Arkansas Insurance Department (AID)

Rate Review Project

Phase 1 – Assessment of Current Process

Executive Summary

Under the Affordable Care Act (ACA), the Arkansas Insurance Department (AID) has received Cycle I grant funding from Health and Human Services (HHS) to improve their health insurance rate review process. To this end, Aon Hewitt has completed an assessment of the current rate filing review process. In this report, we describe the current process, compare this to the ACA requirements, and recommend areas that should be improved upon, including:

1) **Defining "subject-to-review" and "unreasonable"** in regulation or bulletin form.

2) **Developing more specific requirements for the data, assumptions, and methodology description** that is included in rate filings (or disapproving filings that do not have sufficient information for an actuary to review the filing).

3) **Creating internal training materials, a rate review manual, and electronic job aids**.

4) **Improving consumer outreach**.

5) **Developing an internal database with pertinent rate filing information**.

In Phase II, we plan to work with the AID to develop specific recommendations for these areas.

Introduction

On March 30, 2010, the ACA was enacted, introducing sweeping changes to the nation's health care system via changes to the Public Health Service Act (PHS Act). Among these changes was a new section 2794 of the PHS Act, which directed the Secretary of HHS to establish a process for the review of unreasonable premium increases. This process was to include requiring health insurance issuers to submit preliminary justifications for the increases to HHS and the applicable state. HHS was charged to work with the National Association of Insurance Commissioners (NAIC) in developing requirements for the preliminary justification documents.

On December 23, 2010, HHS released a proposed regulation[1] to implement the rate increase disclosure and review disclosure requirements of the ACA. The NAIC and HHS have also been working on draft requirements for the preliminary justification documents[2]. HHS has also released proposed regulations and sub-regulatory guidance on other aspects of the ACA (e.g., minimum loss ratio requirements).

As part of the ACA, HHS announced initial grant awards ("Cycle I grants")[3] to the states to help improve the oversight of proposed health insurance premium increases, including:

- Pursuing additional legislative authority,
- Expanding the scope of health insurance premium review,
- Improving the health insurance premium review process,
- Making more information publicly available, and
- Developing and upgrading technology.

The Arkansas Insurance Department (AID) applied for and received a Cycle I grant from HHS. As part of this grant funding, the AID has retained Aon Hewitt to 1) perform a comprehensive assessment of the current health insurance premium increases; and 2) research, develop, and recommend a comprehensive plan for the complete upgrade of the existing AID system of health insurance rate review as well as all related and applicable technology. The assessment of the current process is "Phase I" of the project. "Phase II" is comprised of developing a comprehensive plan for future improvements and is expected to be largely complete by the end of June.

The report below contains Aon Hewitt's "Phase I" findings. This analysis is based on the proposed rate review and disclosure regulation issued by HHS on December 23, 2010, and the draft preliminary justification documents and instructions released by the Centers for Medicare & Medicaid Services (CMS, part of HHS) on March 1, 2011. There are still many open questions regarding the proposed regulation and how it will be implemented, and the preliminary justification documents are still only in draft form. Our analysis below is therefore based on the information available at this time.

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[1] Proposed HHS rule on rate increase disclosure and review: http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf. (December 23, 2010)

[2] Draft requirements for preliminary justification documents: http://www.federalregister.gov/articles/2011/03/01/2011-4552/agency-information-collection-activities-proposed-collection-comment-request#p-2. (March 1, 2011)

[3] Cycle I grant award announcement: http://www.hhs.gov/news/press/2010pres/08/20100816a.html. (August 16, 2010)

These findings from Aon Hewitt are based upon professional, actuarial knowledge and opinions regarding individual and group health insurance rate filings with state regulators. They are not legal opinions and we encourage AID to receive their own legal reviews.

ACA Rate Increase Review and Disclosure Requirements

Rate Increase Review

The ACA requires an annual review of unreasonable increases in premium for health insurance coverage. This rate review requirement was later interpreted by HHS in the proposed regulation to be an annual review of potentially unreasonable increases, since a rate increase cannot be determined to be unreasonable from an actuarial standpoint until it has been reviewed. Some high increases may be justifiable from an actuarial perspective (e.g., due to high increases in provider costs); while some lower increases may not be justifiable.

Recognizing that rate increases should be reviewed before being determined unreasonable, but not wanting to review every rate filing, HHS has proposed a two-step process:

1) All rate increases at or above a specific threshold will be deemed **"subject to review".**

2) All rate increases that are "subject to review" will be reviewed by HHS and determined to be **reasonable or unreasonable**.

The review process will take effect July 1, 2011, and the initial "subject to review" threshold will be 10%[4]. HHS plans to develop state-specific thresholds later, based on data for: 1) each rate increase that is "subject to review, and 2) data from states receiving "premium review grants". The requirements apply to individual and small group rate filings only[5], except for Grandfathered plans which are exempted from these requirements. For all rate filings that are subject to review, carriers must comply with the rate increase disclosure requirements.

HHS made clear in the proposed regulation that the new review requirements do not supplant existing State laws or processes; the requirements only supplement and complement these. If a state has an "effective" process in place, HHS will defer to the state's determination. Otherwise, the review will be done by HHS. The main factors for an "effective" rate review program according to HHS are:

1) Does the state **receive from the issuer's data and documentation** that is sufficient to determine if rate increase is unreasonable?
2) Does the state effectively **review the data and documentation**?
3) Does the state examine the **reasonableness of the assumptions**?
4) Does the state apply a **standard set forth in statute or regulation** when making the determination of reasonable vs. unreasonable?

[4] Because this is an annual review process, this includes multiple rate increases that total 10% or more in a given year.
[5] Based on state definition of Small Group, not for other purposes under ACA.

If HHS does the review, they plan to review: 1) the actuarial estimates that form the basis of the rates, and 2) the methodology used to develop the rates. The determination of unreasonable will be based on whether the rate increase is "excessive", "unjustified", or "unfairly discriminatory". However, HHS is soliciting comments regarding whether to include other factors (e.g., structure and competitiveness of a market).

Rate Increase Disclosure

If a rate increase is above the "subject to review" threshold, the issuer must submit to the HHS Secretary and the applicable state a preliminary justification before implementation. There are three parts to the preliminary justification:

1) Part I: Rate increase summary

2) Part II: Written Explanation of the Rate Increase

3) Part III: Rate filing documentation

The first two parts comprise a descriptive and quantitative analysis for consumers. They are required for all rate increases subject to review, to be submitted to state and HHS. HHS will post these documents to its website.

The third part is only required to be submitted if HHS is doing the review. In this case, HHS will post on their website such information from Part III that is not "confidential" under HHS' Freedom of Information Act. HHS will then provide the final determination of whether the requested rate increase is "unreasonable".

Post-Review Steps

If the applicable state is doing the review, the state must provide the determination of reasonable vs. unreasonable to the issuer and to HHS, including the rationale for the determination. If HHS is doing the review, HHS provides the determination to the issuer. In both cases, HHS will post the final determination on its website.

For rate increases determined to be unreasonable where HHS is doing the review, and if the issuer decides not to implement the rate increase or to implement a lower increase, the issuer must provide a final notification to HHS. If a lower increase is to be implemented, this new rate increase will again be subject to review if it meets or exceeds the threshold (10% for 2011). If the issuer decides to proceed with implementing the unreasonable rate increase, the issuer must submit a final justification.

