating methodology that could result in a more user-friendly form and process. In general, we recommend the Center for Consumer Information and Insurance Oversight (CCIIO) undertake a periodic review of the URRT to determine and document whether each component is still required for rate filing and review purposes. For example, Section 2 of Worksheet 1 may have once been used to populate information on the consumer information sheet via healthcare.gov; however, that is no longer being done. So, the question is whether the components in that section are still needed. Understanding the purpose and use of each component is crucial to ensure uniform comparison among issuers.

Below are our suggested changes to both the URRT and the rating methodology.

Unified Rate Review Template (URRT)

To the extent possible, we recommend providing explicit instructions on what should and should not be included in each line of the URRT.

We recommend ensuring consistency between aggregated data inputs/results (Worksheet 1) and plan-level data inputs/results (Worksheet 2), meaning that the URRT should not compare items from Worksheets 1 and 2 unless they are supposed to be the same. Currently, there are inputs or calculations on Worksheet 2 that are compared to values on Worksheet 1; however, these values are not comparable because they have different meanings. Furthermore, we recommend that for comparisons that generally should be the same, the margin for error should be reduced below 2 percent. Some examples of mismatched comparisons are as follows:

- Experience period incurred claims on Worksheet 1 (cell F15) are not expected to equal total incurred claims on Worksheet 2 (cell F67) because experience period incurred claims on Worksheet 2 reflect the impact of risk adjustment and reinsurance and the corresponding line on Worksheet 1 does not. However, the URRT includes a comparison of these two values requiring that an explanation be provided if they are not within 2 percent of each other.

¹ The American Academy of Actuaries is an 18,500+ 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.

- The plan-adjusted index rate on Worksheet 2 (for the experience period, F54, and for the projected period, F80) is compared to the aggregate premiums on Worksheet 1 (for experience period, G14, and for projected period, V43). For the experience period, the use of projected demographics, geographies, etc., as assumed in the experience period plan-adjusted index rate development (two years prior) presented on Worksheet 2 do not correspond to the actual demographics used on Worksheet 1.
- For both the experience period and the projected period, the values on Worksheet 2 assume the entire population are non-smokers (i.e., the revenue is before adjustment for tobacco status). However, the values on Worksheet 1 are after any tobacco status factors have been applied. In addition, for small groups, the values on Worksheet 2 represent a weighted average of all the effective periods (i.e., four quarters) while the values on Worksheet 1 are for the first effective period (e.g., first quarter) only. If CCIIO decides to keep these comparisons, we recommend widening the tolerance.
- When values are compared, it is often assumed by issuers that they should be the same values or meanings. This creates confusion and can result in issuers providing results that are different from what CCIIO might expect.
- We recommend that the URRT *not* compare items from Worksheet 2 to Worksheet 1 unless they are supposed to be the same, and then change the margin of error to be less than 2 percent.

In Section 2 of the URRT, Worksheet 2, we recommend CCIIO not require including changes in reinsurance and risk adjustment in *Taxes and Fees*. Changes to reinsurance recoveries (excluding fees) and risk adjustment (excluding fees) would be included in the claims calculations (through recovery projections or morbidity adjustments) in order to get to a statewide average. As such, these changes should be included in the service category lines.

We encourage CCIIO to ensure that any pop-up comments that are still in the URRT are valid and align with the URRT instructions. For example, there is a warning alert that pops up in row 65 of Worksheet 2—if you enter a non-zero amount in row 65 of Worksheet 2, a pop-up appears “WARNING - Wksh 2 - Plan Product Info - Cell AD65 - (Section III - Portion of above payable by HHS’s funds on behalf of insured person in dollars) should be 0 for exchange plans for year 2014 and 2015.” For filings after the first two years of Affordable Care Act (ACA) enactment, the pop-up warning was correct; there would not have been any subsidies in the base experience period data used in pricing. However, for the 2016 plan year, issuers used 2014 data to populate this field. As a result, there would be non-zero values for claims subsidies and government cost-sharing reduction (CSR) payments because issuers had actual ACA data to use in pricing. We recommend removal of the pop-up completely and allow the field to be populated with both zero and non-zero values, which are now both possible as outlined above.

We suggest the URRT reflect the various allowed components of rate building on Worksheets 1 and 2, including items such as *Market Adjusted Index Rate*. The projected index rate is on Worksheet 1. The *Plan Adjusted Index Rate* is on Worksheet 2 as an input. If the *Market Adjusted Index Rate* also could be included on Worksheet 1, along with the adjustments to get to the *Market Adjusted Index Rate*, that would help reviewers, as all the main elements would be included both in the URRT and in the actuarial memorandum. Further recommendations related to the *Market Adjusted Index Rate* are as follows:

- We recommend in Worksheet 1, following the index rate, adding lines for exchange fees and market adjusted index rate. The market adjusted index rate would be calculated as index rate

+ (exchange fee – cell V35 risk adjustment – cell V37 reinsurance (if program continued))/cell V33 paid to allowed.

