May 8, 2010

To: Lou Felice
Chair, Health Care Reform Solvency Impact Subgroup, NAIC

Steven Ostlund
Chair, Accident & Health Working Group, NAIC

Julia Philips
Chair, Rate Review Subgroup, NAIC

From: Mike Abroe
Chair, Premium Review Work Group
American Academy of Actuaries

Re: Considerations Relating to PPACA Premium Review Provisions (Section 2794)

Dear Lou, Steve and Julia:

The American Academy of Actuaries' [1](Academy) Health Practice Council has formed several work groups to focus on specific implementation issues relating to the passage in March of the *Patient Protection and Affordable Care Act* (PPACA). The Premium Review Work Group is focused on the provision addressing unreasonable rate increases to be reported by health insurance issuers included in Section 2794 of the Public Health Service Act (PHSA), which was added by PPACA.

Our work group is in the process of analyzing Section 2794, as well as preparing a response to the request for comments on Section 2794 issued by the U. S. Departments of Treasury, Labor, and Health and Human Services and published in the *Federal Register* on April 14, 2010. In our group's initial conversations, we have quickly concluded that there are a number of important questions that need to be addressed. Given the long history of cooperation between the Academy and the NAIC on regulatory issues, we wanted to reach out to NAIC at an early stage of the PPACA implementation process in order to provide input on issues that we believe are particularly important to your work.

In this letter, we have identified several key questions. These are not the only questions that we have related to Section 2794; however, we believe those framed may be the most relevant to

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

your work as the NAIC develops its own comments and requests for clarification related to Section 2794.

1. Section 2794 is silent with respect to the market segments that will fall under the rate review provision. Will these affected market segments be consistent with market segments that fall under the minimum loss ratio provisions of Section 2718, or will they be different and specified in regulation? In either case, the review process would likely vary significantly by market for various reasons. Since the review process is of company rates, we believe the focus should be on what companies will file:

    a. Group (large and small)—For insured groups, the starting point for calculation of premiums and premium increases is the rate manual. One approach for reviewing rates would be to track changes in the rate manual or manuals maintained by the companies.
    b. Individual—For individual products, rate tables and the table increases are typically based on achievement of a set of durational and lifetime loss ratios. The tables are filed with and commonly approved by states. One approach for reviewing rates would be to track changes in the approved rate tables by form.

2. Section 2794 of PPACA contains language referring to a process for an annual review. There is an initial premium review process that addresses premium renewals that would be subject to higher rates prior to 2014. There is a continuing premium review process that could expand upon the initial process, but it would apply additional rules relative to products sold in the exchanges. Alternatively, this could be a replacement for the initial process. It is not clear which interpretation is appropriate.

    The issues below are framed with an assumption that the initial process is continued but possibly modified to reflect the addition of exchange premiums. The initial review process requirements are:

    Section 2794 (a)(1)(2)
    "(a) INITIAL PREMIUM REVIEW PROCESS.—
    "(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.
    ''(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers."

    The term "annual review" could mean a single, short period during which premium rate increases that have been filed with a state(s) over some prior period are reviewed. This seems consistent with the requirement in (b)(1)(A) to "provide the Secretary with <u>trends</u> in premium increases." [emphasis added] Since companies will be filing for premium rate increases

throughout the year, it would appear that the states alone will make the determination of which premium increases are unreasonable and those increases would be subject to the annual review. Under this approach, a company would provide the HHS Secretary and the relevant state with its justification for such increases following the state's approval of the increase. A company could implement this increase without regard to the annual review period.

Another interpretation is that the annual review process relates to anticipated filing of rate increases on an annual basis. Under this approach, the Secretary would potentially need to be involved whenever a premium increase meets the state's definition of "unreasonable." This would extend the period of time until any rate increase is implemented. We are concerned that such delays will create the need for larger rate increases in the future, as the costs of the coverage are ongoing and will continue to increase whether rates are increased or not.

We note that many states have a process called "file and use" under which companies may file premium rate increases and implement them prior to the state's review of the increases. Companies are careful to follow the rules of these states so that when a state reviews the rates (sometimes after they are in effect), a company does not have to adjust premiums for periods that have already passed. Assuming a clearly defined standard for "unreasonable rate increases," states that use this approach may continue to allow "file and use" for rate increases under that state's standard but require prior approval for any increase that exceeds the standard for what is deemed reasonable. The annual review process would not seem to apply to these increases, but clarification is important.

Will the NAIC establish a required uniform method for these reviews or will there be variability allowed on a state-by-state basis? How will differences in approval processes be resolved between states, especially once the exchanges become a significant source of coverage?

The manner in which the Secretary would monitor premium increases under (b)(2) could be limited to the review of only unreasonable rate increases, but it may be more useful to focus on the increases that result from maintaining actuarially sound premiums from period to period.