Regardless of who does the review, HHS will post the final determination and the issuer's final justification (if applicable) on its website.

Outstanding Legal Questions

As mentioned above, there are still outstanding questions regarding the proposed regulation. For example:

1) **Will deemers be allowed?** Many states currently have provisions that allow rates to be deemed approved if the state does not disapprove them within a specified time period (for example, 30 days). One carrier has heard that allowing rates to be deemed approved may not constitute an "effective" rate review process, since not all rate filings are marked as approved or disapproved.

2) **Do the requirements only need to be applied to renewals/closed blocks**, or do they affect new business as well? Based on conversations with AID personnel, they have indicated that they plan to apply the new requirements to both new business and renewals. However, one carrier indicated a preference for applying the requirements only to renewals.

Other Health Care Reform Changes

The ACA will affect many aspects of health insurance, not just rate increase review and disclosure. Actuaries may cite some of these changes as explanations for requested rate increases. Below is a list of some of the ACA changes that could impact rates requested by actuaries or the rate filing review process:

1) Change in dependent eligibility age to 26
2) Grandfathered status
3) Prohibiting preexisting conditions
4) Removal of lifetime dollar limits
5) Limiting/removal of annual dollar limits
6) Restrictions on rescissions
7) Patient protections
8) Preventive health services
9) Minimum loss ratio requirements
10) Change in small group definition (other than for rate filing, but could affect rates)
11) Expansion of Medicaid
12) Exchanges
13) Age band and tobacco rating limits
14) Risk adjustment of individual and small group plans, both inside and outside the exchanges
15) Premium subsidies for small group (<25 employees)
16) Etc.

As part of the rate review process, the AID and will need to consider how to evaluate filing actuary's assessment of the impact of these factors. Some of these changes may have been implemented in other states before (e.g., age band limits) and so data may be available to evaluate the reasonability of these assumptions. However, other changes will be more difficult to evaluate, and the AID may need to rely on actuarial resources (an internal actuary or actuarial consulting resources) to evaluate the reasonability of the actuary's estimates.

Aon Hewitt's Phase I Activities

During Phase I, Aon Hewitt performed the following tasks:

1) Initial Kick-off Discussion with the AID
2) Initial interviews with AID personnel, including:
    a. Life and Health Compliance Officer
    b. Health Insurance Rate Review Manager
    c. Director of Life and Health
    d. Director of Information Services
    e. Chief Information Officer
3) Joint meetings with carriers and AID, to get carrier's views on current processes. We met with the following carriers:
    a. Golden Rule
    b. QualChoice
    c. Blue Cross/Blue Shield of Arkansas (BCBS of AR)

    See Appendix A for the discussion guide used for the carrier meetings.
4) Follow-up questions sent to AID personnel
5) Prepared analysis of potential changes needed to SERFF (see Appendix B)
6) Interview with Public Information Officer

Rate Filing Requirements, Staffing and Process

Current Situation

Currently, both the rate filing requirements and the AID personnel resources devoted to reviewing rate filings are fairly limited in scope. Arkansas currently only requires rate filings to be submitted for individual rates and HMO (except for new form filings), though AID intends to begin requiring rate filings for small group non-HMO. By statute AID has the authority to deny rate submissions in the individual health market and for HMO filings. AID will be requiring small group non-HMO rate filings, but does not presently have the legal authority to deny these rate requests.

There are only 1-2 personnel that spend a significant amount of their time reviewing rate filings, and there are no personnel at the AID with actuarial or underwriting experience. The AID receives only a few health

rate filings each year and at the Commissioner's discretion sends some of these out to actuarial consultants for review.

Current Rate Filing Requirements

Individual

Prior to enactment of health care reform, individual rate filings have been required on an ongoing basis (not just in association with form filings). Rate filings are filed and approved, with a 30-day review period (see Table 1 below). The AID tries to review all filings within 30 days. If more time is needed, a deemer letter is sent, extending the approval period by another 30 days.

Individual rate filings are required to be accompanied by actuarial data. The data required is outlined in AID Bulletin 4-79, and is summarized as follows:

1) Description of the type of coverage and designation of the affected policy or contract form number.
2) Rate change history.
3) Estimated number of persons in Arkansas that will be affected.
4) Percentage rate increase. If this is not level for all members, the maximum, minimum, and average rate increase need to be provided.
5) Latest three calendar years of experience on an earned premium to incurred claim basis.
6) Description of how the proposed rate increase relates to actual historical as well as future expected experience.

The Arkansas Insurance Code and the regulations issued by the AID do not cite any specific list of permitted rating variables or other rating restrictions for individual rates. Variables based on actuarial information may be used. There appear to be no other obvious restrictions on the rating variables that can be used for individual rate filings, though unfair discrimination in the premiums is not allowed under Arkansas statute and AID rules[6], including due to marital status, physical or mental impairment, or blindness.

Small Group and Large Group

For most purposes, including HIPAA protections, the current definition of small group in Arkansas is groups with 2-50 eligible employees[7]. However, for non-HMO rate filing requirements, small group is defined to be only 2-25 eligible employees in Arkansas[8]. Any groups with more than 25 eligible employees are considered to be large group for non-HMO rate filings. The AID is planning to write a rule to change the definition of small group to 2-50 for rate filing purposes.

For both small group and large group, carriers must maintain a rating manual onsite, detailing rates, rate development, and rating methodology. Rate filings are required to be submitted to the AID only for new product form filings[9], in which case the rate filings must be accompanied by an actuarial memorandum and certified by an actuary that rates are reasonable.

[6] §23-66-206(14)(B), §23-66-206(14)(E), §23-66-206(14)(F), and AID Rules 28 and 37.
[7] §23-86-303(34)
[8] §23-66-202(12)(A)
[9] §23-79-109(a)(1)(A)

Table 1: Current State of Arkansas Rate Filing Requirements

Segment	Eligibles	Rate Filing Requirements[10]	Risk Adjustment Factor (RAF) Band	Permitted Case Characteristics (Outside RAF Band)	Basic Rating Formula	Member Notification of Rate Change
Individual	1	File and approve, accompanied by actuarial data[11], description of % rate increase (incl min, max, average)	n/a	n/a	n/a	Required 30 days in advance (but must be after rate approval)
Small Group	2-25	Rate filings required only for HMO (file and approve with 60-day deemer). Must maintain rating manual; file annual actuarial certification on March 1. Rating manual and actuarial certifications not publicly disclosed.	15% (1.0-1.15), based on claims experience, health status, or duration of coverage	Geographic location, age, industry[12]	Rate = (Base Rate) x (Geo Factor) x (Age Factor) x (RAF)	Required 30 days in advance
Large Group	26+	Rate filings required only for HMO (file and approve with 60-day deemer). Must maintain rating manual. Rating manual not publicly disclosed.	n/a	No known restrictions	n/a	Required 30 days in advance

[10] For new products, filing must be accompanied by and actuarial memorandum and certified by an actuary that rates are reasonable.
[11] Actuarial data required for individual rate filings is outlined in AID Bulletin 4-79. If 500 or greater people in AR will be affected, need to send AR-specific experience in addition to nationwide experience.
[12] Industry not explicitly called out as a rating variable in regulations, but industries can be de facto excluded by not paying commissions. Gender is also not explicitly called out, but it is used by carriers in rating and is considered an acceptable rating variable.

