National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

January 30, 2014

The Honorable Kathleen Sebelius
Secretary
United States Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Mr. Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Secretary Sebelius, Administrator Tavenner and Director Cohen,

**NAIC Comments on the Department of Health and Human Services' SECOND DRAFT of the 2014 Submission Year Part I Unified Rate Review Template Instructions and Part III Actuarial Memorandum and Certification Instructions**

**State Discretion With Respect to Rate Review and Confidentiality of Part I and Part III Information**

We request that CMS give careful consideration to the comments regarding confidentiality of Part I Unified Rate Review Template (Part I) and Part III Actuarial Memorandum (Part III) information and state discretion submitted on December 30, 2013, in the NAIC Health Actuarial (B) Task Force's Comments on the Department of Health and Human Services' Draft 2014 Submission Year Part I Unified Rate Review Template Instructions and Part III Actuarial Memorandum and Certification Instructions.

Draft 2 of the Part I and Part III Instructions, released for comment by CMS on January 10, 2014, indicate that Part I is required to be submitted by all issuers in the individual, small group and/or combined markets that are proposing a rate increase on any single risk pool compliant products, and that a Part III must be submitted with each Part I. Draft 2 of both instruction documents further indicate that all issuers are required to file Part I and Part III annually for an effective date of January 1 each year.

States recognize the need of CMS to collect standardized data regarding individual and small group market health insurance rates for a number of purposes, including implementation of the risk adjustment, reinsurance and risk corridor programs and the federal monitoring of health insurance rates required under the Affordable Care Act (ACA). However, we believe the necessary data collection could reasonably be accomplished while allowing states far greater discretion in regulating their jurisdiction in the manner that best addresses the unique circumstances of their health insurance markets.

It is important to understand that the information required to be filed by insurers in the proposed Part I and Part III instruction documents is far more extensive than ever requested before by the federal government and, in many cases, state rate reviewers. Much of this information would, in many state jurisdictions, be considered proprietary information not subject to public disclosure because it deals with very sensitive business matters. For example, the information requires that insurers disclose their provider discount information, their particular claims assumptions, and explain the mix of policyholders the insurers are expecting to insure. The disclosure of this information provides a window into the operations of each and every insurer. The disclosure will provide enough information to competitors that it will be a road map to their operations and could lead to unfair competition. In states with a competitive market, it would allow larger players to develop strategies to drive out competition. In states without a competitive market, it will discourage new market entrants that could lead to more competition in the market.

As stated previously, we acknowledge that the federal government has a legal obligation under the ACA to monitor rates and ensure compliance with market rating rules. In many instances, responsibility for monitoring for compliance with the market rating rules has been formally delegated to states through partnership agreements or other means. We propose that the federal monitoring requirement be met through delegation of data collection responsibilities to states, consistent with other areas of monitoring for ACA compliance. We propose that any rate information collected in a state determined to have an effective rate review program (ERRP) under 45 C.F.R. §154.301 be considered data owned by that state. Effective rate review states would continue to collect data in the format prescribed by CMS in Part I, and CMS would continue to have direct access to Part I data submitted through HIOS. The proposal is not to limit CMS's right to define Part I data elements or CMS's access to it, rather to transfer ownership of the Part I data to the effective rate review state. Transfer of ownership of the data would allow states with an ERRP to protect data elements they believe should be kept confidential.

We further propose that states determined to have an ERRP be allowed discretion regarding the completion of Part III. To accomplish this, the Part III instructions would be revised to include a prominent statement indicating the requirement to submit the requested information may be waived at the discretion of the regulatory authority responsible for the filing review. States wishing to practice discretion with respect to completion of Part III would be required to ensure that carriers have prepared and can readily produce upon request of the state a version of Part III that includes all elements identified in the Part III instruction documents. States would be required to submit notification to CMS providing, (1) the sections of Part III not required in the state, (2) the information requested in the waived sections will be kept on file by the carrier, (3) the information requested in the waived sections will be made available to CMS upon request, and (4) certification that the state has the ability to readily obtain the information from the carrier upon request.

