Understanding the ACA: Rate Filing Review and Disclosure

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Academy Health Practice Council – Practice Note

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

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American Academy of Actuaries

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Purpose of the Practice Note

- Practice note is intended for actuaries with a beginning or intermediate knowledge of the rate submission and review process
- Practice note is intended to be used as a reference manual
- Practice note does not cover issues unresolved as of July 2012, such as essential health benefits, actuarial value, reinsurance, and risk adjustment
- The actuary should recognize subsequent federal and/or state actions are likely

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Presenters

- Mike Abroe - Moderator
- David Shea – Review of Unreasonable Rate Increases
- Brian Collender – Recommendations for Completing HHS Required Documentation
- Joyce Bohl – Considerations for Developing Rate Increases for Health Benefit Plans

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Review of Unreasonable Rate Increases

David Shea, MAAA, FSA

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Introduction

- Practice note is intended for actuaries who prepare, review and/or comment on PPACA health insurance rate filings
- Practice note is also intended to encourage discussion and foster dialogue between actuaries involved in the rate review process
- Section 2794 of PPACA will very likely increase the public's awareness of the role of the actuary
  - HHS website will display actuarial memoranda signed by actuaries

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Introduction

- PPACA excludes certain types of products from the rate review requirements, and hence are not subject to this practice note:
  - Grandfathered plans
  - Certain excepted benefits
  - Large group
- Focus of the regulation is on rate increases, so new benefit options and new product filings are not addressed in this practice note

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Background

- Section 2794 of PPACA requires the creation of a process for the review and disclosure of "unreasonable" rate increases
- HHS promulgated regulations (45 CFR 154) and supporting materials to implement the law
- Focus is on transparency and consumer protection
- Regulation supplements but does not replace a state's law
- HHS makes a determination of whether a state has an "effective rate review program" (as of July 2012, six states have no effective rate review program)

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State Laws and Association Business

- The actuary is expected to be familiar with specific states laws and regulations regarding rate filings and rate increases
- State and federal regulatory processes will likely evolve and change over time, so it's vital to stay current
- Actuary must know if a rate increase needs to be submitted to the state, HHS, or both
- HHS definition of association business

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Review of Unreasonable Rate Increases

- Products subject to review
  - PPACA defaults to state definitions of individual and small group markets
  - This will change to the PPACA definitions in 2016
  - Rate increases at or above the threshold are subject to review
- Exceptions to the review requirements
  - Grandfathered plans----March 23, 2010 is the key date
  - Excepted benefits----generally, anything other than comprehensive major medical coverage
  - Large group is currently excluded, but this could change

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Review of Unreasonable Rate Increases

- Exchange and non-exchange products
  - Issuers may be excluded from a state's exchange if they demonstrate a pattern or practice of excessive or unjustified rate increases
  - Identical products sold in and out of the exchange must have the same rates
  - HHS and states will monitor premium increases in and out of the exchange
  - The offering of exchange products to large groups will be dependent on the "excess of premium growth" outside the exchange compared to inside the exchange

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Review of Unreasonable Rate Increases

- Definition of an "increase"
  - PPACA mentions "premium" increases, but HHS has interpreted this to mean "rate" increases
  - Focus is on a change to the underlying rate structure of a policy form, and not on how an insured's premium bill changes
  - Increase is calculated on an annual basis for all insureds at the "product" level; benefit options are not considered "products" under this definition
  - Weighted average increase is calculated based on premium volume, not enrollment

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Review of Unreasonable Rate Increases

- Definition of an "unreasonable" rate increase
  - Increases meeting or exceeding 10 percent (currently) must be submitted to HHS
  - If a state has an effective rate review program, HHS will accept the state's rate increase determination; otherwise, HHS will make the determination
  - HHS will consider a rate increase unreasonable if it is "excessive, unjustified, or unfairly discriminatory"
  - If HHS determines that a rate increase is unreasonable, the issuer can either change the increase or submit a final justification of the increase, post the information on its website and implement the increase

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Review of Unreasonable Rate Increases

- The regulation requires a justification if the projected medical loss ratio (MLR) is less than the federal minimum
  - The federal minimum applies to an entire market in a state, not to separate policy forms
  - The federal minimum MLR calculated differently than loss ratios typically used in rate development
  - The federal minimum MLR is retrospective, whereas rate increase filings are prospective

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Review of Unreasonable Rate Increases

- The filing actuary might not necessarily have violated ASOP No. 8, *Regulatory Filings for Health Plan Entities*, if the filed rate increase is determined to be unreasonable by HHS
- Reviewing and filing actuaries may have differing opinions on the reasonableness of assumptions used in rate increase filings
- In these situations, both actuaries should refer to ASOP No. 41, *Actuarial Communications*

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Recommendations for Completing HHS Required Documentation

Brian Collender, FSA, MAAA

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Background

- Required for those rate filings that are "subject to review"
- Preliminary justification:
  - Part I – Rate increase summary form
  - Part II – Written explanation of the rate increase
  - Part III – Rate filing documentation (only required for those rates reviewed by CMS)
- Instructions can be found at:

http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf

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Background

- What needs to be filed for each state can be found at

http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html

- Perform data testing/review to ensure that the data quality is consistent with ASOP No. 23, *Data Quality*