Current Staffing

The AID has very internal limited resources for reviewing health rate filings, as relatively few health rate filings are received each year. Rate filings are primarily reviewed by the Life and Health Compliance Officer, with oversight by the Deputy Commissioner/Director of Life and Health.

Personnel

The following is a list of personnel currently involved in the rate review process or whose role is related to rate review and/or rate transparency:

1) **Insurance Commissioner** (currently Jay Bradford): Sets policy for department and has ultimate approval of regulations, rules, bulletins, and rate filings.
2) **Chief Deputy Commissioner** (currently Lenita Blasingame): Oversees Deputy Commissioners except Health Insurance Rate Review Manager and assists with legislative matters.
3) Deputy Commissioner/**Health Insurance Rate Review Manager** (currently Lowell Nicholas): Project management for implementing health care reform.
4) Deputy Commissioner/**Director of Life and Health** (currently Dan Honey): Provides supervision and guidance for the Life and Health Compliance Officer. Dan is tasked to review rate filings that include a request for a rate increase.
5) Deputy Commissioner/**Director of Information Services** (currently James Winningham): Oversees information services division and provides advice to commissioner on technology-related matters.
6) **Health Insurance Rate Review Attorney** (currently Bob Alexander): Drafts legislative changes, rules, and bulletins.
7) **Director of Consumer Services** (currently Jackie Smith): Handles consumer complaints and outreach/education activities.
8) **Public Information Officer** (currently Sandra McGrew): Responsible for implementing transparency improvements as required under health care reform, in cooperation with the Information Services (IS) division.
9) **Chief Information Officer** (currently Britton Kerr): Day-to-day coordination of IT elements with the NAIC. The IS division provides direct support to AID regulatory staff, via development and support of computers/software.
10) **Life and Health Compliance Officer** ("Compliance Officer", currently Rosalind Minor): Performs all technical reviews and communications regarding rate approval/disapproval. Also reviews non-health filings and spends only an estimated 10% of her time on health rate filings.
11) **Administrative Assistant** (currently Jennifer Newkirk): Logs all rate filings received by the AID, not just life and health filings.

Outside Resources

The AID also uses outside actuarial resources at the Commissioner's discretion. Historically, a consulting actuary might be obtained to review the rate filing if:

1) There is a considerable number of enrollees in Arkansas affected,
2) The rate increase is substantial, or
3) The rates are being submitted in association with a new form filing.

Recently, actuarial resources have been asked to review most of the health rate filings.

Workload

Arkansas currently receives very few health rate filings. The AID personnel's time spent on each varies from approximately one hour to several days, depending on whether the rate filing is eligible for expedited approval, whether there is correspondence back and forth with the company, the level of involvement with outside actuaries, and whether the rates are negotiated with the carrier.

Training/Expertise

There is currently no formal training conducted within the AID on how to effectively review rate filings. Additionally, there are no training materials in-house that could be used to train future staff. Educational opportunities provided by the National Association of Insurance Commissioners (NAIC) and other organizations are extremely limited and used on an as-needed basis.

Several personnel involved in the rate filing process have been at the AID for a long time and are experienced at their roles (in particular, the Compliance Officer, has been at the AID for 23 years). However, none of the personnel who review rate filings have any underwriting or actuarial background.

The carriers we talked with perceive the AID personnel to be knowledgeable, as well as generally responsive and approachable.

Current Rate Filing Review Process

Effective March 1, 2011, all rate filings in Arkansas are submitted via the System for Electronic Rate and Form Filing (SERFF), maintained by the NAIC. An administrative assistant also logs all rate filings when they arrive, as a backup. The Compliance Officer then checks each filing for:

1) Completeness (all required data included):
    a. Last 3 calendar years' experience on an earned premium and incurred claims basis (nationwide and AR experience),
    b. Rate history, and
    c. Number of individuals insured in the block of business
2) New products only: Checks if product and rates are compliant with AR laws, regulations, and AID bulletins.

Expedited approval is granted if the rate filing meets all of the following conditions:

1) The average rate increase is less than 30%,
2) The number of Arkansas citizens affected is less than 100,
3) There has been no rate revision within the past 12 months,
4) The filing was submitted at least 60 days before the effective date, and
5) Policyholders will be notified at least 30 days prior to the effective date.

According to AID personnel, it is rare for a rate filing to qualify for expedited approval. AID personnel have stated that in practice they might consider granting expedited approval to more filings if there were too many of them.

If the conditions for expedited approval are not met, a projected loss ratio is calculated using the following formula[13]:

$$\frac{(\text{Historical Incurred Claims}) \times (1 + 15\%)}{(\text{Historical Premium}) \times (1 + \text{Requested Rate Increase})}$$

Where the historical incurred claims are for the last 3 years of experience.

Whether the filing is approved, modified, or rejected would historically depend on the following factors:

1) Projected loss ratio: less than 50% is considered "unreasonable"
2) History of previous rate increases
3) Financial history of the company
4) Medical trend
5) Whether the insurer has filed a loss ratio guarantee. If the insurer complies with the loss ratio guarantee, the rates are deemed retrospectively approved by the commissioner.

At the commissioner's discretion, rate increases are sometimes negotiated with insurance companies. Over the year preceding this report, requested rate increases greater than 10% were negotiated with the Commissioner. In addition, at the Commissioner's request, recently the AID has been extending the deemer provision an additional 30 days for all rate filings with requested rate increases, in order to allow for additional analysis and possibly negotiation with the issuer. Also, the current commissioner requires that all rate filings with requested increases be reviewed by him before they are approved.

Analysis of Rate Filing Review Performance

Aon Hewitt examined three rate filings submitted to the AID recently, including looking over the consulting actuary's review of the filing (where applicable). We reviewed the following filings:

SERFF Tracking Number	Date Filed	Issuer	Segment / Product	Purpose of Filing	Requested Rate Change	Actuary Reviewing Filing	Final Disposition
n/a	4/23/2009	BCBS of AR	Individual PPO	Rate Increase for Closed Block	+27.3%	Milliman	Approved +11.0%
AMMS-126323074	11/24/2009	Golden Rule	Individual Major Medical	Rate Increase for Closed Block	+7.0%	n/a	Approved +7.0%
UHLC-127132858	4/25/2011	UnitedHealthcare of AR	Small Group HMO	Changing base rate, area factors, and trend	-4.3%	n/a	Approved -4.3%

[13] Formula provided in e-mail from Lowell Nicholas (Health Insurance Rate Review Manager) on May 3, 2011, in response to a question posed to Rosalind Minor (Life and Health Compliance Officer).