In summary, we propose that any information collected by an effective rate review state in connection with a rate filing review remain data owned by that state. By agreement, the state would share that information with CMS but the information would not be treated as information owned by CMS. CMS would continue to have the right to review and analyze any data collected in the context of the rate review process in order to fulfill its obligation to monitor rates, compliance with market rules, and the rate review process in the state. Anyone else requesting the data would be subject to the agreement between the state and CMS and/or the state's open records laws. This is consistent with a number of other processes states and the federal government use to meet regulatory objectives while protecting the confidentiality of financial and market information. States would be required to provide access to all data related to rate filing reviews to the federal government for at least three years after the last date the rate was used.

We believe this process will result in a number of tangible benefits. First, individual effective rate review states would be allowed to make decisions on which data elements should be subject to open records laws and therefore available to the public. The laws in place and positions taken in two states may vary significantly, but both may reflect appropriate and effective public policy in the state in which they apply. Second, this process ensures that the federal government has access to the information necessary to complete its obligations under the ACA.

Finally, because only effective rate review states would be collecting the data in this way, it would provide a tangible benefit to effective rate review states without impairing CMS's obligation to monitor compliance.

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Notwithstanding the above comments, the NAIC appreciates the incorporation of many of its suggested language and formatting changes into the second drafts of the Unified Rate Review Template Instructions and the Actuarial Memorandum and Certification Instructions. In particular, we appreciate CCIIO's recognition of the need for further explanation and graphical depictions of the various new index rate values, the impact of taxes on expense and profit components, and the effect of the President's transitional memorandum on the 2015 single risk pool. We further appreciate the opportunity to provide additional comments on the second draft as listed below:

**Part I Unified Rate Review Template Instructions SECOND Draft**

- Allowable rating methods and factors (page 3): Family structure appears to be missing from the list of allowable rating factors permitted to have a calibration factor. Family structure would need calibration in states with per-member rating for families having more than 3 children and in states with family tiered rating for the distribution between tiers.

- Allowable rating methods and factors (page 3): The reference to transitional policies may be confusing for companies filing small group rates in 2014. While the reference does state that 2013 experience should include transitional policies, you may wish to clarify that transitional experience should be explicitly excluded from 2012 experience when filing quarterly small group rate changes in 2014.

- Projected Risk Adjustments, PMPM (page 16): We suggest adding the word "appropriate" before "published transfer equation" in recognition of the states (e.g. MA) that established an approved state-specific risk transfer methodology different from the federal methodology.

- Inclusion of grandfathered experience (page 21): We believe there may be some confusion with including grandfathered experience when the single risk pool is defined as including non-grandfathered business. You may wish to include a reference to the ACA Section 1312 permitting the inclusion of grandfathered business at the issuer's discretion.

- Definition of "AV Pricing Value" ( page 24): The URRT Instructions define "AV Pricing Value" with reference to so-called "fixed reference plan". We also read: "The fixed reference plan should be identified by the Issuer and described in the Part III Actuarial Memorandum." On the other hand, on page 20 of Part III – Actuarial Memorandum and Certification Instructions, we read: "Identify the fixed reference plan selected as the basis for the AV Pricing Values. *The reference plan is described further in the instructions for the Part I Unified Rate Review Template.*" [Italics added for emphasis.] In other words there seems to be some circularity, without any one of the above two documents giving a clear definition of the "*reference plan*" and describing how such plan is to be determined.

- Taxes & Fees definition for Worksheet 2 (page 29): To avoid confusion with the Worksheet 1 definition of Taxes & Fees, we suggest changing the title of the Worksheet 2 definition to reflect the inclusion of risk adjustment and reinsurance payments and charges.

**Part III Actuarial Memorandum and Certification Instructions SECOND Draft**

- Use of "calibration" and "normalization": We are confused by the change from normalization to calibration when referring to demographic adjustments to historical and projected premiums. "Normalization" is a generally accepted and well-known actuarial term used in this context. Unless "calibration" means something other than normalization, we suggest the use of "normalization" to refer to

these types of adjustments.