- We recommend in Worksheet 2, adding lines above the *Plan Adjusted Index Rate* for the *Market Adjusted Index Rate* (from Worksheet 1), *Cost Sharing Adjustment*, *Plan Design Behavior Change Utilization Adjustment* (these two items make up the *Plan AV & Cost Sharing Adjustment* – but we recommend splitting them for transparency), *Network Adjustment*, *Benefits in Addition to Essential Health Benefits (EHBs) Adjustment*, *Administrative Cost Adjustment*, and *Catastrophic Plan Adjustment*. The plan adjusted index rate could then be calculated as the product of the lines above. The cost sharing adjustment and plan design behavior change utilization adjustment would replace the current *AV & Cost Sharing Adjustment*, which includes both concepts.
- We recommend providing guidance to issuers in the instructions regarding naming conventions for version control. Alternatively, CCIIO could build a version/date stamp into the URRT such that there is an easy way to manage version control. This will be of great value to reviewers of the URRT.
- We recommend providing explicit instructions on what to input in the rate change sections for terminating plans.

For abortion services included in the EHB package, we recommend that the issuer who offers qualified health plans (QHPs) on the exchange remove the portion of EHB costs for abortion services in the percentage of claims that are EHB services in order to calculate the subsidies correctly. But for QHPs offered off the exchange only, we recommend clarifying the instructions to reflect what CCIIO would like to have reflected—either use the same adjustment as described in the instructions, or provide additional instructions regarding QHPs and non-QHPs offered only off the exchange. We assume that because QHPs only offered off the exchange as well as non-QHPs would not be eligible for subsidies, the adjustment to remove the portion of costs for abortion services is not necessary.

For the *Plan Adjusted Index Rate* for the experience period, we recommend clarifying that the input for transitional plans should be zero. The instructions state to use zero for terminated non-single risk pool compliant plans, but they do not mention continuing transitional non-single risk pool compliant plans. Therefore, we recommend removing comparison for this item, because zeros will be included in the average for the experience period on Worksheet 2.

Rating Methodology

We recommend that the guidance for mapping plans from the experience period to the projection period and plans from the current period to the projection period be synched with the uniform modification rules. We suggest these be updated and released early enough to allow comments and modification or clarification in the instructions based on feedback received. We also recommend including in the instructions for the actuarial memorandum a requirement to provide the mapping of plans from the experience period and the current period to the projection period, as well as membership by plan. The membership would be the most current membership as of a particular date defined by the issuer, or the final membership as of the date the plan was closed. The membership “as of” dates also should be provided.

Because reinsurance and risk adjustment fees are not claim related, we recommend keeping these fees in the *Taxes and Fees* line, not in claims. This affects both the URRT and the overall rating methodology. This change would mean that reinsurance and risk adjustment fees are not subtracted

in the development of the *Market Adjusted Index Rate*. There are several reasons for this recommendation:

- The *Index Rate* is at an allowed claims level. Adjusting for reinsurance and risk adjustment, which are both claim items, would make sense; however, subtracting fees at the claim level would result in the *Market Adjusted Index Rate* being a combination of allowed claims with reinsurance and risk adjustment fees removed from claims.
- Another reason to keep the fees in *Taxes and Fees* is that by treating them differently from how they are treated in the medical loss ratio (MLR) calculation, CCIIO could be creating a potential for rebates to be paid even if the results are exactly as expected. In the URRT, reinsurance contributions are offset against projected incurred claims (together with reinsurance receivables); for the MLR and risk corridors, reinsurance contributions and risk adjustment fees are treated as taxes. Taxes are subtracted from premiums. In other words:

URRT: loss ratio = $[C + Rc] / P$

MLR and risk corridor: loss ratio = $C / [P - Rc]$

Where

C = Claims

P = Premium

Rc – Reinsurance contributions and risk adjustment fees

Simplified illustrative example:

If C = \$80 and Rc = \$1 and rates are priced according to URRT instructions targeting 80 percent MLR, we get $P = \$81 / 0.8 = \101.25

Assuming experience was the same as the assumptions used in pricing claims come in at \$80, the MLR Reporting Form would have $MLR = \$80 / [\$101.25 - \$1] = 79.8$ percent, and rebates would result.

Therefore, treating the fees the same way as they are treated for MLR will not create a problem with the rating. Recognizing that reinsurance fees will be going away in 2017, this issue still applies to the risk adjustment fees.