BCBS of AR, 4/23/2009 Individual Rate Filing

This was a complex rate filing, submitted for a block of some previously closed forms, two newly closed forms, and two open forms. Analysis of closed block individual rate filings can be extremely difficult, as the required rate increase is influenced by underwriting wear-off (durational factors), anti-selection, and whether the carrier included statutory active life reserves (contract reserves) in their initial rating of the policies. Unfortunately, the carrier included very little detail in their actuarial memorandum about the assumptions and methodology. The memorandum did not include the trend factors or any mention of the durational model that was used to project the experience. They included a factor for "rating cell mix changes" that was not described at all, and this terminology could be used to represent a wide variety of factors. There was also no explanation for why the carrier needed a loss ratio of 72.5% for this block, though the AID rules do not require a breakdown of the retention (1 minus target loss ratio) into components such as administrative costs, profit, commissions, and premium tax/assessments.

The AID extended the deemer period by 30 days via a letter issued on 5/20/2009 (within the original 30-day deemer period). The AID then appropriately requested comparative data from the Finance department, using NAIC data. Some of the trends in this data looked unusual (e.g., 1% increase in industry premium per member in 2007). The AID may want to consider using other sources for comparative data.

The AID also appropriately sought an actuarial review for this filing, though it appears that the actuarial consultants did not begin asking their questions until May 29, so there may have been a delay in bringing them into the process. It took multiple rounds of questions from the actuarial consultants (Milliman) to understand the assumptions and methodology. The responses given by the carrier were sometimes difficult to understand or did not appear to be answering the questions completely. However, Milliman's review of the filing appeared thorough and competent. After Milliman's review, the AID negotiated a rate increase of 11%, which was approved on July 15, 2009. We were not able to locate a second deemer extension letter extending the deemer period another 30 days after the initial letter on 5/20/2009. The carrier refused to submit a revised rate filing with an actuarial certification, since the final rates were not the work of their actuaries.

This rate filing took nearly 3 months to review, which is an unusually long period of time. However, it appears that this was partly caused by a very incomplete methodology and assumptions description provided by the carrier. Also, as mentioned above, this was a very complicated filing.

Golden Rule, 11/24/2009 Individual Rate Filing

Although this rate filing was also for a closed block of individual policyholders, it was much more straightforward. Golden Rule met all the requirements for expedited approval (including having a loss ratio guarantee in place for this block), so under AID Bulletin 4-79, the filing was automatically eligible for approval after the AID checked that the conditions were satisfied. There is no documentation showing that these conditions were checked, but the rate filing does appear to satisfy these conditions, and the filing was approved within 7 days (on 12/1/2009). Thus, the AID appeared to follow the procedures of Bulletin 4-79 for this filing. Presumably because the filing was eligible for expedited approval, the carrier provided little explanation of assumptions and methodology.

UnitedHealthcare of AR, 4/25/2011 Small Group HMO Rate Filing

The rate filing requirements for small group and large group HMO in AR are fairly minimal. Carriers need to only file new factors before using them, though the rates must be approved by the AID before they are used. There are no specific data requirements for HMO filings. Hence, the filing contained very little information regarding assumptions and methodology. It also appeared that the carrier was only filing factors that changed, so other factors used for ratings were not included. The carrier also did not include a comparison of the factors versus the previous filing or a description of the rating formula. Therefore, it would be difficult to assess the impact of the changes on specific policyholders (e.g., in a certain area) without comparing against a previous filing with these factors. Also, it would not be possible to calculate a rate for a specific policyholder using this rate filing, since it appears to be missing some factors (for example, age factors). If a policyholder complained to the AID about rates, the carrier's rate calculation could not be readily checked by the AID.

The AID does appear to have followed the very limited regulations for the HMO product when reviewing this rate filing.

Aon Hewitt's Assessment of AID Rate Filing Review Process

Fulfilling HHS' Requirements

The AID has expressed that they would like to be able to perform rate filing review without HHS involvement. To allow this to happen, the rate filing process needs to be deemed "effective" by HHS. The following is a discussion of the AID's current process in light of HHS requirements for an effective rate review program.

Standard for "Unreasonable" Rate Increases

HHS will consider whether a given state applies a standard set forth in statute or regulation when making the determination of whether a requested rate increase is unreasonable. Currently, the AID does not have a standard definition for determining that rates are "unreasonable", as is the case with most states (though some states have minimum loss ratio requirements). There is currently a standard for a "reasonable" projected loss ratio (50%) that is part of the process of determining whether to approve an individual rate filing. However, if a filing meets this standard, it is not clear if the filing might still be considered "unreasonable" or under what conditions this would occur. Also, this standard is well below the minimum loss ratio requirements of the ACA, so in practice every filing that is in compliance with the ACA would be considered reasonable automatically. This would most likely not be considered an effective standard for reasonability by HHS.

Additionally, the AID currently negotiates some rates and initially disapproves filings with rate increases now. This is not disallowed under the ACA, but the determination of "unreasonable" cannot be negotiated, and the standard for "unreasonable" must be spelled out in statute or regulation. Otherwise, HHS will likely not consider the process to be "effective".

The rate review process has also generally been subject to the discretion of the Commissioner who has been in office at the time. The ACA does not say anything about using the Commissioner's discretion to impact the approval/disapproval of rate filings, though arguably this can contribute to carrier dissatisfaction (one carrier expressed frustration over recent changes to the process, in particular that

rates are now subject to negotiation). The Commissioner's discretion should not be applied to the determination of "unreasonable" for specific rate filings if the AID wants to have an effective rate review process.

If the AID desires to allow the Commissioner's perspective to influence the process, the standards for "subject to review" or "unreasonable" could be set by the Commissioner then in office via rule. This standard would then be applied to all filings in the same way. Note that this procedure would not necessarily prevent the Commissioner from using his or her discretion to disapprove filings, as this is a separate issue from the determination of "unreasonable". The AID should consult with their legal counsel on this issue.

Other rate review procedures (for example, when to use outside actuarial resources) should also be established within the AID and handled consistently across all health rate filings. These procedures could be modified by each Commissioner, as long as they are applied consistently.

Data and Documentation

HHS will also consider whether the state receives data and documentation that are sufficient to determine if a requested rate increase is unreasonable. Currently, rate filings are now required for all individual and HMO rate changes in Arkansas, and the AID expects to begin requiring rate filings for small group non-HMO. The filings are filed and approved with a 30-day deemer. It is not clear in the HHS regulation whether deemers will be allowed for an "effective" rate review program (see outstanding legal questions above).

Experience and a description of the rate development are collected from the carrier as part of the rate filing. Also, rate filings include an actuarial certification. Under actuarial standards of practice, the description of the rate development must be sufficient for another actuary qualified in the same practice area to make an objective appraisal of the actuary's works as presented in the actuary's report[14]. However, according to AID personnel, rate filings vary widely by carrier in terms of the quality of this description. Also, rate filings that include a loss ratio guarantee provide very little information.

Currently, carriers are asked to provide the historical loss ratio, but they are not asked to provide the projected loss ratio using the current rates ("on-rate" loss ratio) or using the proposed rates. The AID does use a projected loss ratio formula when reviewing filings, as described above[15]. However, this formula has the following problems:

1) **It does not account for rate increases requested during the historical period**. Note that this can be fairly complex when rate increases impact groups or individuals at different renewal dates throughout the year ("anniversary" renewal instead of a "focal" renewal that hits all members at once).