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Part I - Rate Increase Summary Form

- Base period data
- Claims projection
- Components of current and future rates
- Components of rate increase
- List of annual average rate changes requested and implemented in the past three calendar years
- Range and scope of proposed increases

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Part I - Rate Increase Summary Form – Base Period Data

- Generally should include the data that was utilized to determine the rate increase
- Assumes 12-month periods
- Base member months should be used for non-base medical categories
- Total allowed claims
  - Need to include incurred but not reported (IBNR)
  - Need to adjust appropriately for coordination of benefit (COB) and provider incentives as cost sharing is developed by calculation based on paid and allowed amounts

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Part I - Rate Increase Summary Form – Claims Projection

- Section B1 – Adjustment to current rate
  - Need to adjust claims for changes in benefit and demographic mix unless this was done in the base period data
  - May include impact of new members if deemed appropriate
  - Exclude impact of new products
  - Should reflect 12 months' worth of projection, but need to adjust data appropriately for rate increases in last 12 months
  - Need to reflect allowed PMPM trends by category – may be appropriate to back into these based on paid trends

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Part I - Rate Increase Summary Form – Claims Projection

- Section B1 – Adjustments to current rates
  - What trend should be used in the projection?
    - Option 1: Utilize trend over past 12 months ending with the base period data
    - Option 2: Assume trend used in development of original current rates
    - Option 3: Use the trend developed in section B2 and trend from the base period to the midpoint of the current rating period
  - Be sure to document any assumptions and methodology

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Part I - Rate Increase Summary Form – Claims Projection

- B2 – Claims projections for future rates
  - Must be one year after start date
  - May need to back into allowed trends and ensure that paid claims and cost sharing appear reasonable
  - Need to ensure capitation trend is accounted for appropriately

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Part I - Rate Increase Summary Form – Claims Projection

- B3 – Medical trend breakout
  - "Pure" trends should be reflected in cost and unit categories with other impacts shown in "all other"
  - Utilization could be calculated by weighting trend based on PMPM cost
  - Unit cost change should be calculated excluding impacts of severity, service, and provider mix (e.g., a basket of goods analysis)
  - If trends cannot be pure due to data issues, this should be disclosed in Part II
  - Capitation costs should be considered in trend development

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Part I - Rate Increase Summary Form – Claims Projection

- B3 – Medical trend breakout
  - "Other" may include impacts of:
    - Severity
    - Service
    - Provider mix
    - Cost share leverage impacts
    - Impacts due to capitation or other provider payments not attributed elsewhere
    - Demographics

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Part I - Rate Increase Summary Form – Future Rates and Prior Estimates

- Future rates
  - Underwriting gain/loss
  - Overall rate increase – assumes a 12 month period between rate increases
- Prior estimate of current rates
  - Projected net claim costs – intent is to use the same population as current rate increase request
  - Administrative costs – updated for demographic and benefit mix
  - Underwriting gain/loss – updated for demographic and benefit mix

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Part I - Rate Increase Summary Form – Other Information Required

- Should reflect annual rate increase requested and implemented over the past three years
- Range and scope of increase
  - Number of individuals affected by rate increase
  - Threshold of rate increase – rate increase calculated under the "subject to review" test

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Part II – Written Explanation of Rate Increase

- Actuary may want to provide a reason behind the request for the rate increase in terms the public can understand
- Would need to summarize at least two key drivers of the rate increase
- Should include:
  - Scope and range of rate increase:
    - Should be consistent with information from Part I
    - Should identify policyholders and enrollees affected by month
    - Should note where rate increases are not uniform and why

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Part II – Written Explanation of Rate Increase

- Should include (cont.):
  - Changes in benefits and how they affect rate increases
    - Should differentiate between plan changes and changes required by regulation
    - If actuary cannot differentiate between benefit change effects required in addition to changes made because of operational simplicity, this should be clearly documented or estimated.
  - Administrative costs and anticipated profits:
    - Description of impact of changes in admin/profits on rates
    - Discussion of retained earnings importance, if applicable

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Part III - Rate Filing Documentation

- Only required when CMS is reviewing the filing
- Need to include impact of changes in “reserves” – actuary would need to define his or her definition of reserves
- Need to state source of data, assumptions, and methodology used in completion of other forms
- If a required item is not relevant to development of the rate increase, it would need to be identified and an explanation would need to be provided why it was not relevant

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Part III - Rate Filing Documentation

- Underwriting method should describe how groups and individuals are underwritten
- Scope and reason for rate increase should include:
  - Inefficiencies of prior rates
  - Changes in reimbursement
  - Changes in administrative costs/profit
  - Changes in benefits
  - Level of increase and individuals affected

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Part III - Rate Filing Documentation

