Actuaries Club of the Southwest
Spring 2012 Meeting

HEALTH INSURANCE RATE REVIEW AND REGULATORY ISSUES

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Presentation Overview

2

- The Impact of the Affordable Care Act (ACA) on Rate Review
  - Prior to the ACA
  - New Requirements under the ACA
  - The Enhanced Review Process and Its Impact
- Data Requirements for Rate Filings
  - SERFF Requirements
  - Data Required by Federal Regulations
- Rate Review in the Exchange

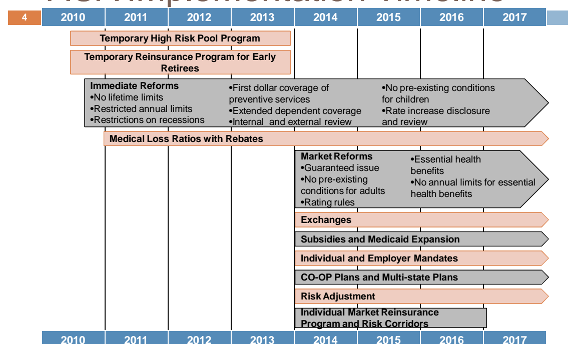
Prior to the ACA

3

- Reviewed limited selection of individual and small employer rates
- Reviewed rates that generated complaints
- Focused on rates that required approval
- Resources limitations prevented more expansive review

ACA Implementation Timeline

4



Rate Review Requirements under the ACA

5

1. The Secretary must establish a process for annual review of unreasonable premium increases.
2. Issuers must submit justifications for increases to HHS and states before they take effect and post justifications on their website.
3. HHS will award grants to states to assist them in reviewing rates and to create data collection centers.

Rate Review Requirements under the ACA

6

4. States that receive grants must provide HHS:
   - Data about trends in premium increases and
   - Recommendations about which issuers participate in the Exchange based on patterns of excessive increases.
5. Beginning in 2014, HHS and states will monitor premium increases inside and outside the Exchanges.
6. States must take into account any excess premium growth outside the Exchange when deciding to offer large group plans on the Exchange.

Rates Subject to the Regulations

7

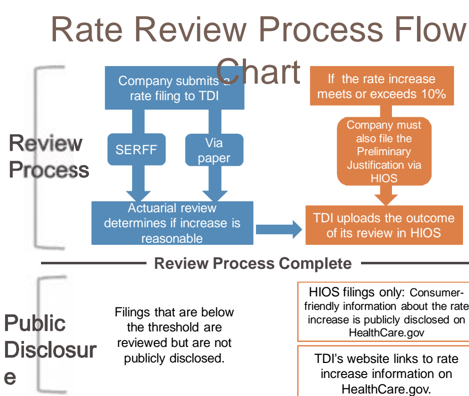
- Health insurance coverage excluding "excepted benefits" under the Public Health Services Act
- Individual and small employer markets
- Non-grandfathered plans
- Association coverage that, if not sold through an association, would be considered individual or small employer coverage
- Rate increases of 10 percent or greater in a 12-month period

Grant Funding to Support Rate Review

8

- Federal government provided grants to states
- TDI received a $1 million grant in September 2010
- TDI received an extension to continue operations through September 2012
- Grant requirements:
  - Develop a plan to enhance rate review
  - Quarterly reporting on health insurance rates and trends
- HHS deemed Texas a state with an effective rate review program.

Rate Review Process Flow Chart



The Review Process At-A-Glance

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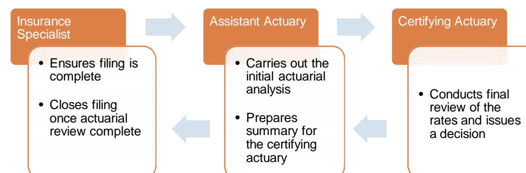


Steps in the Actuarial Review Process

11

1. **Determine the pricing methodology and pricing target**
2. **Determine why and how the company is changing rates**
3. **Verify that the magnitude of the rate change is appropriate**
4. **Verify the assumptions used to produce the rate change**
5. **Review calculations and assumptions for accuracy and consistency**

Links to HealthCare.gov

12

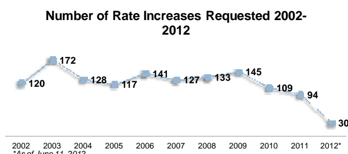
The regulations require that rate increases be publicly disclosed.

http://companyprofiles.healthcare.gov/

Impact of Enhanced Review Process

13

- A wider range of rate filings are now reviewed.
- All rates increases must now be justified.
- The number of rate increases in the individual market has declined since 2009.
- There has been a general decrease in the magnitude of rate increases for these products.