Proposed Approach for Reasonable/Unreasonable Rate Increases

We propose an approach whereby a reasonable increase in premiums is defined as the change in actuarially sound premiums. An actuarially sound premium is one in which the rate-setting process is consistent with Actuarial Standards of Practice (ASOPs), the Code of Conduct promulgated by the Academy and adopted by the five U.S. actuarial organizations, and/or applicable law. All assumptions underlying the determination of premiums would be identified, and documentation would be available for the state actuary to review. The state and company actuaries should agree on assumptions; however, the NAIC may want to consider ways to address situations in which the two actuaries are not able to reach an agreement quickly. It should be noted that actuarially sound premiums, and the resulting increases, may vary between companies based on the companies' underlying assumptions.

Experience subsequent to that used in developing the current premiums may imply current premiums are too high or too low. Regardless, such experience would be used in developing the new premiums. However, the rate increase would be still deemed reasonable as it would be based on the increase in two actuarially sound premiums; therefore, the definition of an unreasonable rate increase should not be a simple percentage.

We would expect states to have a process for rate review that allows for the timely use of new actuarially sound premiums, within which increases based on such actuarially sound premiums would not be considered unreasonable.

Some increases to reasonable rates will be larger than others. Variations in deductibles and other components of the benefits will produce different medical cost trends for different products, yet those would still be reasonable under this approach if both prior and current rates are actuarially sound.

Delays in implementing actuarially sound premiums will result in larger rate increases at future filing dates. The process for the annual review involving the Secretary should not delay any rate approval process. The manner in which the Secretary could monitor premium increases could focus on the maintenance of actuarially sound premiums from period to period. The amount or percentage of premium increases across a wide range of companies analyzed as part of this monitoring could focus on the critical connection between premium rates and the underlying increases in medical costs.

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

a. Reasonable, without additional justification;
b. Reasonable, based on additional solvency requirements;
c. Reasonable, based on other justifiable factors; or
d. Unreasonable, not justified.

3. If the approach above is implemented, or even if another approach used, there are a number of issues that will need to be addressed. We outline below some of these issues:

    a. Will the unreasonable rate increase standard or standards be published so insurers and consumers will know what the parameters are and how the process will work?

    b. Will the basis used to determine if an increase is unreasonable be clear-cut so that the insurer will know in advance of filing? Or will it be a determination made by states during the review? Or will the determination be made at some later date?

    c. For all increases that are to be reviewed, will any circumstances be considered de facto not unreasonable? For example if an insurer is operating at a medical loss ratio (MLR) significantly in excess of the minimum which ultimately will impair solvency, is there such a thing as unreasonable rate increases?

d. Is the reasonability of an increase determined at the individual or group health level or some other level? For instance, if the increase is different for different benefit types, how finely would the unreasonable label be applied?

e. Is the concept of unreasonable premium increase limited to renewing business? In other words, is changing new business premiums outside the scope of unreasonable premium increases?

f. Will solvency concerns be a necessary part for the approval of an unreasonable rate increase? If so, will the solvency standards be stated?

g. Will rate adequacy be a necessary factor for the approval of an unreasonable rate increase?

h. If a state review determines that an increase is unreasonable, a justification for the public will be prepared. Will the justification be reviewed by the state? How will an insurer know in advance that justification is needed? Will it require review from state policy forms experts or merely state rate experts? How long will it take to get approval for public release?

i. What changes, if any, will need to be made to the state rules regarding notification and approval of a premium change? It would appear that timely review and communication of rate changes will be necessary. It wouldn't make sense for companies having to delay implementation of approved rates.

4. What is the definition of "plan year?"

   The beginning of any plan year after 9/23/2010 will be the date a state's definition of unreasonable rate increase is published and shall only apply to rate increase filings submitted, if required to be submitted, after such date. Is this a correct interpretation?

   Another possibility is to define plan year as the calendar period during which states accumulate information for purposes of the annual review with the Secretary.

5. We believe special considerations should be given to grandfathered business. The manner in which these considerations would be accomplished will likely depend upon the answers to the following questions:

   a. Will individual grandfathered business be subject to both lifetime and annual loss ratio requirements?

      We believe that individual grandfathered business subject to lifetime loss ratios should not involve the MLR requirements within the rate review process.

   b. Will there be transition rules for current business?

For grandfathered group business, a short transition period would be useful and appropriate since this business has been typically rated on a year-by-year basis.

For individual business, no transition rules would be needed for the rate review process; however, transition rules would appear to be needed for application of the MLR requirements because of the historical durational loss patterns.

c. As the number of lives in grandfathered business decreases over time, we suggest pooling should be considered to increase rate stability and credibility.

* * * * *

We hope these questions are helpful to you as the NAIC commences its work on Section 2794 implementation issues. If you have any immediate questions regarding this letter, please contact Heather Jerbi, the Academy's senior federal health policy analyst, at jerbi@actuary.org or 202.785.7869.

Sincerely,

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

Cc: Jay Angoff, Director, Office of Consumer Information and Insurance Oversight, HHS
Richard Kronick, Deputy Assistant Secretary, Health Policy, HHS