- Average premium before and after increase
  - Should include historical rate increase approval dates/rates
  - Dollar increase should assume same demographics before and after
- Past experience and alternative/additional data used
  - Should have more detailed impacts by policyholder if asked (by plan, month, etc.)
  - Support for credibility analysis
  - Detailed documentation may be need for IBNR calculations, including documentation on manual adjustments
  - Methodology to develop contract reserves

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Part III - Rate Filing Documentation

- Description of how the rate increase was determined:
  - Describe underwriting gain/loss and reason for need
  - Historical detail on general expenses
  - Historical detail on other administrative expenses
  - Changes in the rate scale before and after increase (e.g., age slope)
  - Description of how the revised rates were determined (e.g., projection methodology, application of assumptions, etc.)
  - Interest rate assumptions

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State Reporting Requirements to HHS

- Reporting trends by area, product, market, and benefit level
  - Report by area using three to five digit ZIP code levels
  - Differentiate by HMO, PPO, CDHIP, etc.
  - Market – individual, small group, large group, and exchange/non-exchange products
  - Benefit level – based on deductible level
- States can recommend if plans participate in exchanges
- Rate increase between exchange/non-exchange products

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Considerations for Developing Rate Increases for Health Benefit Plans

Joyce E. Bohl, MAAA, ASA

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Introduction

- This section discusses factors an actuary may want to consider when developing rate increases
- The focus is specific to the ACA requirements, but these underlying principles apply to the review and preparation of all health benefit plan increases
- Under the new ACA requirements, actuaries may want to provide additional supporting information in response to requests from the state or federal reviewers

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Administrative Expenses

- General expenses
- Commissions and broker fees
- Health care quality improvement expenses
- Other administrative costs
- Reinsurance
- State taxes, licenses, and fees
- Federal income taxes

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Claims Trends

- Internal and external factors driving medical-cost increases
- Policy duration (for medically underwritten business)
- Policyholder lapses/changes in enrollment mix
- Leveraging effect of deductible
- Correction of prior estimates
- Programs that drive utilization to lower-cost places of service
- Impact and timing of new medical management programs and the effect on service intensity and unit cost
- New and evolving technologies
- New Rx generic drug dispensing opportunities

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Historical Rating Methodology

- Claims trend and premium increases, historical
- Base period claims and premium experience
- Adjustment to claims such as credibility, large claim pooling, and seasonality
- Durational claims adjustments
- Durational premium adjustments
- Relationship between durational claims and premium index
- Interest rate to accumulate past experience

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Projection Methodology

- Claims trend and premium increases, projected
- Plan mix change for premium and claims, if applicable
- Policy renewal distribution by calendar month
- Lapse assumptions
- Cohort of members used in projection (members in force 12 months after the rate increase effective date)
- Interest rate to discount future projections
- Number of projection years

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Other Considerations

- Capital and surplus
- MLR calculations
- MLR rebates
- Attestations – ASOP No. 41

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Actuarial Standards of Practice

- ASOP No. 5—*Incurred Health and Disability Claims*
- ASOP No. 8—*Regulatory Filings for Health Plan Entities*
- ASOP No. 12—*Risk Classification* (for all practice areas)
- ASOP No. 23—*Data Quality*
- ASOP No. 25—*Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*
- ASOP No. 26—*Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*
- ASOP No. 41—*Actuarial Communications*

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Communications

- Precept 1: An actuary should act with integrity and competence in a manner to fulfill the profession's responsibility to the public.
- Precept 2: An actuary shall perform actuarial services only when qualified to do so on the basis of basic and continuing education, experience, and satisfaction of applicable qualification standards.
- Precept 3: An actuary shall ensure that actuarial services performed satisfy applicable standards of practice.
- Precept 4: An actuary shall take appropriate steps to ensure that the actuarial communications are clear and appropriate to the circumstances and for the intended audiences.
- Precept 10: An actuary shall perform actuarial services with courtesy and cooperate with others.

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Rate Review Principles

- The purpose of the review is to ensure that premium rates meet state and federal requirements.
- Open communications between the filing and reviewing actuary is expected.
- The process should ensure premiums for health benefit plans are adequate to cover the following:
  - projected claims
  - administrative expenses
  - margins for adverse deviations
  - profit/contribution to surplus
  - All state and federal taxes and fees, including the new fees under the ACA
- All assumptions and methodologies employed should be demonstrable and based on data and actuarial analyses

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And finally…Documentation!

- General information
  - Specific plan information, e.g.,: plan benefits and details on product groupings
  - A full description of the rating structure including rate tables, rating factors, rating algorithms, including sample rate calculations
- Historical experience
  - Claims and premium exhibits, including the effects of reinsurance, rebates, and risk adjustment
  - Distribution of the covered lives by risk characteristic and policy variations
- Proposed changes and future projections
  - Projections to fully support the requested rate increase, including a detailed explanation of any changes to the existing assumptions
  - Rate increase distribution by cohort group, including the average impacts and a discussion of any variations by group or member
  - Capital and surplus considerations, if appropriate
  - Full support for all significant actuarial methods and assumptions

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Questions?

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