- Allowable rating factors (page 3, last bullet): Similar to the comment on Part I, we believe calibration of the family structure factor should be permitted.

- Use of "average" when referring to calibration adjustments (page 3, last bullet): The use of average age in this context may confuse readers to believe the calibration adjustment should be a weighted average of ages. We believe it should be made clear that the "average" age is the age associated with the weighted average age factor. Similar clarifications could be made for family structure, geography, and tobacco factors.

- Tobacco Calibration (page 18, second paragraph): Since tobacco factors can only be greater than one when tobacco rating is used, the parallel language to the geographic calibration is confusing. We suggest changing the paragraph or reference to something like the following: "If the issuer uses tobacco factors, the issuer must provide the tobacco calibration that is applied to the projected single risk pool."

- Definition of "Plan Termination": We suggest including in the instructions a definition of "plan termination". This could be accomplished by reference to existing regulation or providing the definition in the instructions, provided that definition is consistent with the definition in other regulations.

We also identified a number of grammatical and typographical corrections to the URRT instructions. These are included below:

**APPENDIX: Suggested grammatical and typographical corrections to URRT Instructions**

- Many incidences of "index rate" were changed to "Index Rate" while several others were left as "index rate." We are unclear as to the distinction between the two.

- Pages 6, 25 – "Most products will be made up of multiple plans produce an actuarial value equal to one of the metal levels permitted under…"
    - Missing "that" – ("plans **that** produce").

- Page 9 – "Active life reserves (policy reserves, contract reserves, contingency reserves, or any kind of reserves except traditionally defined reserves for claims incurred but not paid) or change in such reserves)."
    - Superfluous close parenthesis at end of sentence.

- Page 9 – "Experience Period Member Months: Enter the total number of months of coverage in the experience period for all members that had coverage during any portion of the Experience Period."
    - "Experience Period" appears capitalized and on lower case in the same sentence.

- Page 15 – "Paid to Allowed Average Factor in the Projection Period: Enter the average paid to allowed factor for the projection period."
    - The second phrase "projection period" probably ought to be capitalized here.

- Page 16 – "The risk transfers should reflect the projected morbidity, including any projected Population risk Morbidity changes column in Section II."
    - This might read better as, "The risk transfers should reflect the projected morbidity, including any projected Population risk Morbidity changes in column J in Section II."

- Page 17 – "Projected Incurred Claims: The template calculates this value by subtracting Projected Risk Adjustments, PMPM and Projected ACA Reinsurance Recoveries, Net of Premium from Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM."
    - Including single quotes or brackets around variable names would improve the readability of this paragraph (and some others in the document). "Projected Incurred Claims: The template calculates this value by subtracting 'Projected Risk Adjustments, PMPM' and 'Projected ACA Reinsurance Recoveries, Net of Premium' from 'Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM.'"

- Page 18 – "Single Risk Pool Gross Premium Avg. Rate, PMPM: The template calculates this value by dividing the Projected Incurred Claims by 1 minus the Administrative Expense Load percentage less the Profit & Risk Load percentage less Taxes & Fees percentage."
    - The order of operations is lost in the definition as stated. This may be better presented as an equation. "Single Risk Pool Gross Premium Avg. Rate, PMPM: The template calculates this value as Incurred Claims / [1 – (Administrative Expense Load percentage + Profit & Risk Load percentage + Taxes & Fees percentage)]"

- Page 32, 33, 38, 39 – "If the plan is a QHP offered in the Federally Facilitated Exchange or State-Based Exchange, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package.)"
    - The last parenthesis should come before the period.

- Page 35 – 'Net Amt of Rein' and 'Net Amt of Risk Adj' – "This value should be calculated consistent with the…"
    - Should read "This value should be calculated consistently with the…" (adjective vs adverb)

- Page 38, 40 – "Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfy the requirements of 45 CFR 154.215 and 156.470."
    - Should read "Submission of the Part I Unified Rate Review Template and corresponding Part III Actuarial Memorandum satisfies the requirements of 45 CFR 154.215 and 156.470." (subject verb agreement)

Sincerely,

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