Impact of Enhanced Review Process

14

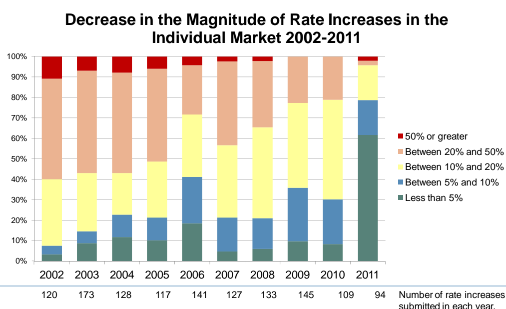
Decreased rates and neutral rates comprise a greater portion of rate filings in 2012.

Year	Count	Average	Minimum	Max
2011	28	-2.75%	-14%	0%
2012	34	-2.06%	-13%	0%

- Number for 2012 exceeds 2011 in only 6 months
- Largely due to one issuer that used a lower trend assumption and decreased base rates
- Three other issuers have also filed decreased or neutral rates in 2012

Impact of Enhanced Review Process

15



16

Data Requirements for Rates

Helpful Tips to For Filing Rates with TDI

Required Data in SERFF

17

- Required as a condition of grant funding
- Reported quarterly
- HHS reviewed data for FFY 2011 quarters 3 and 4
  - Requested TDI ask issuers to revise inaccurate data
  - Reopened over 150 filings for post-submission updates
  - TDI developed a checklist based on HHS' review

SERFF Data: Helpful Tips

18

Applies To	All rates submitted, including SERFF and paper filings.	Reviewers use the checklist to ensure: ❑All fields are complete ❑Issuer entered HIOS ID ❑Rate increase is in a range of minimum, maximum, and weighted average (unless a uniform increase) ❑Data is specific to that filing, not national or company-wide (i.e. covered lives figure is the actual number covered by the plans in that filing) ❑Member months bear a logical relationship to reported covered lives ❑Can calculate average new rate by dividing total projected premium by member months ❑Prior rate and new rate dollar amount figures are in PMPM format
Nature of Data	•High-level data •Provides an understanding of the scope of the rate change	

Data Required by Federal Regulations

19

Two Categories:

- Section 154.301(b) of the final rule
  - Lists 12 data elements states should consider in the review process, if applicable
- Preliminary Justification
  - Submitted in HIOS only when rate is at or above 10%
  - Consists of an Excel worksheet with experience data and a written explanation of the rate increase
  - Guidance on CCIIO's website for completing the filing: http://cciio.cms.gov/resources/training/index.html#rir

Section 154.301(b)

20

(3)(i) Medical trend changes by major service categories.
(3)(ii) Utilization changes by major service category.
(3)(iii) Cost-sharing changes by major service categories.
(3)(iv) Benefit changes.
(3)(v) Changes in enrollee risk profile.
(3)(vi) Any overestimates or under estimates of medical trend for prior year periods related to the rate increase.
(3)(vii) Changes in reserve needs.
(3)(viii) Changes in administrative costs related to programs that improve health care quality.
(3)(ix) Changes in other administrative costs.
(3)(x) Changes in applicable taxes or licensing or regulatory fees.

Tips:
Regulations require this information to be reviewed to the extent applicable.

Tell us what is driving the rate increase for that particular filing and provide supporting exhibits that allow us to draw the same conclusions.

Use this list as a checklist for what you need to explain in your filing.

21

Rate Review in the Exchange

How Rate Review Fits into the Exchange

22

Plan Management Functions

- Licensing and Solvency
- Accreditation and Quality
- Rate review
- Form review
- Network Adequacy
- Marketing

Other Core Exchange Functions:
Eligibility
Enrollment
Financial Management
Consumer Assistance

- Plan Management is one "core function" of the Exchange

Qualified Health Plans

Certification Requirements

23

- Issuer must submit justifications for rate increases prior to implementation
- Post the justification on its website
- Charge the same premium rates for QHPs it offers inside the Exchange and similar plans outside
- Once certified, QHPs must
  - Submit rates at least annually
  - Continue to file justifications before increases take effect
  - Set Small Business Health Options Program (SHOP) rates for an entire benefit or plan year

Rate Review in the Exchange

24

- Guaranteed issue and renewal
- Modified community rating
  - Geographic rating areas
  - Age, maximum ratio of 3:1
  - Family size and composition
  - Tobacco use, maximum of 1.5:1
- Risk mitigating programs
  - Risk adjustment (permanent)
  - Reinsurance (temporary)
  - Risk corridors (temporary)

Contact Information

25

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