

## Rate Review White Paper

*The purpose of this white paper is to assist state policymakers with the implementation of the Affordable Care Act (ACA) provisions related to health insurance rating, rate filing and rate review. The focus of the paper is the rate review requirements related to the certification of qualified health plans (QHPs) in the Exchanges, but many of the ACA provisions impacting rate review apply to all plans in the individual and small group markets.*

### I. Introduction

The federal Patient Protection and Affordable Care Act (ACA)<sup>1</sup> includes several provisions that will affect health insurance rating and rate review. These provisions include requirements for the review and disclosure of rate increases above certain defined thresholds, rating and underwriting requirements and limitations, programs to mitigate adverse selection and pricing risk, and additional requirements placed on plans offered through Exchanges. Although some of these provisions have already been implemented, those with a significant impact on rating will be effective for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by state insurance regulators, as applicable, in advance of January 1, 2014, and, in the case of qualified health plans (QHPs) offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013.

Issuers and state insurance regulators will need to create a process for developing, submitting and reviewing rates that allow for potential differences between grandfathered and non-grandfathered plans, plans inside and outside of the Exchange, plans by market if the states have varying levels of review authority and effective rate review designations, and rate increases, where applicable, at or above defined thresholds (currently 10%) vs. those under the defined thresholds.

Additionally, rate review processes and requirements should be consistently applied for multi-state plans and Consumer Operated and Oriented Plans (CO-OPs) to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with medical loss ratio (MLR) requirements, and any new federal or state taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new adjusted community rating requirements and underwriting limitations, pooling risks across products within a market (or in some cases across markets), and changes in the small group market.

The ACA also creates roles related to rate review for the federal government and new Exchange entities. Exchange governance and functional responsibilities will vary across the states and may include various combinations of state insurance regulators, Exchange entities and the federal government. The federal government will specifically play a role in rate review in cases where a state either does not have an “effective rate review program” or does not establish a certified state-based Exchange (SBE) or plan management Partnership Exchange. The states might consider how to effectively and efficiently work with these various entities to ensure non-duplication, maintain consistency within the market, and mitigate issuer burden and consumer confusion.

### II. Individual and Small Group Market Rate Review in the States before the ACA

State oversight of health insurance rates has, historically, varied substantially. While many of the states review proposed increases to determine if they are reasonable before they are used in the marketplace, other states lack the legal authority or resources to review rates prior to their implementation. Some of the states had no authority whatsoever to deny or reduce proposed rate increases.

#### A. **Types of Rate Regulation**

There are four main types of rate regulation in place in the individual and small group markets today:

1. **Actuarial Justification:** In markets with actuarially justified rating requirements, issuers must demonstrate a correlation between case characteristics and increased medical claims costs. The NAIC has adopted safe

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<sup>1</sup> Pub. L. 111-148 (ACA), as amended by Pub. L. 111-152 (federal Health Care and Education Reconciliation Act of 2010).

harbors for case characteristics commonly used for setting premiums within which plans may generally vary rates without providing justification. These are used by most of the states. Plans that vary rates in excess of these safe harbors may be required to submit data justifying their use of the characteristics in question.

2. **Rating Bands:** Particularly in the small group market, many of the states have implemented rating bands that limit the variation in premiums attributable to health status and other characteristics. Rating bands are either expressed as a ratio of the highest rating factor to the lowest (e.g., 1.5:1) or as the allowable variation above and below an index rate (e.g., +/- 25%). Rating bands may also take the form of composite rating bands that place limits on the combined effects of multiple case characteristics (e.g., a composite rating band that allows 4:1 variation based on health status, age, gender, industry and group size combined).
3. **Adjusted Community Rating:** Adjusted (or modified) community rating laws prohibit the use of health status or claims experience in setting premiums. Other case characteristics, such as age and geography, may be used to vary premiums, although limits may be placed upon these factors, as well.
4. **Community Rating:** “Pure” community rating laws prohibit the use of any case characteristics besides geography to vary premiums.

## B. Commonly Used Risk Classifications

Following is a list of some of the more commonly allowed risk classifications. Use of these classifications varies greatly from state to state.

1. **Health Status and Claims Experience:** The most direct way for issuers to base premiums on expected costs for an individual or group is to use health status information collected during the underwriting process or claims experience for policies being renewed. Most of the states that allow health status to be used for rating purposes in the small group market limit it using rating bands that vary from +/-10% to +/-60%. Premium increases due to changes in a business’ health status may also be limited to 15% per year in many of the states.
2. **Age:** Because an individual’s health status deteriorates as he or she grows older, leading to increased claims, age has become one of the most commonly employed case characteristics. Under the NAIC safe harbor guidelines, overall variation of 5:1 or less is reasonable in the small group market based on the expected claim costs of 22-year-olds and 62-year-olds.
3. **Gender:** During childbearing years, women can be expected to incur medical costs that are more than 45% higher than men, excluding the costs of normal maternity coverage. The difference in expected claims narrows with increasing age and, by their mid-50s, men surpass women. At age 62, men can be expected to have costs that are at least 17% higher than women.
4. **Group Size:** Issuers often charge higher rates to smaller companies for two main reasons: 1) it is more expensive to issue and service a policy for a small business than for a larger one; and 2) small employers purchasing coverage are more likely to have greater knowledge of their employees’ potential future needs for health care services, creating a greater risk of adverse selection for the issuer. This risk is higher in a guaranteed-issue environment where denial of coverage based on underwriting criteria is prohibited, and businesses with one to four employees may be charged as much as 20% more than for those with 10–24 employees.
5. **Industry and Occupation:** Working conditions and the type and lifestyles of workers may lead to higher claim costs in some industries than in others. The NAIC has adopted a safe harbor of 15% for premium variation due to industry in the small group market. Occupation is also often used as a factor in the individual market.
6. **Geographic Location:** The cost of delivering care varies dramatically from one area to another, and issuers often vary their rates by county or by ZIP-code using the employer’s business address in the small group market, or the applicant’s home address in the individual market. Safe harbors for geography have been set

for each state, depending on the variation in medical costs within the state, and range from no variation in the District of Columbia to 1.9:1 in Florida. Not all of the states allow use of the safe harbor.

7. **Duration of Coverage:** In medically underwritten, guaranteed-renewable markets, an issuer has the best picture of the health of enrollees on the date that they submit their application. Over time, enrollees' health may deteriorate from what it was at the time of application, leading to higher claims costs. To offset this, issuers in the individual market will often charge higher premiums to individuals who have been enrolled in the same plan for several years. This practice can encourage healthy enrollees who can pass medical underwriting to reapply in order to get the lower, new enrollee rate, exacerbating the very phenomenon it is attempting to fix.
8. **Wellness:** In recent years, several of the states have allowed issuers in the individual market to provide premium discounts or other incentives to individuals participating in wellness programs in order to encourage them to adopt healthier lifestyles. In practice, this has been a difficult policy to implement without allowing carriers a back-door way to use health status in setting premiums, and, in at least one state where it is allowed, no carriers are using it. State flexibility and further study of the best way to use wellness in setting premiums may be warranted.

### C. Pooling of Risk

In applying rating factors, issuers will group policyholders into classes and blocks of business.

1. **Class of Business:** Issuers will maintain different "classes of business" that reflect administrative differences in how policies within them were sold or acquired by the company. For instance, a company may maintain one class of business composed of policies sold by its agents in the regular market, a second class of business may contain policies sold through a purchasing pool, while a third may be made up of policies that were acquired from another issuer. Most of the states limit the number of classes that an issuer may maintain and the variation of premiums between classes. Most of the states with community rating or adjusted community rating disallow the maintenance of separate classes of business. The 1993 NAIC *Small Employer Health Insurance Availability Model Act*,<sup>2</sup> which is the basis of most of the states' small group rate regulation, limits issuers to nine classes of business and limits the index rate for the highest priced class of business to 120% of the index rate for the lowest priced class of business.
2. **Block of Business:** Issuers will also group business by the form of the policy, creating a block of business. In the individual market, issuers will also create "rating blocks" based on initial health status classification. For instance, an issuer may group all-new business that is charged a 25% health adjustment into a single block and then apply experience adjustments to the entire block, rather than re-underwriting each renewed policy every year. When issuers stop actively selling a block of business, the result is a closed block, which can experience rate spirals as those who can pass medical underwriting purchase other coverage, leaving a pool of risk that becomes progressively sicker. In the small group market, limitations on the use of rating factors apply across all blocks of business.