2) **It does not account for the fact that there is typically a gap between the end of the historical period and the projection period.**

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[14] Actuarial Standard of Practice No. 41, "Actuarial Communications", Section 3.3.3, March 2002; http://www.actuarialstandardsboard.org/pdf/asops/asop041_120.pdf .

[15] $$\frac{\text{(Historical Incurred Claims) x (1 + 15\%)}}{\text{(Historical Premium) x (1 + Requested Rate Increase)}}$$

3) **A flat 15% factor is used to trend claims forward** regardless of: a) current national (or regional) annual claims cost trends, and b) the period of time between the midpoint of the historical period and the midpoint of the projection period.

The AID's current projected loss ratio formula may be causing it to approve rate increases that in reality are associated with projected rate increases less than 50%.

Another potential issue is that issuers do not currently distinguish grandfathered vs. non-grandfathered plans. The ACA only requires non-grandfathered plans to comply with an effective rate review process. However, if the AID does proceed with its stated intent to review both grandfathered and non-grandfathered plans, the fact that issuers do not distinguish between these will not be a problem.

For small group non-HMO, filings not currently required. The AID has the authority to make rules for small group non-HMO and plans to draft a rule requiring rate filings for small group non-HMO. This would need to occur in order for the AID to have an effective rate review process for small group non-HMO.

Review of Data and Documentation

Another criterion for an effective rate review program is that the state effectively reviews the data and documentation that are provided by the issuer. AID personnel have stated that they do review the data and documentation, unless the rate filing gets expedited review (uncommon). However, completed checklists are not maintained for rate filings, demonstrating what was reviewed, so it is not possible to verify that the right items are being checked.

Currently only a small proportion of rate filings are not reviewed by an actuary, though as noted above, external actuarial consultants are used to review these filings, since there are no current internal personnel with underwriting or actuarial expertise. The actuarial consultants that are used by the AID are perceived by carriers to be asking the right questions and to have the appropriate expertise.

However, internal training and documentation for how to review a rate filing is minimal. There is no rate filing review manual, and there are no job aids. A checklist exists for reviewing form filings, but not rate filings. Bulletin 4-79 is used informally as a guide for what to check in each filing.

Two carriers commented that the AID is reasonable to deal with. All three carriers we spoke with noted that AID personnel are normally prompt in getting back to them. However, one of the carriers noted that this has changed recently, and filings are not being approved within 30 days. They noted that deemers are extended beyond the initial 30 days more frequently now, which was confirmed by AID personnel. Both the carrier and AID personnel noted that the current Commissioner has been more actively involved in reviewing and negotiating rate filings, which has caused the process to slow down to some extent.

Examining Reasonability of Assumptions

The final requirement for an effective rate review program is that the state examines the reasonableness of the assumptions. In reviewing individual health rate filings the AID uses the following checks:

1) Projected loss ratio: less than 50% is considered "unreasonable",
2) History of previous rate increases,

3) Financial history of the company,

4) Medical trend, and

5) Whether the insurer has filed a loss ratio guarantee.

The AID does not have the actuarial expertise to check more complex assumptions, such as the effect of changes under health care reform and the impact of a diminishing risk pool. However, the AID could (and does) send filings out to consultants for review when the filings are complex. Due to all of the upcoming health care reform changes, the impending transition to reviewing Small Group non-HMO rate filings, and the current conservative standard for "subject to review", the AID will likely need to send more rate filings out to actuarial consultants or hire internal actuarial resources, at least initially.

Interaction of Rate Filing Review and State Exchange

The AID proposed a bill to develop a state exchange in Arkansas, but this bill was not approved by the legislature. Since the legislature does not meet again until 2013, this means that the exchange will need to be developed by an outside entity, likely a non-profit group. Therefore, all rate filings that are "subject-to-review" will need to be reviewed by the AID and not by the exchange.

Other Process-Related Comments

Generally, the carriers seem to be providing the bare minimum data required in the filings. For at least one very complex rate filing, it appears that a significant amount of time (and perhaps money on consulting resources) was spent clarifying the intent, methodology, and assumptions in the filing. While actuaries should be providing this information under actuarial standards of practice, some actuaries are also under a significant amount of pressure from their employers to provide as little information as possible. To make the rate filing review process less time-consuming and expensive, the AID should consider doing one or more of the following:

1) **Spell out more extensive and specific rate filing requirements via regulation or bulletin**. These requirements could be developed in a way that does not make them onerous, but does require the actuaries to provide what is needed for another actuary to review the filing.

2) For any rate filings that do not provide sufficient information for a review of the filing, **ask the carrier to send the information**. The letter with the request should indicate that the 30-day review period does not start until this data was received (a regulation and/or bulletin may need to be released to allow the AID to do this). A checklist could be used by the Compliance Officer to ensure that this information is included before the filing is sent to outside actuaries for review.

3) **Disapprove any rate filings that do not contain sufficient data for a review**.

Assessment of Staffing

Adding Small Group non-HMO filings will almost certainly increase the workload, especially in the beginning, as carriers become accustomed to the new requirements. One compliance officer who also works on non-health filings (and no actuarial resources internally) will most likely not be enough resources, especially given all of the changes with health care reform that could affect filings and given

current strict standards for expedited review. The individual market is expected to roughly double in membership when exchanges are opened in 2014[16], which may cause the number of individual carriers or the frequency of rate filings to increase.

Below are some options for dealing with the increased rate filing review demands:

1) Make expedited review easier to achieve,
2) Increased automation and job aids,
3) Hire more staff, particularly with actuarial or underwriting expertise, or
4) Farm out more of rate filings to actuarial consultants initially, then possibly cut back on usage of consultants if and when internal resources have been hired.

Assessment of Training

The AID rate filing compliance officer has a long tenure at the department. Currently, she seems to understand the process well, but little is documented. Additionally, internal staff does not have actuarial/underwriting expertise to review complex filings.

AID staff can attend outside seminars periodically, most commonly those held by the NAIC. However, AID personnel have commented that they would like assistance in identifying outside vendors offering more pertinent seminars.

Below are some improvements that can be made:

1) Create training materials to explain basic rate filings concepts.
2) Create rate filing review rate manual to spell out expectations of review process, give guidance, and delineate when actuarial resources need to be used.
3) Create job aids, including checklists of what to look for:
    a. Require that checklist is filled out and maintained for each filing (e.g., in paper file or scanned into a database).

The documents listed above should be updated and modified on an ongoing basis, as circumstances change.

Transparency and Consumer Relations

Current Situation

Transparency

As noted above, the AID has not historically made rate filing information available to the public until it is deemed closed by the commissioner. Therefore, the AID has not historically sought consumer input prior

[16] "America Under the Affordable Care Act," December 2010, Urban Institute and Robert Wood Johnson Foundation. Matthew Buettgens, Bowen Garrett, and John Holahan.

to approving or disapproving a rate filing. Current law requires a 30-day public notice from the carriers for rate increases prior to implementation.

After the approval or disapproval of a rate filing, publicly releasable filing information is posted on the AID website. The disposition letter that is posted states the percentage rate increase, but the language is complex and may be hard for the public to understand. Rate filing detail, including actuarial formulas and assumptions, cannot be publicly disclosed due to ACA.23-61-103(d)(4).

