ACA Rate Reviews from a State Perspective

Actuaries' Club of the Southwest
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Presenters

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The Reviewer's Perspective

- Key objectives of Rate Review:
  - Insurer provides data and documentation in connection with rate increases that are sufficient to conduct a thorough review
  - Review the insurer's proposed rates, including
    - Reasonableness of assumptions and validity of underlying historical data
    - Compare past projections with actual experience
    - Determine reasonableness of proposed rates based on the list of considerations for Effective Rate Reviews 45 CFR § 154.301
  - Provide substantial documentation of the rate review process
  - Make recommendations to the regulating entity regarding the insurer's proposed rates

Unreasonable Rates

- List of Considerations for Effective Rate Reviews: 45 CFR § 154.301
  - Medical trend changes
  - Utilization changes
  - Cost-sharing changes, including actuarial values
  - Benefit changes, including essential health benefits
  - Enrollee risk profile and pricing
  - Prior over/underestimation of medical trend

Unreasonable Rates

- List of Considerations for Effective Rate Reviews: 45 CFR § 154.301 (continued)
  - Changes in reserve needs
  - Changes in administrative costs
  - Changes in applicable taxes, licensing or regulatory fees.
  - Medical loss ratio
  - Issuer's capital and surplus
  - Reinsurance and risk adjustment payments and charges

Is the Rate Unreasonable?

- Not compliant with applicable federal laws and/or all state laws, regulations, and guidance
- Federal Requirements
  - Excessive
  - Unjustified
  - Unfairly discriminatory
  - Unreasonable Rate Increases 45 CFR § 154.205
- State Requirements vary
  - Actuarially sound
  - Inadequate
  - Assumptions not supported

Reviewer's Qualifications

- Actuary qualified to perform the review
  - Mostly credentialed, some analyst work
- Deep technical knowledge of federal ACA market and rating rules
- Expertise with standard rate filing templates
- Familiarity with state-specific rate and benefit requirements
- Understanding of applicable ASOPs
- Understanding of the state's goals/objectives

The Typical Review Process

- Much of the process depends on the state's particular rating environment, rules, and goals
- Rate filing is submitted via SERFF
  - Validated for completeness of filing materials
  - Notification to reviewing actuary of the filing
- Actuary obtains the complete filing material
- Review, question, document, and clarify
- Finalize the disposition of the filing

Typical Review Process, cont.

- Average number of hours spent reviewing a rate filing
- Typical number of interchanges between review actuary and filing entity/actuary
- Timing Requirements
- Public Comments
- Hearings

What We'll Cover

- By filing component
  - What we normally expect to see
  - Examples of appropriate and… less appropriate submitted components
  - Red flags
  - Common issues
  - What should match?
  - Federal vs. state requirements

Rate Filing Components

- Part I URRT
- Part II Explanation of Rate Increase
- Part III Rate Filing Documentation and Actuarial Memorandum
- Documentation and justification
  - Claims projection assumptions
  - Non-claims assumptions
  - AV Calculator and unique actuarial certifications
  - Plan pricing factors
  - Allowable rating factors – age, tobacco, area, family tier

Part I URRT

- The URRT serves as the rate increase summary and must include:
  - Historical claims experience.
  - Trend projections related to utilization, and service or unit cost.
  - Any claims assumptions related to benefit changes and anticipated population.
  - Risk adjustment payments (charges) and Reinsurance payments.
  - Administrative Expenses
  - Index Rate & Average Premium

Part II Explanation of Rate Increase

- The written description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase.

Part III Actuarial Memorandum

- Sufficient to conduct an examination and determine whether the rate increase is an unreasonable increase.
- Includes an actuarial certification & must be submitted with the URRT.
- Provides support for the values entered into the URRT. All assumptions should be adequately justified with supporting data, where possible, or other rationale for the use of the chosen assumptions.
- Provides as much detail and supporting documentation as possible with their original submission to potentially reduce the amount of time in a review. Additional information will be required if the regulator determines that it is necessary to properly complete its review of the rate submission.

Claims Projection Assumptions

- Changes in the Morbidity of the Population Insured
  - Accounts for anticipated differences in the average morbidity of the population in the experience period and the issuer's population anticipated to be insured in the projection period.
- Changes in Benefits
  - Adjusts the experience period claims to reflect the impact of benefit changes that must be provided.
- Changes in Demographics
  - Adjusts the experience period claims to reflect differences between the average mix of the population by age, gender, and region underlying the base period experience and the average mix anticipated during the projection period.

Claims Projection Assumptions

- Other Adjustments
  - Factors for any other adjustments that are not specifically addressed.
- Trend Factors (cost/utilization)
  - Impact of medical trend changes and utilization changes by major service categories, including an explanation why the adjusted source data is applicable.

Non-Claims Assumptions

- Administrative Expense Load
- Profit (or Contribution to Surplus) & Risk Margin
- Taxes and Fees
- ACA related costs

AV Calculator and Unique Actuarial Certifications

- AV calculation must be determined by the AV Calculator
- In the event the plan design is not compatible with the AV Calculator, most issuers used the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and certified the appropriate adjustments for plan design features that were not compatible with the AV Calculator.

Plan Pricing Factor

- Differences from the AV Metal Value calculation could include:
  - Cost-sharing design of the plan
  - Area-specific population versus the standard population
  - Differences in age
  - Network/discounts
  - Excess benefits (beyond EHB – this could vary by product)
  - OON benefits
  - Administrative Expenses

Allowable Rating Factors - Age

- Federal default - 3 defined age bands
  - Children: ages 0 – 20
  - Adults: ages 21 – 63
  - Older Adults: ages 64+
- Standard age factor examples
  - Ages 0 – 20: 0.635
  - Ages 21 – 24: 1.000
  - Age 42: 1.325
  - Age 64+: 3.000
- State-Specific Age Curve
  - Individual Market: DC, MA, MN, UT
  - Small Group Market: DC, MA, MN, NJ, UT

Allowable Rating Factors -Tobacco

- Federal – 1.5:1 Band
- Some States have tightened the ratio
  - Individual Market: AR, CA, CO, CT, DC, KY, MA, NJ, NY, RI, VT
  - Small Group Market: AR, CA, CO, CT, DC, KY, MA, NJ, NY, OR, RI, VT
- Some issuers have set the factors by age
  - Adjustment factors must be actuarially justified

Allowable Rating Factors - Area

- Number of regions by state designated by HHS – based on MSAs, Counties, Combination
- Apply equally to all issuers within state
- No specification on allowable rating factor, but must be actuarially justified
  - WA – 1.15:1.00 (highest:lowest)
  - NM – 1.40:1.00 (highest:lowest)
- States with 1 Rating Area
  - DE, DC, HI, NH, NJ (Ind), RI, VT

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