### D. Rate Review Processes

Many of the states use "prospective" regulation of rates, while others use "retrospective" regulation. Prospective regulation includes prior review and/or approval of rates, while retrospective regulation includes "file and use," where the rates go into effect, but the regulator can take action if the rates are later determined to be unreasonable under a standard such as one of the above. Retrospective regulation often relies on consumer complaints to indicate a problem with a company's rates.

The NAIC has several documents to provide guidance to the states in rate review, including the *Health Policy Rate and Form Filing Model [Act] [Regulation]* (#165), the *Guidelines for Filing of Rates for Individual Health Insurance Forms* (#134) and the *Guidance Manual in the Evaluation of Ratings Manuals and Filings Concerning Small Employer and Individual Health Insurance*.

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<sup>2</sup> The 1993 *Small Employer Health Insurance Availability Model Act* was replaced by a 1995 version. The 1995 version provides for adjusted community rating in determining premium in place of classes of business.

Most of the states with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with state law, as described in Model #134. This allows the states to rely on the Code of Professional Conduct and the Actuarial Standards of Practice that actuaries must follow. In addition, the states often look at the whole financial picture of a company when reviewing rate filings.

Most of the states have different types of prospective or retrospective rate regulation for different comprehensive medical markets, such as individual, small employer, association group, employer-paid, blanket coverage, mini-medical coverage and state/local employee plans.

#### **E. Filing of Rates**

Forty-nine states, the District of Columbia and Puerto Rico use the NAIC's System for Electronic Rate and Form Filing (SERFF) for the filing of rates. While rating rules and policy requirements can differ greatly from state to state, SERFF helps companies by walking them through a checklist of state-specific and federal requirements and then submitting their requests to the states.

### **III. Rate Increase Disclosure and Review Requirements Under ACA**

#### **A. Background**

The ACA reorganizes, amends, and adds to the provisions of Part A of title XXVII of the Public Health Service Act (PHSA) relating to group health plans and health insurance issuers in the group and individual markets. Section 1003 of the ACA adds a new Section 2794 of the PHSA (42 USCS §300gg-94). In particular, this section:

1. Directs the Secretary of the Department of Health and Human Services (Secretary), in conjunction with the States, to establish a process for the annual review, beginning with the 2010 plan year, of "unreasonable increases in premiums for health insurance coverage";
2. Requires health insurance issuers to submit to the Secretary and the relevant State justification for an unreasonable premium increase prior to the implementation of the increase. Requires health insurance issuers to prominently post the submitted justification on their website;
3. Requires the Secretary to carry out a program to award grants to the States during the 5-year period beginning with fiscal year 2010 to assist such States in reviewing and approving premium increases for health insurance coverage, and to establish centers to collect medical reimbursement information;
4. For those States that are awarded grants, requires the State insurance commissioner to provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State and to make recommendations, as appropriate, to the State Exchange about continued participation in the Exchange by an issuer based on a pattern or practice of excessive or unjustified premium increases;
5. Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States, must continue to monitor premium increases of health insurance coverage offered through the Exchange and outside the Exchange; and
6. In determining whether to offer QHPs in the large group market through an Exchange after 2016, the States are required to take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange.

On December 23, 2010, the U.S. Department of Health and Human Services (HHS) published in the *Federal Register* a Notice of Proposed Rulemaking (NPRM) to implement Section 2794 of the PHSA.<sup>3</sup> In announcing the proposed rulemaking, the Secretary addressed a letter to insurance commissioners stating:

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<sup>3</sup> [www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf](http://www.gpo.gov/fdsys/pkg/FR-2010-12-23/pdf/2010-32143.pdf).

“This proposed regulation recognizes and builds upon the traditional role the states have played in regulating insurance rates and complements existing State-based rate review processes. All proposed rate increases at or above 10 percent would be subject to review, and issuers in the individual and small group markets would be required to provide a justification to both the states and HHS to comply with Section 2794’s requirement that such information be publicly disclosed prior to the implementation of the increase. States with effective rate review programs would review such proposed increases to determine whether they are in accordance with state law. In the small number of states that do not have the legal authority or resources to review rates, HHS would review proposed rate increases of 10 percent or more to determine whether they are reasonable, based on actuarial and other analyses that are currently used by many states to assess rate increases.”

On May 23, 2011, HHS published in the *Federal Register* a final rule requesting comments on amending the definitions of “individual market” and “small group market” in 45 CFR §154.102 to include coverage sold to individuals and small groups through associations in all cases.<sup>4</sup>

On September 6, 2011, after consideration of the comments, HHS published in the *Federal Register* amendments to the May 23, 2011, final rule to provide that individual and small employer policies sold through associations will be included in the rate review process, even if a state otherwise excludes such coverage from its definitions of individual and small group coverage.<sup>5</sup>

## **B. Application of Section 1003 to Issuers, CO-OPs and Multi-State Plans**

### **1. Issuers**

Section 1003 of the ACA applies in the individual and small group markets. It does not apply to grandfathered health insurance coverage, nor does it apply to self-funded plans. This section will apply to QHPs offered in the Exchange beginning in 2014.

### **2. CO-OPs**

Section 1322(a) of the ACA directs the Secretary to establish the CO-OP program to foster the creation of member-governed qualified nonprofit health insurance issuers to offer CO-OP QHPs in the individual and small group markets in the states in which they are licensed. The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help set up and maintain health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly and high-quality health insurance options.

Starting January 1, 2014, CO-OPs will be able to offer health plans through the Exchanges. In addition to offering health plans through an Exchange, CO-OPs may also offer health plans outside of an Exchange. An Exchange must recognize a health plan offered by a CO-OP if it is deemed certified by the U.S. Centers for Medicare & Medicaid Services (CMS) or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP QHPs set forth in the ACA and, except for a few narrow exceptions, all state-specific standards established by an Exchange for QHPs operating in that Exchange. Thus, it would appear that Section 1003 will be applicable to CO-OPs offering plans inside and outside of the Exchange.

### **3. Multi-State Plans (OPM Plans)**

The ACA authorizes the U.S. Office of Personnel Management (OPM) to enter into an agreement with issuers to offer multi-state plans in the individual and small group markets through an Exchange. OPM must contract with at least one nonprofit carrier and the plans offered as a multi-state plan are to be considered QHPs and the Exchange must allow them to be offered. However, nothing in the ACA exempts these multi-state plans from applicable state laws and/or regulations. OPM is in the process of promulgating regulations relating to these plans.

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<sup>4</sup> [www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf).

<sup>5</sup> [www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf).

**IV. ACA Rules and Regulations that Will Impact How Issuers Price Health Plans and How the States Perform Rate Review**

The ACA includes several provisions that will affect health plan rating and rate review. Although some of these provisions have already been implemented (and are not explicitly covered below), those with a significant impact on rating will be implemented for plan years beginning on or after January 1, 2014. Rates reflecting these changes will need to be developed and filed by issuers and reviewed by state insurance regulators, as applicable, in advance of January 1, 2014, and in the case of QHPs offered through the Exchange, rates will need to be approved, if applicable, prior to open enrollment expected to begin October 1, 2013.

**Note:** Non-grandfathered plans outside of the Exchange will also be affected by the ACA market reforms, and health insurance offered in the outside market may be issuing renewal notices as early as July 1, 2013, for plans effective after January 1, 2014. Therefore, rates will need to be approved months in advance of the October 1, 2013, date for Exchange enrollment.

Issuers and state insurance regulators will need to create a process for the timely development, submission and review of rates that allows for potential differences between grandfathered and non-grandfathered plans; plans inside and outside of the Exchange; and plans by market if a state has varying levels of review authority and effective rate review designations. Delays in implementing rate increases could result in an inadequate premium being charged which could result in higher subsequent rate increases. Additionally, rate review processes and requirements should be consistently applied for multi-state plans and CO-OPs to maintain a level playing field. Rating and plan accounting will also need to take into consideration new payments and charges to plans, including those for risk adjustment, reinsurance, risk corridors, rebates associated with MLR requirements, and any new federal or state taxes and assessments. The rating process will also need to account for several potentially significant changes in the market, including covering new populations and benefits, adhering to new rating requirements and underwriting limitations, pooling risks across products within a market (or, in some cases, across markets), new benefit requirements and changes in the small group market.