The AID is currently exploring statutory and/or regulatory changes to improve and clarify transparency, including what specifically constitutes "actuarial formulas and assumptions".

Consumer Complaints/Inquiries

According to the AID Director of Consumer Services, there are very few complaints or inquiries each year from consumers regarding health insurance rates. AID personnel have expressed concern that questions from consumers might increase significantly under health care reform, particularly once the exchange is operational in 2014.

Consumer Outreach

Historical activities

Prior to health care reform, the AID did not have any consumer outreach activities related to health insurance rates. Because rate filings have historically been treated confidential until they are deemed closed, there have been no public announcements and requests for comments on proposed rate increases, the AID does not hold town hall meetings to discuss rate increases, and there have historically been no consumer education seminars or tutorial materials such as videos or Power Point presentations.

The Life and Health Division does have a website, which appears mostly geared toward people working in the health insurance industry. It is very functional in appearance and not very consumer friendly. The terms on the website are not defined, and many of the terms would be unfamiliar to consumers.

Changes Under Cycle I Grant

Using rate review grant funding, the AID has hired a Public Information Officer to develop and implement a Communication Action Plan. The goals of this project are to improve consumer knowledge and involvement in the rate approval process. The Public Information Officer has developed a Communication Action Plan, met with consumer groups, and begun planning for improvements to the website in cooperation with the IT department. Additionally, a new section has been added to the website for the Health Insurance Premium Rate Review Division. This site contains basic educational information, such as a definition of "health insurance premium", how to reduce insurance premiums, etc.

Aon Hewitt's Assessment of Transparency and Consumer Relations

If the AID wants to improve transparency and the ability for the public to provide input prior to approving rates, the practice of holding rate filings confidential before they are deemed closed will need to be changed to allow the AID to provide information about proposed rate filings to the public. As noted above, the AID plans to clarify what constitutes "actuarial formulas and assumptions". The AID could then redact confidential information from filings or request the actuary to submit separate public vs. confidential

rate filings, as is currently done in the State of Washington. This would allow the AID to post filings on the website prior to approval, provide press releases announcing pending rate increases, invite consumers to comment, and possibly hold town hall meetings to hear consumer opinions. However, one carrier did note that public forums such as town hall meetings would make the process much more cumbersome for them.

Although there have not been many consumer complaints and inquiries historically regarding health insurance premiums, the AID should anticipate this changing after health care reform is enacted. The AID should consider proactive education activities to help handle these inquiries later. For example, consumer questions regarding how to obtain coverage via an exchange could be answered by pointing consumers to an education pamphlet or web page that explains exchanges and how to access them. Although this requires up-front investment, it will save the AID time and expense later.

More general consumer outreach could be improved via an enhanced website. Oregon in particular is a good example of a state that has a very consumer-friendly website, with a consumer guide, links to resources for finding coverage or federally funded clinics, a basic primer on health insurance, and links to resources to help improve health. The AID should consider this for members who have access to and familiarity with the Internet. However, other approaches may need to be used for residents who do not use the Internet much, due to lack of good Internet coverage in rural areas, unfamiliarity with the Internet, and for those who simply prefer more traditional approaches.

Information Technology and Database Management

Data for Reporting

The AID needs to have the ability to run reports summarizing the information in all health rate filings, in order to provide data to HHS and the public. Currently, the AID does not store much rate-related data in a database format that can be easily accessed for reporting purposes or by consumers. There is a basic master ledger document that is used to track all rate filings internally, mostly as a back-up to SERFF. This master ledger only contains a few basic fields, such as the date received, fees paid, analyst assigned to do the review, etc.

All rate filings are now required to be submitted via SERFF, as of March 1, 2011, so information can be pulled out of SERFF for each filing. However, this information is not currently in a format that the AID can readily run reports from. For example, it would not be possible for the AID to run a report on the average projected loss ratio for all health filings in a given year. SERFF stores most of the rate filing information as file attachments, so the AID would need to open each one of these attachments, which would be too cumbersome for reporting purposes.

It was relayed to us from AID that SERFF originally committed to make the changes needed so that all required data was available in order to meet HHS' needs for rate review. However, it is not clear whether this will be in a format that can be used to readily run reports, and it also appears that SERFF is significantly behind in making these changes (still in the planning phase). As a result, the AID should consider the following approaches, depending on whether SERFF makes changes in time and whether they meet the AID's needs:

1) **Press SERFF to make the modifications needed to store all data elements as separate fields**. If this is accomplished in time, the AID would then need to be able to run reports from these data elements. If the AID's reporting needs are extensive and frequent, or if these data elements are needed for other rate filings needs (e.g., automated job aids to help with rate filing review), the AID may want to pull relevant data down from SERFF periodically (e.g., weekly, for health filings only) for use internally.

2) If SERFF can only store data as files (e.g., disclosure documents), the AID may want to **create a way to extract the data from each file into database format** for use internally.

3) The AID may want to make its own **comprehensive internal database**, to store data from SERFF (obtained through method #1 or 2 above), as well as additional fields that are not in SERFF. For example, the HHS preliminary justification does not include any information on the impact of plan design changes. Some carriers may implement benefit reductions on their plans in an effort to ensure that they fall below the "subject-to-review" threshold for rate filings (10% for HHS in 2011). The AID may wish to separate the effect of true underlying cost trend vs. the effect of plan design changes by creating its own data fields.

At this time, it appears that SERFF will only be able store the required data as files (#2 above). Therefore, in order to facilitate reporting to HHS and allow for some basic automation in the rate filing process, we recommend that the AID start developing some sort of database internally now, populating it manually at first. Then data could be downloaded directly from SERFF if and when this becomes possible. This downloading could be done by writing a procedure to automatically extract data elements from a standard Excel file submitted by the actuary and load them into the database.

Incorporating Other Data

The AID should also consider incorporating other data sources into the process: internal to AID and also from external sources. For example, for at least one of the rate filings, the Director of Life and Health requested from the Finance department an analysis of the annual statement and recent financial trends from the NAIC database. Some of this data could be incorporated into an internal database and be accessed during the rate filing review process. However, the value of data often lies in how it is interpreted; the commentary from the Finance department was also useful and cannot be captured easily in a database or formula. The use of data should be combined with a critical analysis of the data from someone who understands it. Further, it would be helpful to incorporate data from outside of AID; such as developing regional and national rate trends from HHS and cost trends from sources such as Standard & Poors and the Centers for Medicare & Medicaid Services.

Automating the Rate Filing Review Process

The AID has expressed interest in automating some aspects of rate filing review. The AID currently has no job aids for rate filing review other than Bulletin 4-79. There are many aspects of rate filing review that could be improved via electronic job aids, such as:

1) **Formulas to check the total annual rate increase**. Carriers sometimes file more than once a year. If the AID sets an annual "subject-to-review" threshold, the AID would need to combine the rate increases from these filings. If members experience rate increases on an anniversary basis (upon

renewal at different times during the year, not all at the same time), this can actually be somewhat complex to calculate for each renewal date.

2) **Formulas to check the actuary's calculation** of projected experience from the historical experience. Errors found in the actuary's calculation or assumptions can sometimes cause a large impact on the rate increase.

