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State Health Reform Assistance Network
Rate Review Process Overview

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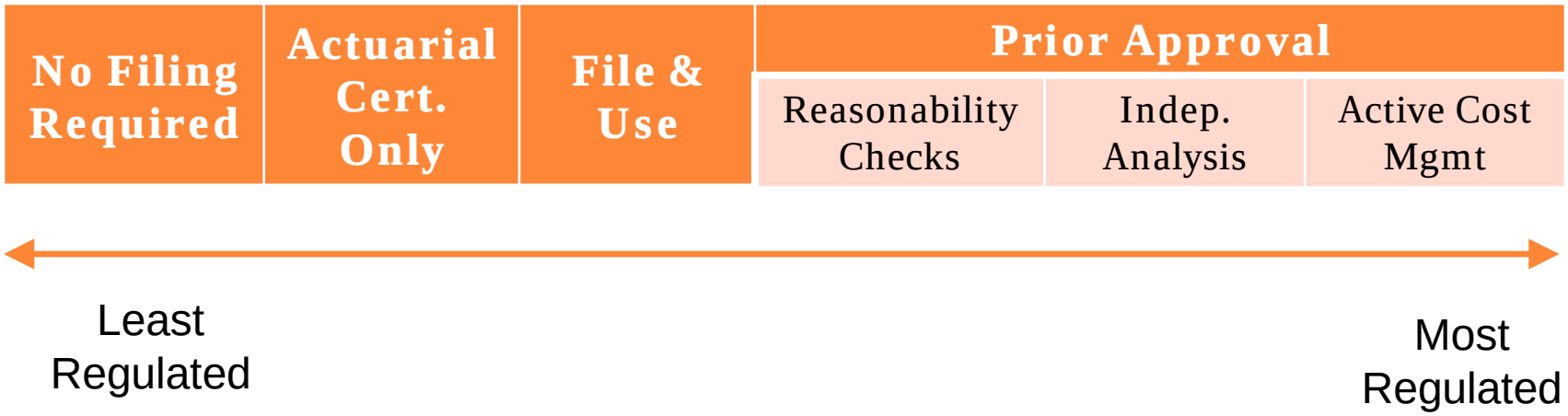
Agenda

- Insurance Department Role
- Rate Review Process
- Rate Review Timeline
- Opportunities to Leverage APCD

Insurance Department Roles

- Most states have statutes requiring that rates not be excessive, inadequate or discriminatory
- State Insurance Departments' rate review authorities vary and lie on the following spectrum



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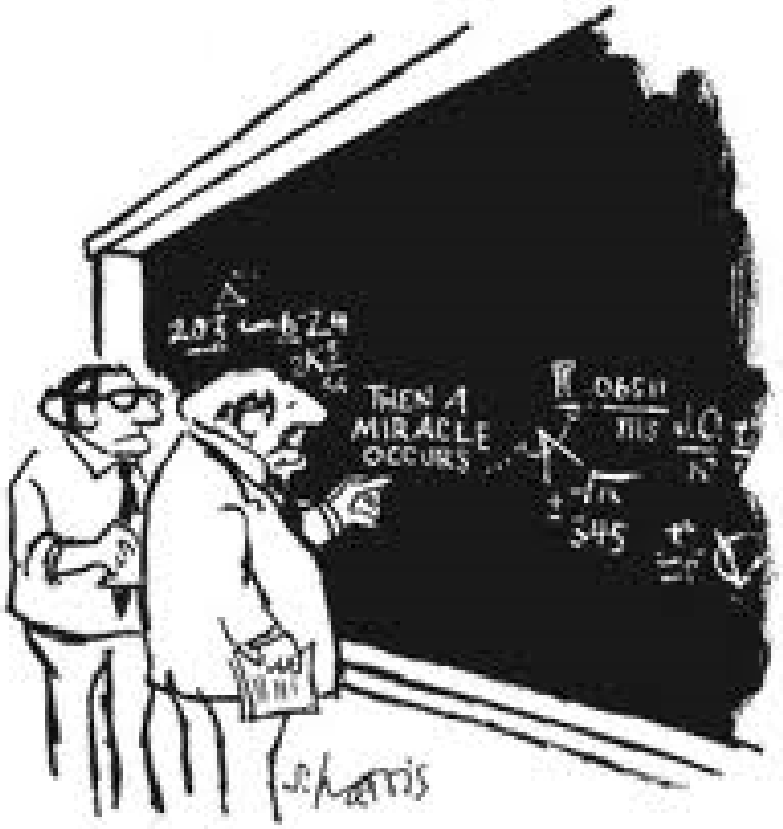
Rates and Binders and Forms (oh my!)