It is clear that the significant number of unknowns that will require issuers to estimate, as well as the interplay of the new elements, present a challenge to issuers and state insurance regulators.

Considerations for each of these issues are outlined below.

**A. Underwriting Limitations**

Issuers will be significantly limited in their ability to deny coverage or charge high premiums to individuals and groups with higher than average health risks. Underwriting provisions in ACA include:

- Guaranteed availability of coverage (non-grandfathered only): Issuers must accept all individual and employer applicants, limited to open enrollment periods in the individual Exchange.
- Elimination of medical underwriting for non-grandfathered plans in the individual and group markets.
- Prohibition of pre-existing condition exclusions.

The impact of these changes on rates and premiums in most markets is expected to be significant. In addition, these provisions could lead to adverse selection if not sufficiently addressed by other provisions in the ACA or required by the states.

**B. Other Provisions Resulting in Demographic Changes**

The ACA includes other provisions that are expected to have an impact on the population covered by health plans. The following provisions are expected to bring new entrants into the health insurance market:

1. **Establishment of Exchanges:** Exchanges will provide a mechanism for individuals and small groups to perform more standardized comparisons of available health plan options.
2. **Individual Mandate:** Individuals will be required to have health insurance or will pay a penalty, unless they are exempted for religious, affordability or other allowable reasons.

3. **Premium Subsidies and Cost-Sharing Reductions:** For coverage purchased through the Exchange, federal subsidies will be available to individuals and families with household incomes up to 400% of the federal poverty level unless they have affordable minimum essential coverage available to them. Individuals and families with household incomes up to 250% of the federal poverty level will also be eligible for cost-sharing reductions.
4. **Medicaid Expansion:** The significant increase in the number of people eligible for Medicaid under the ACA will impact the demographics of the individual market.

The above provisions, coupled with the underwriting limitations and rating requirements, are expected to encourage previously uninsured individuals into the health insurance market. The relative health risk and expected cost of this population is a significant unknown. Issuers will need to work with regulators to develop reasonable assumptions related to the expected cost of these new enrollees.

### C. Rating Requirements

The ACA also limits rating variations for non-grandfathered plans in the individual and small group markets, to the following:

1. **Geographic Rating Area:** The states are charged with defining standard geographic rating areas, subject to approval by the Secretary. The states will need to consider how narrowly to define geographic rating areas to balance affordability and access considerations for individuals in potentially high-cost areas. The selection of geographic rating areas may also have an impact on risk adjustment in the state.
2. **Age:** Age factors will be limited to a ratio of 3:1 for adults; permissible age bands will be defined by the Secretary in consultation with the NAIC.
3. **Benefit Coverage:** Guidance with regards to flexibility related to benefit coverage factors has not been provided at the time of this writing. It is unclear, for example, whether benefit coverage factors could account for selection or utilization differences resulting either from group demographics or benefit design.
4. **Family Structure:** Guidance with regard to flexibility related to family structure factors has not been provided at the time of this writing.
5. **Tobacco Use:** Rating for tobacco use is limited to a ratio of 1.5:1. Note that HHS is still considering how tobacco use will be accounted for in the risk-adjustment model they are developing. Use of tobacco rating factors may also have an impact on the affordability of health insurance. In addition, the most recent Internal Revenue Service (IRS) regulation on premium subsidies indicates that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.<sup>6</sup>

**Note:** The rating limitations above apply to large group insured, non-grandfathered plans beginning in 2017 if the state allows large group coverage to be offered through the Exchange.

Under the ACA, a state may further restrict use of rating factors, as long as the state law does not “prevent the application” of the federal law. For example, given that under the IRS regulation tobacco use penalties would not be reflected in the federal subsidy, and that such penalties are difficult to enforce, a state could prohibit rating based on tobacco use.

### D. Risk Pools

The ACA also requires issuers to consider all enrollees in non-grandfathered plans within a given market (individual or small group) as part of a single risk pool. Grandfathered plans can be priced in their own risk pool. The states also have the option of merging the individual and small group markets into a single risk pool.

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<sup>6</sup> [www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf](http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf).

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The states will need to consider how rates should be filed for effective dates starting in 2014. Because there will be a single risk pool in each of the individual and small group markets, the states may want to consider how the filing process may differ from historical methods, including evaluating whether all filings will need to be made on a plan basis in the future, or whether issuers may provide a single filing for non-grandfathered rates to reduce duplication.

Additionally, in those states that define small group as groups with 50 or fewer employees, the small group market will be expanded to include groups of up to 100 employees beginning in 2016.

**E. Benefit Changes**

Issuers of non-grandfathered plans will also need to price for several required benefit changes, including:

1. Essential health benefits (EHBs) applicable for years 2014 and 2015 may be defined at the state level by sometime in the third quarter of 2012, or will be defined by the federal government if the state does not act. Annual dollar limits will not be permitted on EHBs.
2. Annual maximum out-of-pocket cost sharing for plan years beginning in 2014 will be limited to those in effect for health savings accounts in that year.
3. Deductibles in small group plans will be limited.
4. Non-grandfathered plans in the individual and small group markets (both inside and outside of the Exchange) will need to meet actuarial value requirements such that each plan fits into a metal level of coverage (bronze, silver, gold or platinum), except for the catastrophic plans offered to certain enrollees.

Note that the states may need to engage their actuaries as part of the form review process, to validate actuarial equivalence for benefit substitutions as defined in EHB guidance, along with verification of a plan's metal level.

**F. Risk Mitigation Programs (Three Rs: Reinsurance, Risk Adjustment and Risk Corridors)**

In order to mitigate selection and pricing risk for issuers, the ACA includes implementation of three risk-mitigation programs. First is a temporary reinsurance program that reimburses non-grandfathered individual plans, both inside and outside of the Exchange, for a portion of the cost of high-cost enrollees. The aggregate amount of reinsurance payments will be fixed at a state level at decreasing amounts over three years (2014 through 2016). Second is a permanent risk-adjustment program that will transfer funds from non-grandfathered individual and small group plans with a lower-than-average risk population to such plans with a higher-than-average risk population. The risk-adjustment program will be budget-neutral within each market (individual and small group) at the state level. Third is the federal risk corridor program.

The risk adjustment program is designed to equalize risks across plans within each applicable market. As a result, theoretically, all issuers should price their non-grandfathered individual and small group plans, assuming they get an average risk population. In practice, however, risk adjustment is not perfect and does not account for all selection differences across plans. In addition, given other ACA changes, there is significant uncertainty related to what an "average risk population" will be, especially in the individual market. Once the market stabilizes and relative health risks across issuers are better known, plans should be able to price their plans based on anticipated risk adjustment payments and charges.

In the meantime, issuers will need to work with regulators to develop reasonable assumptions related to the impact of anticipated population changes in 2014. This pricing risk, based on high levels of uncertainty in the individual market, is intended to be addressed by ACA's third risk mitigation program: risk corridors. In this program, issuers participating in the individual and small group markets will be limited in their level of gains and losses for their QHPs in calendar years 2014–2016. Specifically, HHS will reimburse QHPs 50% of the difference between allowable costs and a target amount for differences between 103% and 108%, and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs in excess of 108% of the target amount. Conversely, HHS will charge 50% of the difference between allowable costs and a target amount for differences between 92% and 97% and an amount equal to the sum of 2.5% of the target amount and 80% of allowable costs less than 92% of



the target amount. Risk corridors will be applied after reinsurance and risk adjustment. Issuers and regulators should consider the impact of risk corridors in determining reasonable levels of margin to include in rates for 2014–2016, as well as rate adequacy given the program subsidizes losses. Issuers and regulators will also need to consider the interaction of the risk mitigation programs with the calculation of MLR rebates.

#### **G. MLR Requirements**

The ACA requires issuers to provide rebates to consumers if certain minimum MLRs are not met. Those ratios are, generally, 80% for the individual and small group markets and 85% for the large group market. A state may choose a higher level, and several of the states have applied for and received adjustments that lower the ratio in the initial years (this applies to the individual market only). This requirement became effective calendar year 2011, with rebates paid by August of subsequent years.