3) **Basic checks on assumptions for trend, loss ratio, etc.** Error messages could indicate to the Compliance Officer when assumptions are unusual.

4) **Electronic checklist of items to be checked by the Compliance Officer** before sending it on to actuarial consultants (where applicable).

Because some rate filings can be extremely complex, some human analysis will need to be part of the process. However, the process can be greatly improved with the assistance of some electronic job aids.

IT Capabilities and Resources

As noted above, we recommend that the AID begin developing an internal database that could be used for HHS reporting and basic automation of some aspects of the rate filing process. In Phase II, we plan to do a deeper assessment of: 1) the current state of the data systems, and 2) whether the AID's IT department can carry out these activities on their own or whether they will need outside resources to make the necessary enhancements.

Conclusions

The AID currently receives filings, and the requirements for these filings are fairly minimal. There are also few resources available for training or job aids. In order to comply with the ACA and improve the current process, communications, and information technology, the AID should consider the following:

1) **Develop standards for filings that are "subject-to-review" and "unreasonable".** The determination of "unreasonable" will likely need to involve some subjective judgment (e.g., by an actuary), but the AID should at least provide a general outline of how a filing is determined to be "unreasonable".

2) Consider **developing more specific requirements for the data, assumptions, and methodology description** that need to be included in rate filings. This should help to minimize resources spent on reviewing filings, including internal staff time and external actuarial resources. Alternatives to developing specific requirements include disapproving filings that do not include enough documentation and/or developing a list of data elements to check for each filing.

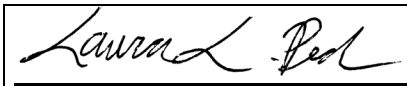
3) **Create internal training materials, a rate review manual, and electronic job aids** to help with the rate filing review process.

4) **Improve consumer outreach**, including educational documents, website layout and content, the release of least portions of rate filings publicly available before they are closed, and possibly press releases and/or town hall meetings to discuss rate requests.

5) **Develop an internal database with pertinent rate filing information** that will either be loaded with information manually by AID personnel or electronically from SERFF. This database will be used for reporting to HHS and for helping with rate filing review.

Next Steps

In Phase II of this project, we plan to present specific recommendations to the AID for consideration. We will then work with the AID to agree upon the changes to be made. Next, we will create internal training materials, a rate review manual, and job aids. We will also work with the Information Technology division, the Public Information Officer, and Internal Legal Counsel to help provide feedback and recommendations for their work. Finally, we plan to present our Phase II results both in person and in written form to the AID.

 Laura Peck, FSA, MAAA	June 20, 2011 (date)
 Richard Rush, FSA, MAAA	

Arkansas Insurance Department

Health Insurance Rate Review Process

Phase I Discussions with Carriers

Discussion Guide (April 26, 2011)

Introduction

The Arkansas Insurance Department (AID) has obtained Cycle I grant funding under the Patient Protection and Affordable Care Act (PPACA) to enhance current state processes for reviewing health insurance premium increases. Using part of this funding, the AID has retained Aon Hewitt to 1) perform a comprehensive assessment of the current health insurance premium increases; and 2) research, develop, and recommend a comprehensive plan for the complete upgrade of the existing AID system of health insurance rate review as well as all related and applicable technology. The assessment of the current process is "Phase I" of the project. "Phase II" is comprised of developing the comprehensive plan for future improvements and is expected to be complete in a few months.

For each of these two phases, Aon Hewitt plans to obtain carrier input, primarily via conference calls. The purpose of these calls is to get feedback from the carriers regarding the current process (Phase I) and proposed changes to the process (Phase II). We feel that carrier input will be valuable in helping to develop effective recommendations that allow the AID to review rate filings without the need for assistance from the United States Department of Health and Human Services (HHS).

During Phase I, these calls will consist of discussions of the current process. To assist with this discussion, we have included below a discussion guide for the Phase I calls.

Aon Hewitt Participants

The following Aon Hewitt actuaries will be leading these calls:

- **Richard G. Rush, FSA, MAAA:** Rick is a senior vice president in Aon Hewitt's Health and Benefits practice in Denver, CO. Rick has over 25 years of employee benefits actuarial experience, including executive positions with insurance companies, actuarial consulting firms, and the human resources responsibilities of a *Fortune* 500 company. His insurance company and related consulting experience includes chief executive and chief actuary responsibilities for health insurers and regional HMOs, and a federal court-appointed rehabilitator and liquidator of two separate insolvent HMOs.

- **Laura L. Peck, FSA, MAAA:** Laura is an actuarial consultant at Aon Hewitt in Newport Beach, CA. She has over 12 years of health care actuarial experience. Prior to joining Aon Hewitt, Laura interned at the California Department of Health and Human Services, worked in consulting for two years, and

worked at a health insurance carrier for eight years. Laura experience submitting rate filings for individual, small group, and large group—both HMO and PPO.

Discussion Topics for Phase I

Below is a list of sample questions for discussion. If you file rates in other states, please feel free to reference your experiences in these states.

1) What changes, if any, do you plan to make to your rate filing process nationwide in response to PPACA? For example, are you developing a standard plain language summary that will be used as a template in all states? Do you plan to automatically submit additional justifications when requesting rate increases of 10% or more? Is there any other rate filing standardization being done nationwide as part of PPACA?

2) Have there been any technological issues with filing rates? Are you accustomed to filing via SERFF, and does this process work well for you? Do you have any technological concerns about SERFF? E.g., trouble with submitting filings, system downtime, etc.

3) Are the current data requirements for Arkansas health rate filings reasonable and appropriate in your view? What, if any, changes would you suggest to the data requirements for rate filings?

4) If the AID responds to a rate filing with additional questions, are they asking the right questions in your view?

5) If rate filings are sent back as not approved, why are they typically disapproved? What actions have you taken after a disapproval? E.g., re-submit with additional data or a lower rate increase, etc.

6) When communicating with the AID regarding rate filings, does the staff seem to have the right level of training, knowledge, and experience to understand the complexities of rate development (both in the past and for future rate filings that may be impacted by health care reform changes)? Have there been any challenges with explaining the rationale for rate changes?

7) Does the AID respond to rate filings or questions from carriers regarding rates in a timely manner?

8) As the AID looks to begin reviewing small group rate filings as required under PPACA, are there any suggestions that you have? What data requirements would you suggest for small group rate filings?

In Closing

We thank you for participating in this process and look forward to working with you again during Phase II.

Arkansas Insurance Department

Health Insurance Rate Review Process

Potential Changes Needed to SERFF

May 6, 2011

Introduction

The following is a discussion of potential changes that may be needed to SERFF, in order to enable the Arkansas Insurance Department (AID) to conduct an effective rate review process that complies with the draft HHS rate review regulations[17] and also to facilitate enhancements to Arkansas' rate review process.

We have used the following documents as the basis for this list:

1) Draft HHS rate review regulations (12/21/2010)

2) Proposed HHS Preliminary Justification (Disclosure) Form and Instructions (3/1/2011)[18].

3) Current fields available in SERFF

The discussion below is a preliminary draft based on current information. We expect it to change as additional guidance becomes available from HHS and/or the NAIC and as we develop our recommendations for changes to the AID's rate review process.