- Pre-ACA:
  - Two filings – rate and form
  - Form (insurance contract) and rate filings typically reviewed separately and at the product level
- Post-ACA:
  - Three interrelated filings – rate, form and “binder”
  - Template driven, more data intensive
  - Plan level reviews: AV, plan relativities, network factors
  - Cross carrier comparison / outlier analysis

How are rates developed and reviewed?



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

How are rates generally developed?

- Start with historical claims and enrollment data
- Apply a bunch of projection factors, including
  - Trend (unit cost and utilization)
  - Impact of population changes (demographic & risk profile)
  - Impact of benefit and cost sharing changes
  - Impact of network changes
  - Impact of reinsurance and risk adjustment
- Add on administrative costs, taxes, and fees
- Normalize and apply age, geographic, tobacco use, and in some cases family tier factors

What's included in a rate filing?

- Federal requirements
  - Unified rate review template (URRT)
  - Actuarial memorandum
- State requirements (varies)
  - Template (?)
  - Separate Actuarial memorandum (?)
  - Additional exhibits (?)

What does rate review entail?

- To be deemed by HHS as an "effective rate review state," state's review process must include examination of:
  - Reasonableness of the assumptions used and validity of the historical data underlying the assumptions.
  - Issuer's data related to past projections and actual experience.
  - Reasonableness of assumptions used by the issuer to estimate the rate impact of the reinsurance and risk adjustment programs.
  - Issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.

Challenges for Regulators

- Regulator may have limited tools for performing independent verifications
  - Limited data sources available for base data validation are limited and may not align with rate filing (e.g., includes grandfathered policies)
  - Limited benchmarks
  - Reliance on issuer actuary who may provide limited supporting documentation
  - Longitudinal/cross issuer analysis may be difficult/manual

Timeline for Rate Reviews

- Below is the timeline for exchange rate review for 2014 plans on the federal exchange

- Filings submitted
- Filings reviewed
- Iterative Q&As with issuers
- Disposition
- Data submitted to exchange
- Exchange testing
- Open enrollment

How might regulators use APCDs for rate review?

- Independent verification and analysis of claims
- Benchmarking
- Plan design & benefit modeling
- Cost driver/trend analysis
- Geographic analysis
- Outlier identification

Questions?

"Effective" Rate Review Requirements (45 CFR § 154.301)

(a) *Effective Rate Review Program*. In evaluating whether a State has an Effective Rate Review Program, CMS will apply the following criteria for the review of rates for the small group market and the individual market, and also, as applicable depending on State law, the review of rates for different types of products within those markets:

1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.

2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.

"Effective" Rate Review Requirements (45 CFR § 154.301) (cont'd)

3) The State's rate review process includes an examination of:
   i. The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and
   ii. The health insurance issuer's data related to past projections and actual experience.
   iii. The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.
   iv. The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.

4) The examination must take into consideration the following factors to the extent applicable to the filing under review:
   i. The impact of medical trend changes by major service categories;
   ii. The impact of utilization changes by major service categories;
   iii. The impact of cost-sharing changes by major service categories, including actuarial values;
   iv. The impact of benefit changes, including essential health benefits and non-essential health benefits;

"Effective" Rate Review Requirements (45 CFR § 154.301) (cont'd)

v. The impact of changes in enrollee risk profile, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act;

vi. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;

vii. The impact of changes in reserve needs;

viii. The impact of changes in administrative costs related to programs that improve health care quality;

ix. The impact of changes in other administrative costs;

x. The impact of changes in applicable taxes, licensing or regulatory fees;

xi. The impact of changes in applicable taxes, licensing or regulatory fees;

xii. Medical loss ratio; and

xiii. The health insurance issuer's capital and surplus.

xiv. The impacts of geographic factors and variations.

xv. The impact of changes within a single risk pool to all products or plans within the risk pool.

xvi. The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

"Effective" Rate Review Requirements (45 CFR § 154.301) (cont'd)

5) The State's determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.

b) *Public disclosure and input.* In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide, for the rate increases it reviews, access from its Web site to the Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS's Web address for such information) and have a mechanism for receiving public comments on those proposed rate increases.

c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.