Although the MLR requirement in ACA is a retroactive standard, some issuers may want to address the requirement prospectively in their rating to mitigate the risk of having to pay rebates.

**Note:** The MLR is calculated on a statewide aggregate level by segment, whereas rates are often at the plan level (and will be at the plan level of QHPs). Thus, some care should be taken when incorporating the MLR requirement into the rate review process and standards.

#### **H. New Federal Taxes and Fees**

Under the ACA, health issuers will be required to pay new annual issuer taxes and fees beginning in 2014. Health insurance issuer excise taxes, calculated based on an issuer’s market share and using the previous calendar year premium as a proxy, are prescribed in the ACA<sup>7</sup> as follows:

Year	Amount (Billions)
2014	\$8
2015	\$11.3
2016	\$11.3
2017	\$13.9
2018	\$14.3
After 2018	Increased by premium growth

In addition, the non-deductible nature of the excise tax will require issuers to build in more than the actual fee amount into their premiums.

Other new fees or assessments that will likely be charged to health insurance issuers include: Exchange user fees; the reinsurance program assessment benefitting the individual market (totaling \$25 billion from 2014–2016); the Patient-Centered Outcomes Research Institute (PCORI) fee; and, in 2018, the excise taxes on high value health insurance that will apply in some cases.

#### **I. Rating Inside and Outside of the Exchange**

Issuers offering QHPs in the Exchange must offer the “same premium rate” for plans offered inside and outside of the Exchange and whether they are sold directly or through an agent. It is unclear what steps regulators will need to take to validate that this requirement is being met. The states may want to consider establishing a process that requires issuers to submit plan filings in the same manner both inside and outside of the Exchange.

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<sup>7</sup> ACA §1406.

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The ACA includes additional rate review requirements for QHPs offered through the Exchanges. Exchanges are required to consider the following as part of QHP certification:

- A justification for a rate increase prior to the implementation of the increase.
- Recommendations provided to the Exchange by the state as required under the premium review grant program.
- Any excess of rate growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

The states with premium review grants are required to make recommendations to Exchanges regarding whether particular health issuers should be permitted to offer plans on the Exchange. This recommendation is based on a “pattern or practice of excessive or unjustified premium increases” and information regarding premium growth rates inside and outside of the Exchange. Those states that have not received a premium review grant can, of course, make the same recommendation to the SBE or the federally facilitated Exchange (FFE).

It is unclear at the time of this writing whether there will be a specific format for Exchange rate increase justifications, and whether those justifications need to be at a QHP level of detail, or some higher level (e.g., product or market). Concern exists over the granularity and credibility of the data should the justifications be required at the QHP level. Exchanges and state insurance regulators will also need to consider the measures to determine excess of rate growth outside of the Exchange.

It is also important to note that issuers wishing to participate in Exchanges will need to submit plan-level data as part of the QHP certification process. Some of the states may choose to review rates at the plan level outside of the Exchange, as well, to ensure consistent processes across the markets. In addition, plans outside of the Exchange will also need to meet the actuarial value (AV) requirements. If the states review actuarial values consistently inside and outside of the Exchange, plan-level data may need to be collected for the non-Exchange plans, as well as the Exchange plans.

#### **J. Small Group Considerations**

The ACA has a specific definition of small group that might not be consistent with current state-specific definitions. For example, the ACA counts employees using an average of the total number of employees on business days during the preceding calendar year, whereas some of the states may count only full-time employees, or use some other counting method. Additionally, the ACA does not treat sole proprietors with no employees (other than a spouse) as small groups, which differs from their treatment in some of the states.

The ACA definition applies to participation in the Small Business Health Options Program (SHOP) and calculation of the MLR. The states might consider aligning their definition of small group with that of ACA to avoid any confusion in the market.

Another consideration in the small group market is the ability to set group-level rates in an employee choice model provided through the SHOP Exchange. It is unclear how group rates would be determined in an environment where employees of a given employer can select multiple plans from multiple issuers.

#### **K. Rating of Grandfathered Plans**

The ACA provides for the grandfathering of health insurance plans in which an individual was enrolled or was offered to a group on March 23, 2010.<sup>8</sup> While some provisions of the ACA do apply to grandfathered plans (e.g., MLR requirements, elimination of lifetime limits), the rating and benefit requirements, as well as many of the underwriting provisions above, do not apply. The ACA also prohibits the states from requiring that grandfathered plans be pooled with non-grandfathered plans for rating purposes. Grandfathered plans are also not subject to the premium review disclosure requirements.

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<sup>8</sup> ACA §1251.

The states will need to consider how to review rates for grandfathered plans. Grandfathered plans are not open to new groups or individuals. Because different coverage and rating rules apply to grandfathered plans, the states may want to consider requiring separate filings for grandfathered vs. non-grandfathered plans.

#### **L. Multi-State Plans and CO-OPs**

The ACA directs the director of OPM to enter into contracts with health issuers (at least one must be a nonprofit) to offer at least two multi-state QHPs through each Exchange in each state.<sup>9</sup> It does not appear that multi-state plans will go through the same certification process required by other plans offered through the Exchange. However, nothing in the ACA exempts multi-state plans from applicable state laws and/or regulations.

The ACA also establishes CO-OPs to “foster the creation of qualified nonprofit health insurance issuers to offer QHPs in the individual and small group markets in the states in which the issuers are licensed to offer such plans.”<sup>10</sup> In the states where CO-OPs are established, they are required to be offered on the Exchanges and comply with all Exchange rules and other applicable state laws and/or regulations.

The ACA requires a level playing field across health issuers, including multi-state and CO-OPs. Specifically, the ACA states that “health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law... if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law.”<sup>11</sup>

There is nothing in the ACA that would preempt state laws and regulations for CO-OPs or multi-state plans. OPM has not yet published proposed regulations for the multi-state plans, but the NAIC has stated in a letter to OPM that multi-state plans will be required to comply with all applicable state laws and/or regulations.

#### **M. Stand-Alone Dental Plans**

The ACA specifically states that stand-alone dental plans may be sold through the Exchanges. These plans must offer pediatric dental services, which are included as a required EHB in the ACA. The states will need to decide how rates for these plans will be reviewed and what rating rules will apply to them.

#### **N. Wellness Program Discounts**

In Section 2705 of the PHSA, premium discounts for participation in wellness programs are allowed if they meet the criteria set forth in the PHSA. How these discount programs interact with rating factors and their impact on the cost of coverage based on health should be considered by the states.

In addition, the most recent IRS regulation on premium subsidies states that the subsidy level will be based on the premium without consideration of any wellness discount or tobacco use penalty.

### **V. Individual and Small Group Market Rate Review under the ACA**

#### **A. State Rate Review**

##### ***1. Reporting of Certain Rate Increases***

Prior to establishment of an Exchange, all issuers must submit rate increases in excess of the rate review threshold established in each state (currently set at 10% in every state) to the federal Health Information Oversight System (HIOS). This requirement applies to all non-grandfathered products. The states with effective rate review programs will review the rates and determine whether rates are considered unreasonable. This determination and associated justification must be reported in HIOS. The states that are determined to not have an effective rate review program will have those rate increases reviewed by HHS, although HHS has no authority to deny a rate increase.

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<sup>9</sup> ACA §1334.

<sup>10</sup> ACA §1322.

<sup>11</sup> ACA §1324.

Beginning in 2014, all QHPs in the Exchange will be required to report any rate increase to HIOS. Plans outside of the Exchange will only be required to report increases that exceed the threshold established in each state.

Under a state-based system, it is assumed that the reasonable or unreasonable determination will be consistent with the state's own approval process. For example, if a state approves a filing, it will also find the rates to be "not unreasonable."

The states receiving rate review grants have additional reporting requirements through HIOS. These include quarterly reports of the activity associated with the rate review grants, periodic conversations with CMS staff, and quantitative reports showing patterns of rate increases. SERFF has provided an interface with HIOS to allow the states using SERFF to seamlessly report the rate activity in their quarterly HIOS reports.