HHS Preliminary Disclosure Requirements

An issuer with a filing that is "subject to review" is required to submit a preliminary justification. HHS has proposed that the preliminary disclosure be composed of the following three parts:

- Part I: Rate increase summary ("Rate Summary Form")
- Part II: Written Explanation of the Rate Increase ("Consumer Template")
- Part III: Rate filing documentation

Together, Parts I and II would provide a descriptive and quantitative analysis for consumers. Part III would only be required when HHS is doing the review.

[17] Interim Final Rule on Rate Increase Disclosure and Review, released by the Department of Health and Human Services (HHS) on 12/21/2010.
[18] Published by the Centers for Medicare and Medicaid Services (CMS) on March 1, 2011

Comments Regarding HHS Disclosure Forms

Usefulness of Information for Consumers

While we would agree that this information may be useful for states to collect and use as part of its review process, much of the material appears to be of limited value to consumers. For example, it's not clear that a trend of x% for lab and radiology would mean much for consumers. Simply listing off percentages by service category may simply add to confusion and cause consumers to focus too much on the wrong issues. Consumers may think that high "trends" indicate poor provider contracts when they may actually indicate that the block was underpriced at inception. On the other hand, a low trend may not indicate good utilization or unit cost management, but rather aggressive plan design changes on the part of the carrier ("cost-shift" to consumers).

Storage of Disclosure Information in SERFF System

Currently, SERFF primarily stores documents and captures basic information regarding a rate filing (name of actuary submitting filing, status of filing, etc.). It does not capture detailed information from each filing. To allow HHS to perform rate filing reviews where needed, SERFF will need to be modified to store the disclosure information. This can be done in one or both of the following ways:

1) **Have SERFF store the disclosure documents as files** on the SERFF system. For example, they would be stored as Excel, Word, or Adobe PDF documents, etc. This would allow HHS (and the states) to retrieve the information, but it would not allow for any high-level reporting.
2) **Have SERFF store each piece of data from the disclosure documents as a separate field** within SERFF. For example, separate fields for base period inpatient member months, base period outpatient member months, etc. While this could potentially require much more modification work within SERFF, it would for more reporting capabilities for HHS and the states.

HHS mentioned in the proposed regulation that an analysis of data from the states' filings would be used to determine future state-specific "subject to review" thresholds. Having a national database with detailed rate filing information in a format that users can query from would help to facilitate this analysis.

The field-by-field approach suggested above would only work well for Part I of the Preliminary Disclosure, the Rate Summary Form. Many of the components of Part II are also in Part I. It is not clear whether HHS intends that at least some of the fields in Part II will be auto-populated from Part I in some way. While some of the information in Part II could be captured in field format, based on the instructions it appears that many elements could not be captured as easily in fields (e.g., "Provide a brief, non-technical description of why the issuer is requesting this rate increase.").

For Part III, it is anticipated that responses from carriers will vary widely, and this information cannot be easily captured in field format unless HHS provides more specific guidance re: what carriers need to provide (e.g., components of loss ratio exhibit).

Additional Fields

HHS and/or Arkansas may want to ask SERFF to add additional fields, beyond those included in HHS' preliminary justification. Below is a discussion of additional fields that may be useful.

Trends

We would suggest at a minimum that HHS (or Arkansas) supplement these requirements by breaking down the total trend into cost "drivers". For example:

1) Unit cost changes
2) Utilization changes (including "mix" changes)
3) Impact of plan design changes
4) Impact of health care reform
5) Underpricing in previous rate filing
6) Changes in target retention (admin and profit) assumption
7) Other factors (to be delineated and described by the filing actuary)

These trend drivers would not need to be broken down by service category; they could be reported only for the total trend. In addition, we would suggest that all trends in the consumer information be presented on an annualized basis, to allow for consistency in reporting for each filing and to facilitate comparisons across filings and carriers.

Loss Ratios

Loss ratios are an integral part of PPACA, they are commonly used in rate filings, and they are referred to in Arkansas' current data requirements for rate filings. Therefore, we would suggest that more loss ratio information be included in the preliminary justification (or required by Arkansas). For example:

1) Historical loss ratio for each of the last three years of experience
2) Projected loss ratio using current rates
3) Projected (target) loss ratio using proposed rates

Inclusion of Fields in Initial Rate Filing

Arkansas may choose to review at least some rate filings that do not exceed the "subject to review" reporting threshold. For example, the AID currently reviews rate filings associated with new forms. In order to allow for aggregate reporting of all rate filings (e.g., average inpatient trend) and to allow for an effective review of these filings, the AID may wish to consider requiring that at least some of the data elements in the preliminary disclosure are included in the initial rate filing.

Complete List of Suggested Fields to Add to SERFF

Based on the discussion above, our preliminary analysis suggests that the following fields should be included in SERFF. Note that the HHS regulation and preliminary justification forms have not been finalized yet. This list is based on information available at this time and may change when HHS releases additional or revised information.

Note: calculated fields are in ***blue bold italic font***.

1) Base period start date
2) Base period end date
3) Base period member months
    a. Inpatient
    b. Outpatient
    c. Professional
    d. Prescription drugs
    e. Other
    f. Capitation
    g. Total
4) Base period total allowed
    a. Inpatient
    b. Outpatient
    c. Professional
    d. Prescription drugs
    e. Other
    f. Capitation
    g. Total (sum of a:f)
    h. Total PMPM
5) Base period net claims
    a. Inpatient
    b. Outpatient
    c. Professional
    d. Prescription drugs
    e. Other
    f. Capitation
    g. Total (sum of a:f)
    h. Total PMPM
6) Base period – total rate PMPM
7) Current rate start date
8) Current rate end date
9) Current rate overall medical trend
    a. Inpatient
    b. Outpatient
    c. Professional
    d. Prescription drugs
    e. Other
    f. Capitation
    g. Total
10) Drivers of total medical trend
    a. Unit cost changes

b. Utilization changes (including “mix” changes)
c. Impact of plan design changes
d. Impact of health care reform
e. Underpricing in previous rate filing
f. Changes in target retention (admin and profit) assumption
g. Other factors (to be delineated and described by the filing actuary)

11) Current rate member’s cost sharing
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total

12) Current rate projected allowed PMPM
13) ***Current rate net claims PMPM***
14) Current rate administrative costs PMPM
15) Current rate underwriting gain/loss PMPM
16) Current rate – total rate PMPM
17) Future rate start date
18) Future rate end date
19) Future rate overall medical trend
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total (sum of a:f)

20) Future rate total allowed
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total (sum of a:f)

21) Future rate net claims
a. Inpatient
b. Outpatient
c. Professional
d. Prescription drugs
e. Other
f. Capitation
g. Total (sum of a:f)

22) Future rate allowed PMPM
23) ***Future rate net claims PMPM***
24) Future rate administrative costs PMPM
25) Future rate underwriting gain/loss PMPM
26) ***Future rate – total rate PMPM***
27) Historical loss ratio for each of last 3 years

Appendix B

28) Projected loss ratio using current rates
29) Projected (target) loss ratio using proposed rates
30) Reason for the rate increases (brief, to limit that field size will allow)