Some elements of the current instructions, listed below, result in rates that are mathematically incorrect unless compensating adjustments are made in other factors, such as the *Plan AV & Cost Sharing* adjustment, which hinders rate review and creates less transparency. Our understanding is that these instructions were based on an interpretation of 45 CFR §156.80(d)(2), which permits only specified plan-level adjustments. We understand and support the need to prohibit rate variations among plans that are not based on the allowable adjustments. However, this prohibition should not prevent mathematically correct adjustments that apply equally to all plans and, therefore, do not result in additional rate variations among plans. As such, we recommend that actuarially appropriate normalization be allowed, which would include the following:

- Allow a multiplicative normalization for age.
- Allow a multiplicative normalization for geography.
- Allow a multiplicative normalization for tobacco. (The current instructions require this to be included in the *Plan AV & Cost Sharing* factor.)
- Allow actuarially appropriate rating for zero dollar premium children. We recommend including it in the age calibration, as the proportion of children with zero dollar premium receive a factor of 0, because the rating factor applied for them is 0. This is another example

of a math problem, not a regulatory problem. According to 45 CFR § 147.102 with respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium. However, that is a requirement for premium setting at the consumer contract level, not the development of the rates themselves. The rules do not prohibit the accounting for the cost of the zero dollar premium children anywhere in the rates, as long as it is spread across the rest of the population and affects all plans equally. This could be referenced as a multiplicative calibration for whether the coverage is for an individual or a family. An alternative to consider if CCIIO does not wish to accept this approach would be to add a comment to the instructions deferring to state regulators.

- If a change in the regulations cannot be made, allow a multiplicative normalization for the revenue shortfall caused by existing regulations, which state that the catastrophic plan allowable rating factor can only be applied to catastrophic plans.

We recommend requiring the development of base rates (rates based on all allowed rating factors of 1.0), which would be the plan adjusted index rate adjusted for the normalization described below. Doing so would provide a direct rate to be multiplied by each consumer's information without having the extra step of calibration/normalization, as long as the normalization is done to develop the "base rates." This process would make year-over-year comparisons more meaningful, because it would remove the change in the underlying population. This also allows comparisons from issuer to issuer to be more direct as well since the difference in the underlying population among issuers would not affect the base rates as the population differences currently affect the *Plan Adjusted Index Rates*. This would require adding a row for *Base Rates* or *Calibrated Plan Adjusted Index Rates* or *Normalized Rates* on Worksheet 2. We recommend that CCIIO also require that the area factors must average to 1.0.

With respect to area factors, we recommend using the methodology from 2014, which would allow different area factors for HMOs versus PPOs. The change after 2014 recommend by CCIIO is that actuaries may put differences into the network adjustment factor, resulting in different plans by area; however, that does not work for all states. For example, in Arizona, PPOs must be statewide, therefore, issuers cannot have different network factors and different plans for PPOs across the state. An issuer offering multiple PPO products within a state would create an issue. In addition, returning to the methodology allowed in 2014 would reduce the duplication of plans for network differences and would make it much easier to implement quarterly trend actions within the small group risk pool due to network disruption. Today, issuers are only permitted to create new product or plan IDs with the annual filing. If network disruption occurs in an area in which an issuer does not have separate plans created, it is not permitted to mitigate the disruption until the next annual filing.

We recommend CCIIO implement a more defined process for obtaining guidance. Oftentimes webinars have provided information without making the material from the webinars available. Thus, only those who can participate in the webinar receive the information. We recommend providing information to everyone via the CCIIO website.

In terms of rounding, we recommend CCIIO allow rounding to the nearest dollar or partial dollar level as allowed by state law in non-enforcing states and in effective rate review states. If the proposal for changing calibration to an algebraically correct normalization is not accepted, rounding could be helpful to remove any error. In addition, in states in which rounding has been allowed by state law, doing so would allow state laws to continue without having to be changed. For

transparency purposes, we do not recommend putting normalization error corrections (if normalization is not allowed) or rounding adjustments into the administrative expense or user fee as previously suggested by CCIIO to some issuers. We believe that would create more potential errors.

With respect to the threshold calculated at plan level, prior regulatory guidance indicated the plan level threshold would be measured by the change in the plan adjusted index rate from one year to the next. In order to calculate that threshold, the current (prior year-filed) plan adjusted index rate would need to be included on Worksheet 2. However, that is not an input on the URRT. A more significant concern with using the plan adjusted index rate is that the filed plan adjusted index rates reflect different populations from one year to the next. It is imperative that the same underlying population be used to determine an appropriate increase. If our proposal to calculate a base rate is accepted with an average area factor of 1.0, and a single population is applied to both the current and the projected base rate, applying the appropriate rating factors, then the results could be compared. If this proposal is not accepted, then we recommend providing guidance that the issuer recalculate the current plan adjusted index rates and the projected plan adjusted index rates using the same population. In the 2016 rate filing year URRT version, the rate increases are to be calculated using a single (projected) population. We recommend using the current population rather than the projected population, as that is a known quantity and thus not subject to unusual shifts in the projected population.

We recommend that as part of the actuarial memorandum, that CCIIO require the minimum and maximum rate increase across the issuer's filed plans be provided, without aging, based on a single population, preferably the current population. This is a requirement of Part II if there is a threshold increase, and is valuable for reviewers.

We appreciate your consideration of these suggested recommendations for potential changes to the URRT and the rating methodology. If you have any questions or would like to discuss these comments further, please contact Heather Jerbi, the Academy's assistant director of public policy, at 202-785-7869 or jerbi@actuary.org.

Sincerely,

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Chairperson, Premium Review Work Group
American Academy of Actuaries