## **2. *Geographic Regions and Age Bands***

The states must report to HHS the proposed rating areas established for the individual and small group markets under Section 2701 of the PHSA. If a state does not establish the rating areas, or HHS deems the rating areas inadequate, HHS will determine the rating areas for the state.

Section 2701 of the PHSA allows individual and small group market issuers to rate based on age provided that the age rates do not vary by greater than a 3:1 for adults. Age bands are required and the selected age bands must be approved by HHS after consultation with the NAIC. The NAIC Health Actuarial (B) Task Force has been working to develop guidance to HHS regarding the establishment of age bands.

As these provisions apply to products sold both inside and outside of the Exchange, the states, along with the NAIC, should endeavor to establish the rating areas and age rating bands by the end of 2012 to provide adequate time for issuers to establish and submit rates for approval, both under state rating laws and as part of the QHP submission process. Time is critical; some issuers will need to submit rate filings as early as October 2012 in order to obtain approval by July 2013 for a January 1, 2014, effective date.

## **3. *Consumer Disclosure***

As required under 45 CFR §154.301 of the rate increase disclosure and review final rules,<sup>12</sup> the states with effective rate review systems must post to its website Parts I and II of the Preliminary Justifications and provide a means for comments to be submitted on any proposed rate increases that exceed the state rate review threshold. The U.S. Center for Consumer Information and Insurance Oversight (CCIIO) has encouraged the states to provide links to the consumer disclosure forms on [www.Healthcare.gov](http://www.Healthcare.gov), rather than posting the Preliminary Justifications on their websites to ease the burdens on the states to update the files on their own websites.

This process could be used to notify the Exchange of rate increases exceeding the state threshold. In addition, the website could be used to post rate increases for all QHPs to allow the Exchange to access all rate changes as part of their requirement to review patterns of rate increases. The states should consider all options to communicate rate increases to the Exchange, especially those that leverage current processes and minimize duplicative effort.

## **4. *General Rate Review Items***

The states will be motivated to maintain their "effective rate review Program" status, as it will be a sign to consumers that the state has a transparent premium oversight process, and it will avoid the additional regulatory burden on health insurance issuers of having to undergo both a state and federal rate review process.

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<sup>12</sup> [www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf).

The American Academy of Actuaries (AAA) has stated that effective premium oversight should be based on the following actuarial principles: health insurance premiums must be adequate to pay projected claims, expenses, and supporting risk charges; premium oversight should be done in conjunction with issuer solvency oversight; premium oversight requires strong actuarial representation; appropriate risk-based capital (RBC) levels must be in place; premiums should be self-supporting and not subsidized by other lines of business; the premium-review process should be transparent and equitable for all issuers; the premium-review process should allow for adequate premiums that appropriately reflect past experience; and the premium review process needs to be coordinate between state and federal regulatory entities.<sup>13</sup>

There are 13 areas of necessary review that are defined in the “effective rate review program.”<sup>14</sup> One thing to keep in mind is that, even if a state already reviews these items for reasonableness, they will now be required to examine the validity of the historical data underlying the assumptions used in rate development and are expected to review the emerging actual experience in relation to the expected of each carrier as part of the rate review process.<sup>15</sup> For many of the states, this will result in a more in-depth actuarial review than they have performed previously.

**a) *The Impact of Medical Trend, Cost and Utilization, and Cost-Sharing Changes by Major Service Categories***

Because trend, cost and utilization, and cost-sharing will usually have the most material impact on proposed rates, this will be where the majority of the time is spent in the rate review process.

The states will need to perform trend analysis broken down by the required major service categories, and by unit cost vs. utilization pursuant to 45 CFR §154.301(a)(3). The medical trend will be analyzed at a more aggregate level, such as class of business. Issuers need to submit the data used to develop the trend assumptions, prior projections of trend assumptions, and the actual trend realized in recent periods. In short, pricing actuaries are expected to report how well previous actuarial assumptions have compared to actual experience, and the basis for their current actuarial assumptions. This new requirement might be something to which state insurance regulators are not accustomed.

If there have been cost-sharing changes, issuers will need to show how the experience used for rate development has been adjusted and disclose the impact of the change. These disclosures could come in the form of changes in plan actuarial values or plan benefit factors.

**b) *The Impact of Benefit Changes***

Along with the impact on rates, issuers will need to show that they have adjusted the experience used in rate development. State insurance regulators will need to be able to check that the effect of benefit changes has not been double-counted (once in the trend and again in the factors).

**c) *The Impact of Changes in Enrollee Risk Profile***

Issuers will be required to submit sufficient information to demonstrate that historical experience has been adjusted to reflect the anticipated enrollee risk profile.

**d) *The Impact of Any Overestimate or Underestimate of Medical Trend for Prior-Year Periods Related to the Rate Increase***

Disclosing the impact of any overestimate or underestimate of medical trend for prior-year periods related to the rate increase may help delineate what part of the rate increase request may be attributable to a prior misestimate. It should be noted that trend is calculated at an aggregated level and should not differ

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<sup>13</sup> American Academy of Actuaries Premium Review Work Group comment letter to HHS regarding Section 2794 of the PHSA (May 14, 2010).

<sup>14</sup> 45 CFR §154.301(a)(4).

<sup>15</sup> 45 CFR §154.301(a)(3).

by plan (with the exception of deductible leveraging). By breaking this out, this will help state insurance regulators better judge the reasonability of the filed rates.

***e) The Impact of Changes in Reserve Needs***

Reviewing the impact of changes in reserve needs will consist of a review of the completion factors used in reserve development. Regulators might want to evaluate the historical adequacy of the claim reserve by having issuers disclose how a prior period's claim reserve compares with the actual claims paid. State insurance regulators also might want to monitor the change in completion factors, as this can skew trend estimations.

***f) The Impact of Changes in Costs Related to Programs that Improve Health Care Quality and Other Health System Improvement Costs***

Requesting that costs related to programs that improve health care quality and other health system improvement costs be categorized in accordance with the federal MLR guidelines will allow the states to monitor the overall MLR level as defined by HHS. However, because some of the states have MLR targets that are independent of the federal guideline MLR requirement, these states might choose to use their own reporting categorizations and definitions.

***g) The Impact of Changes in Applicable Federal Taxes, Licensing or Regulatory Fees***

Issuers should submit actual taxes, licensing or regulatory fees for a period corresponding to the base period used for claims experience, as well as those anticipated during the projected period. If historical taxes, licensing and fee ratios vary materially from those used in pricing, an explanation should be given.

***h) MLR***

Many of the states have established minimum MLRs on a prospective basis, often calculated as the present value of benefits divided by the present value of premiums. The federal government, through the ACA, has established a retrospective standard for minimum MLRs (see Section IV(g) of this white paper). The states should continue to enforce the state-specific standards.

Some of the states have chosen to incorporate the federal minimum MLR requirements in their rate review process, thereby applying the federal standard on a prospective basis. It should be noted that a retrospective credibility adjustment should not be applied to a prospective loss ratio.

The states that do not require issuers to price to the retrospective federal MLR may wish to have issuers indicate their intention to comply with the federal minimum MLR rebate requirements. The states may also wish to request that carriers provide an estimate of the federal MLR as further demonstration of anticipated compliance and to ensure that the range of potential rebates is reasonable.

***i) The Health Insurance Issuer's Capital and Surplus***

Capital and surplus levels are already included in financial statements filed with the state; therefore, some of the states do not require issuers to include this in their rate filings.

***j) Allowed Case Characteristics and Community Rating***

The allowable case characteristics that are permitted in rate filings have varied historically state-by-state. Starting in 2014, all of the states will adopt modified community rating with the following set of allowable case characteristics:

- Geographic rating areas.
- Age.
- Family size/composition.
- Tobacco use.

The states will need to verify that the variation in rates created by each case characteristic complies with federally mandated ratios.

**k) Risk Adjustment**

As a result of guaranteed issue and community rating requirements, there will be increased adverse selection and issuers will have a decreased ability to vary premiums to appropriately reflect the specific risks they are insuring. In response to this, a risk-adjustment mechanism will be implemented in 2014.

A risk adjustment mechanism will need to be calibrated so that it can financially compensate (or charge) issuers when the risk of their block of business is greater (or less) than the average risk in the market in a state. As a result, issuers will need to price their business based on the average risk pool of the state market, rather than the average risk pool of their own block of business. It is not clear what tools or information will be given to issuers in order for them to be able to do this.

Further complicating the matter, any risk adjustment algorithm, no matter how good, will not perfectly compensate issuers for the risk of their member populations. As a result, issuers might add a degree of conservatism to their rates until they understand how the risk adjustment mechanism will affect their financial results.

State insurance regulators will need to be aware that rate filings will include an adjustment for the issuers' expected risk population compared to the expected average market risk, plus potential shortcomings of the risk adjustment program.

It should be noted that the risk adjustment program, as envisioned by HHS, will be based on *relative*, not *absolute*, risk, so it will be nearly impossible for any issuer to assess its relative risk in the first year of operation of the risk adjustment program, and possibly longer given the time frames for filing rates, time frames for risk adjustment settlement and data audit adjustments.

**l) Temporary Risk Mitigation Programs**

Starting in 2014 and lasting for three years, a reinsurance and risk corridor program will be in place to help stabilize the market.

**i. Reinsurance**

The reinsurance program will collect "premiums" from all market participants in the small group, large group, self-insured and individual markets, while the "claims" will be reimbursed only in the individual market. The effect in each market is not neutral, even if the total premium across all markets equals total claims. Also, if reinsurance premiums collected are less than claims covered, then the reinsurance pool would not be able to pay all reinsured claims. Because of this risk, it is possible that issuers in the individual market will add an extra margin to their pricing to cover the uncertainty related to payment of claims.

**ii. Risk Corridor**

The risk corridor likely would not affect pricing or rate review of filings, at least initially.

**m) Small Group: List Bill vs. Composite Rating**

As this relates to the manner of billing rather than rating or pricing one might reasonably expect that it would not affect the rate review.

**5. Coordination of Regulatory Efforts with Exchange**

**a) Coordination of Frequency of Review**

In an effort to minimize the regulatory burden on issuers and to promote efficient Exchange management, the plan management functions should generally be performed by the state insurance department to the extent they have familiarity with and authority to perform the rate review function under plan management. Many of the states require annual filings for rates and, for those states that do so, they should consider coordinating the QHP rate review with the issuer's annual rate filing. To the extent issuers submit rate filings less than annually, the Exchange, in coordination with the state insurance department, should request premium renewal information from the issuer for purposes of evaluating patterns of rate increases.

**b) *QHPs***

As required under 45 CFR §155.1020, an Exchange must receive justification for rate increase for a QHP prior to implementation. It is expected that Exchanges will leverage existing regulatory mechanisms to meet the rate review requirements under plan management.

**c) *Recommendations Provided to the Exchange by the State in Accordance with Section 2794(b)(1)(B) of the PHSA***

Section 2794(b)(1)(B) of the PHSA requires the state insurance commissioner to make recommendations, as appropriate, to the Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases. This provision explicitly involves the state insurance commissioner; therefore, the states should consider developing a process to review issuers' history of rate increases in order to make recommendations to the Exchange. It is appropriate for state insurance regulators to perform this analysis and report to the Exchange on an annual basis unless the Exchange requests an interim review due to a recent pattern of rate increases.

**6. *Other Considerations***

**a) *SERFF***

The NAIC, at the request of its members, has established a project to build out the required plan management functions through SERFF, proposed key functions to support rate review, including: navigation between rate/form filings and plans; managing plans within SERFF; communication and correction of issues by issuers; and state certification of plans according to state-specific needs. A key component for rate review is the navigation function, which will permit SERFF users to leverage plan filings to existing or new forms and rates filed and approved with the state to satisfy the related components of the QHP review and certification process. The remaining components provide the states and issuers with the necessary interface to manage and communicate issues, similar to the current SERFF functionality for rate and form filings.

The SERFF implementation team expects the release of the QHP plan management module to occur in December 2012, with the functionality for renewal and decertification to follow in the second and third quarters of 2013. The plan management functions in SERFF are support an exchange regardless of whether it is an SBE, Partnership Exchange or FFE.

**b) *New vs. Existing Plans***

The QHP certification process will be applied to all plans seeking QHP status on the Exchange effective January 1, 2014. This will include both the review of any rate increase, as well as the evaluation of patterns of rate increases as required under Section 2794 of the PHSA. Once the Exchange has been established, new plans would be expected to follow the same process applied to plans seeking QHP status on January 1, 2014. Existing plans will have the same requirements, but the states can leverage prior evaluations of rate increase patterns to minimize the regulatory effort.

**c) *Grandfathered Plans***



Because grandfathered plans cannot be offered on an Exchange, it is expected the regulatory burden for grandfathered plans to be significantly less than non-grandfathered plans; for example, grandfathered plans are not subject to the federal rate review process. However, the states should understand the size and composition of insureds remaining in grandfathered plans to understand the potential adverse selection effects on Exchange business. Also, the states may apply the same rate review requirements on grandfathered plans.

Due to the numerous triggers resulting in the loss of grandfathered status, it is expected that the number of grandfathered plans will diminish significantly over time.

**d) Catastrophic Plans**

Section 1302(e) of the ACA allows issuers to offer catastrophic-type plans to individuals under the age of 30 that meet certain affordability or hardship standards. The plans will cover EHBs but will include deductibles equal to the amounts specified as out-of-pocket limits for health savings account (HSA)-qualified high deductible health plans (HDHPs).

Because catastrophic plans are considered QHPs, the rate review requirements under QHP certification will apply equally to catastrophic and metal-level plans.

**e) Funding/Resources**

Federal rate review grant funds have been made available to the states for the purpose of upgrading rate review processes to meet the minimum federal standards for an effective rate review process. However, the continued availability of these funds is not guaranteed and, in fact, unlikely. As the states consider enhancing rate review standards and processes the need for additional resources, and the sources of funds to cover those costs, need to be taken into consideration.

**B. Federal Rate Review**

**1. Authority**

Section 2794 of the PHSA requires the Secretary, in conjunction with the states, to establish a process for the annual review of unreasonable rate increases in premiums for health insurance coverage. The ACA requires health insurance issuers to submit to the Secretary and the relevant state insurance departments, a justification for a premium increase over the threshold amount prior to the implementation of the increase.

On May 19, 2011, CMS published in the *Federal Register* the final regulation on Rate Increase Disclosure and Review Requirements.<sup>16</sup> Pursuant to the regulation, CMS must determine if a state has effective rate review authority over health insurance. In 45 CFR §154.301, the criteria for determining whether a state has an effective rate review program includes: receipt of data and documentation sufficient to make the justification determinations required by federal law; timely and effective review of the reasonableness of assumptions; and effective review of the impact of changes to medical trend, utilization, cost-sharing, benefits, risk profiles, reserve needs, MLR and other information relating to administrative costs. In addition, the state's reasonableness determination must be made under a standard set forth in state law or regulation, and the state must provide public access to Preliminary Justifications.

If CMS determines that a state does not have an "effective rate review program," CMS will perform the review of rate increases equal to or greater than 10% or any other "state-specific threshold" identified in later years. In 2011, CMS identified seven states that had ineffective rate review authority or no rate review authority, in whole or in part, over rates in the individual and small employer group non-grandfathered major medical health insurance market. CMS conducts the review of rate increases over 10% pursuant to 45 CFR §154 in those states.

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<sup>16</sup> [www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf).

When reviewing rate increases for an “ineffective” state, if CMS finds that a particular rate increase is “unjustified,” “excessive” or “unfairly discriminatory,” it will make a public announcement of that finding, post it on the CMS website and require the health insurance issuer to post that finding on its website, as well. CMS does not have the authority to “disapprove” a rate increase or prohibit an issuer from using the rate that it found to be unjustified.<sup>17</sup>

An issuer may choose to reduce its rate increase below the 10% and avoid the publicity. If the issuer lowers its rate increase, but not below the threshold, it must submit a new Preliminary Justification and CMS will review it again. If a health issuer implements a rate increase determined by CMS to be “unreasonable,” the issuer must submit a “Final Justification” to CMS that responds to the unreasonable rate increase determination and the health insurance issuer must post the finding on its website. The information in the final justification must be consistent with the information filed in the Preliminary Justification.<sup>18</sup>

## **2. Federal Reporting Requirements**

Beginning September 1, 2011, all non-grandfathered small employer group and individual market health insurance rate increases that are 10% or more (state-specific thresholds may change in subsequent years), must be reported to the Secretary and the state insurance department, if that department has an effective rate review program. CMS will defer to the state’s determination of reasonableness in states that CMS has determined to have an effective rate review program.<sup>19</sup> In the states that do not have effective rate review, all rate increase information required to be reviewed under the regulation is filed with the Secretary through HIOS. CMS has actuaries on staff and under contract who review those rate increases. CMS will share information and discuss its review with the “ineffective” states, if the state insurance commissioner requests that information.

Health insurance issuers must submit to the Secretary a “Preliminary Justification” for each product affected by the increase on a form prescribed by the Secretary that contains the following information: the rate increase summary (Part I), a written justification of the rate increase (Part II) and rate filing documentation (Part III). An “ineffective” state can require that Parts I and II also be filed with its insurance department. However, Part III is sent to CMS only. A single, combined Preliminary Justification can be sent for multiple products, if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same for all those products.<sup>20</sup>

## **3. Consumer Disclosure**

CMS posts Parts I and II of all Preliminary Justifications on its website. The state insurance department must also post this information on their website.

The Preliminary Justification contains a rate increase summary (Part I) and the written description justifying the rate increase (Part II). The rate increase summary must include: historical and projected claims experience; trend projections related to utilization; any assumptions related to benefit changes; allocation of premium increase to claims and non-claims cost; per enrollee per month allocation of current and projected premiums; and a three-year history of rate increases for the product. The written description justifying the rate increase must include a simple and brief narrative describing the data assumptions used, including an explanation of the most significant factors causing the rate increase and a brief description of the overall experience of the policy, historical and projected. Part III of the Preliminary Justification contains documentation supporting the rate increase. Part III information will be posted only to the extent that it does not contain trade secrets or is otherwise confidential. CMS enables the public to comment on the Preliminary Justifications.<sup>21</sup>

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<sup>17</sup> 45 CFR §154.205; 45 CFR §154.225.

<sup>18</sup> 45 CFR §154.230.

<sup>19</sup> 45 CFR §154.210.

<sup>20</sup> 45 CFR §154.215.

<sup>21</sup> 45 CFR §154.215.

CMS posts its determination and a brief explanation of its findings on its website. State insurance departments may also post the information. The health insurance issuer is legally required to prominently post on its website the information relating to CMS's determination of "unreasonable," if the issuer chooses to implement a rate increase determined to be unreasonable by the state or CMS. The issuer must also include its "Final Justification" for implementing the increase despite the unreasonable determination. The health insurance issuer must keep this information on its website for at least three years.<sup>22</sup>

#### **4. *Coordination with and Role of the States***

CMS will coordinate its review with state insurance departments that have been determined to be "ineffective," if that state has some authority to review or investigate health insurance rates and is interested in being involved with the federal effort to implement and enforce the "Health Insurance Issuer Rate Increases: Disclosure and Review Requirements" regulations. State insurance department involvement may benefit consumers and assist with public disclosure.

## **VI. Exchange QHP Review**

### **A. State Based Exchange**

#### **1. *Authority***

The ACA authorizes each state to establish an Exchange by no later than January 1, 2014, for the purpose of facilitating the purchase of QHPs.<sup>23</sup> The Exchange is only authorized to offer health plans that are certified as QHPs.<sup>24</sup>

#### **2. *Rate Review***

##### **a) *QHP Certification***

The ACA requires the Secretary to promulgate regulations to "establish criteria for the certification of QHPs."<sup>25</sup> It also authorizes an Exchange to certify health plans as QHPs if they meet certain requirements, including those specifically established by the Secretary through regulation.<sup>26</sup> A health plan may be certified as a QHP if the health insurance issuer demonstrates compliance with the minimum certification requirements stated in the regulations.<sup>27</sup>

Health plans seeking certification as QHPs must: 1) "submit a justification [to the Exchange] for any premium increase prior to implementation of the increase" and prominently post the justification on their websites;<sup>28</sup> and 2) agree to charge the same premium rate for each QHP it offers, regardless of whether the plan is offered through an Exchange or in the outside market.<sup>29</sup> Exchanges are specifically required to take the justification information submitted by health plans, along with information and recommendations provided by a state related to patterns of excessive or unjustified rate increases, into consideration when determining whether a particular health insurance issuer's plan(s) should be offered through the Exchange.<sup>30</sup> The Exchange is also required to consider information reported by a state regarding "any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange."<sup>31</sup>

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<sup>22</sup> 45 CFR §154.230.

<sup>23</sup> ACA §1311(b); 42 USC §18031(b).

<sup>24</sup> 45 CFR §155.1000.

<sup>25</sup> ACA §1311(c); 42 USC §18031(c).

<sup>26</sup> ACA §1311(e); 42 USC §18031(e).

<sup>27</sup> 45 CFR §155.1000.

<sup>28</sup> ACA §1311(e); 42 USC §18031(e); 45 CFR §155.1020.

<sup>29</sup> ACA §1301(a); 42 USC §18021(a).

<sup>30</sup> ACA §2794(b); 42 USC §300gg-94(b); 45 CFR §155.1020.

<sup>31</sup> ACA §1311(e); 42 USC §18031(e); 45 CFR §155.1020.

**b) Degree of Overlap or Independence with State Insurance Department**

As noted in a) above, Exchanges are specifically required to take information and recommendations provided by a state's insurance department when determining whether a health plan should be available on the Exchange. HHS encourages Exchanges to minimize the potential burden on QHP issuers by leveraging the existing state rate review processes, including adopting the format currently being used by health issuers for the submission of rate justifications to the states,<sup>32</sup> but does not specifically prohibit Exchanges from conducting additional review of rate increases.<sup>33</sup> However, it is noted that an Exchange's consideration of rate increases is limited to determining whether a QHP should be offered on the Exchange.<sup>34</sup> It is also important to note that the requirement for a QHP to post a rate increase justification on its website is required regardless of whether the increase is considered an "unreasonable increase" and subject to review by a state.<sup>35</sup>

**c) Comparison of Rates and Growth of Rates Inside and Outside of the Exchange**

As noted above, an Exchange is also required to consider information regarding excess premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange when considering the rate increase justifications submitted by QHPs. HHS notes that information about rates and rate increases for similar health plans being sold outside of the Exchange may be helpful in this process.<sup>36</sup>

**d) SERFF<sup>37</sup>**

In the fall of 2011, NAIC staff began discussions with HHS officials regarding the potential use of the existing SERFF system as a tool for the states to use when performing rate review functions associated with the certification of QHPs. The NAIC created a SERFF Plan Management Technical Study Group to define the business requirements for the SERFF Plan Management project, with a focus on the capabilities that will be needed in early 2013 when issuers begin to submit their plans for QHP certification. These critical capabilities include: 1) creation and submission of plans by issuers; 2) review functions for approval and certification the by the states and Exchanges; and 3) the ability to share plan data among Exchange-related software applications. Work to implement these functions will continue throughout 2012 and will be available to the states for use in 2013.

While the SERFF development team has been working on modifications to support Plan Management functionality related to Exchanges, SERFF will separate the code for the Plan Management portion of SERFF to greatly reduce the possibility of impacts to non-Plan Management SERFF customers. Users will access SERFF using the same user ID and password they have today, with the intent of presenting a "look and feel" that is consistent with the current SERFF user interface as the additional QHP-specific screens are developed. As with other aspects of SERFF, only the users who need to see and work with the additional Plan Management features will see the associated options in SERFF.

**3. Coordination with State Insurance Departments**

**a) Effective Rate Review States vs. States Without Effective Rate Review Status**

Although the regulations issued by HHS to date do not provide clear guidance regarding the role of states that do not have an "effective rate review program" as it relates to Exchanges, these states may

<sup>32</sup> ACA §2794(a); 42 USC §300gg-94(a).

<sup>33</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,407 (March 27, 2012).

<sup>34</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).

<sup>35</sup> 45 CFR §156.210; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).

<sup>36</sup> 45 CFR §155.1020; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,408 (March 27, 2012).

<sup>37</sup> NAIC HIX Bulletin, Issue 4, April 30, 2012.

still have an obligation to assist Exchanges in meeting their QHP rate justification requirements. HHS has stated that CMS will determine whether rate increases subject to review under Section 2794 of the PHSA are “unreasonable” unless a state has an effective rate review program.<sup>38</sup> However, Section 2794 of the PHSA also requires the states that have been awarded premium review grants to make recommendations to Exchanges regarding whether particular health insurance issuers should be permitted to offer plans on the Exchange based on a “pattern or practice of excessive or unjustified premium increases” and information regarding premium growth rates inside and outside of the Exchange. Exchanges are required to take such recommendations into consideration.<sup>39</sup>

**b) *Coordination of Frequency of Review***

Health insurance issuers offering QHPs in an Exchange must: 1) submit information on rates at least annually in a manner and form specified by HHS; 2) set rates for an entire benefit year or SHOP plan year; and 3) submit justification for any rate increase prior to the implementation of the increase.<sup>40</sup>

During the comment period for the Exchange regulation some commenters expressed concerns about the requirement to set rates for an entire benefit or plan year because of the possible need to establish new rates, quarterly or annually, to accommodate federal or state regulatory changes. HHS declined to make an exception to the “entire year” rule, because it determined that such regulatory changes are generally known to issuers well in advance and it believes the number of changes that would take effect in the middle of a benefit or plan year would be limited.<sup>41</sup>

**c) *Recommendations Provided to the Exchange by the State in Accordance with Section 2794(b)(1)(B) of the PHSA***

See comments in a) above.

**4. *Federal Reporting Requirements***

**a) *HIOS***

As addressed in other sections of this white paper, the ACA requires the states that receive premium review grants to provide quarterly reports to HHS, through HIOS, regarding the number of rate filings received and reviewed, number requesting an increase, and number approved, denied or deferred.<sup>42</sup> The states must also provide specific information about each filing, including the identity of each insurance company submitting a filing and the type and amount of the requested rate change. In addition, the states that have an effective rate review program are also required to provide CMS with a final determination of whether a requested rate increase is unreasonable, which must include a brief description of its analysis of the rate filing and how it arrived at its determination.<sup>43</sup>

**b) *Other Reporting Requirements***

In addition to the general rate review requirements, as stated above, the states have specific reporting obligations related to Exchanges, including information related to “patterns or practices of excessive or unjustified premium increases” and information about the growth rate of premiums both inside and outside of the Exchange.<sup>44</sup>

**5. *Consumer Disclosure***

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<sup>38</sup> 45 CFR §154.210

<sup>39</sup> ACA §2794(b), 42 USC §300gg–94(b); ACA §1311(e), 42 USC §18031(e).

<sup>40</sup> 45 CFR §155.1020; 45 CFR §156.210

<sup>41</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,416 (March 27, 2012).

<sup>42</sup> ACA §2794(b), 42 USC §300gg–94(b).

<sup>43</sup> 45 CFR §154.210.

<sup>44</sup> ACA §2794(b); 42 USC §300gg–94(b).

As stated above in section V.B.3., all QHP issuers are required to submit to the Exchange a justification for all rate increases prior to their implementation and to prominently post these justifications on their websites.<sup>45</sup>

**6. Funding**

Exchange establishment grant funds are available for states through 2015. These funds may be used to cover costs of establishing an SBE, including upgrading systems and processes for rate review. However, funding for the ongoing operation of the Exchange is a responsibility of the states. State insurance departments that will be performing additional functions for the Exchange will need to ensure that additional costs are covered.

**B. Partnership Exchange<sup>46</sup>**

**1. State Partnership with Federally Facilitated Exchange**

In guidance issued in May 2012, HHS provided some insight into how a federal/state partnership might work.<sup>47</sup> In such an arrangement, HHS would retain full authority and responsibility for the Exchange as an FFE, but the states could choose to fulfill the plan management and/or consumer assistance functions of the Exchange.

In the May 2012 guidance, the various functions are broken down as follows:

<b>Plan Management</b>	<b>Consumer Assistance</b>
QHP Certification, Recertification and Decertification	Support, Administer and Oversee Navigators
QHP certification review: <ul style="list-style-type: none"> <li>• Licensure in Good Standing</li> <li>• Service Area</li> <li>• Network Adequacy</li> <li>• Essential Community Providers</li> <li>• Marketing Oversight</li> <li>• Accreditation</li> <li>• Essential Health Benefits</li> <li>• Actuarial Value</li> <li>• Discriminatory Benefit Design</li> <li>• Benefits of Meaningful Difference</li> <li>• Rates (New and Increases)</li> </ul>	Provide In-person Assistance to Consumers: <ul style="list-style-type: none"> <li>• Filing an Application</li> <li>• Receiving an Eligibility Determination</li> <li>• Renewing Coverage</li> <li>• Comparing and Selecting a Coverage Option</li> <li>• Enrolling in a QHP</li> </ul>
QHP Issuer Account Management	
QHP Oversight and Monitoring, Including Marketing	
Collect Data	
Verify Accreditation Status and Collect Data for Exchange	
Collect and Display Quality Data	
Coordinate with HHS on Quality Rating and Enrollee Survey	

A state choosing to partner with the FFE must agree to fulfill all of the functions under plan management and/or consumer assistance in order to be a partner. The states are eligible to receive federal Exchange establishment grant funds, as a partner, to pay for additional expenses to prepare for fulfilling the

<sup>45</sup> ACA §2794(b); 42 USC §300gg-94(b); 45 CFR §156.210

<sup>46</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18325-18,326 (March 27, 2012).

<sup>47</sup> [http://cciio.cms.gov/resources/files/FFE\\_Guidance\\_FINAL\\_VERSION\\_051612.pdf](http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf).

Partnership functions. It is still unclear how operational costs will be covered, or how the roles and responsibilities of the federal and state partners will be finalized, though likely through a memorandum of understanding (MOU).

The enhanced SERFF Plan Management functionality that will be available to states with SBEs will also be available for use by the states that choose to perform plan management as a part of a Partnership Exchange.

Further details on what will be expected of state partners are currently not available. Those states interested in partnering with the FFE should begin discussions with their regional contact to ensure the state's processes will meet the needs of the federal Exchange.

The states must submit an application by November 16, 2012, expressing their intent to partners with the federal government and outlining their plan for fulfilling the functions by October 1, 2013.

## **2. Funding**

The states may receive funds from Exchange establishment grants for the cost of updating systems and processes to perform the plan management functions and/or consumer assistance functions required as part of the partnership agreement. These funds are available through 2015. The grant funds may also be used by states to transition from a Partnership Exchange to an SBE.

However, how ongoing operation costs will be covered is yet unclear. Will the state be responsible for raising the funds to cover operational costs? Will the states be reimbursed by the FFE? Additional guidance and discussion is needed on this issue.

## **C. Federally Facilitated Exchange**

### **1. Authority**

If a state fails or elects not to establish an SBE, HHS is authorized to establish and operate an Exchange within the state.<sup>48</sup> HHS has stated that Section 1321 of the ACA “does not contemplate divided authority over an Exchange” and HHS “retain[s] ultimate responsibility and authority over operations and all inherently governmental functions” of an FFE.<sup>49</sup>

In guidance published in May 2012, HHS indicated that, under an FFE, all QHP certification functions, including the review and approval of QHP premium rates, would be performed by HHS. However, the states would also retain all existing statutory authority related to the review and/or approval of premium rates consistent with the procedures described in other sections of this white paper, including those rates used by issuers for QHPs sold through the FFE operating within the state. HHS has acknowledged that certification of a QHP rate filing by the Exchange would be contingent upon a state's approval of the submitted rate, if appropriate. In addition, as noted above, the states that receive premium review grants would presumably continue to fulfill their obligations to provide the Exchange with information about rate practices and trends both within and outside of the Exchange.

### **2. SERFF**

The enhanced SERFF Plan Management functionality that will be available to the states with SBEs and Partnership exchanges will also be available for use by states that utilize the full FFE model in order to enable the states to affirm plans are approved for use within a state, where the state has the regulatory authority to approve or disapprove.

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<sup>48</sup> ACA §1321(c); 42 USC §18041(c); 45 CFR §155.105.

<sup>49</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,326 (March 27, 2012).