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A Regulatory Perspective on Rate Review Before and After the Affordable Care Act

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INTRODUCTION

The implementation of the Patient Protection and Affordable Care Act (ACA) launched the regulatory rate review actuary into an alternate universe similar in many ways to the magical Land of Oz. Will we emerge from it unscathed, safe in our beds with a smile on our faces reminiscing about a magical land of flying URRTs[1] and AV calculators,[2] or will there be an alternate ending to this story?

As much as we wanted to be holed up with Auntie Em in the storm cellar, rate review regulators were caught up in the same ACA whirlwind as everyone else. SCOTUS[3] dropped the house[4]—and squashed the "wicked" rating practices of the past, the effective rate review slippers are on, and we're off to see the wonderful wizard of CCIIO.[5]

In theory, regulatory actuaries have been asked to perform the same job as before the ACA—rate review—but virtually every aspect of the job has changed. Toss the state insurance code book you have used, studied, memorized, and relied on for years (but not too far just in case the make-up of Congress and the executive branch changes). The old rules don't apply (unless you are reviewing a grandfathered or transitional plan). Now is the time to prove your mettle as an effective rate review state.[6]

RATE REVIEW PROCESS

In the past, states received rate filings throughout the year and reviewers were able to manage and streamline the rate review process based on state-specific requirements and timelines. The regulator would review the actuarial memorandum, which documented the rate development process for each product submitted, to determine if the rates were reasonable and in compliance with state law and the appropriate actuarial standards of practice.

Under the ACA, all annual rate filings are submitted at once, generally in the late spring/early summer in accordance with federal timelines. Regulators have a three-month window, fondly known as the rate review season, to review hundreds of plans. Due to the single risk pool concept, a carrier now submits one filing for all of its plans in a given market in a state. Therefore, there are fewer filings submitted, but, due to the federal definition of a plan under the ACA, the actual number of plans that need to be reviewed has ballooned. It is not unusual for a state with a dozen or so separate single risk pool filings to have over 400 plans that need to be reviewed. This has stretched already scarce state resources, and, even in the states that use consulting actuaries to assist in the rate review process, regulatory actuaries have their hands full keeping up with the plethora of regulations and resolving the many technical issues that come up during the rate review process.

Additionally, the amount of information needed to be reviewed in order to satisfy federal and state requirements has also exploded. Regulators are now responsible for reviewing the URRT, which is a federally required data repository intended to demonstrate compliance with the single risk pool requirements, along with the accompanying Part III Actuarial Memorandum. These two documents are important for reviewing the index rate development for compliance with federal requirements but do not necessarily provide sufficient support for the determination of the reasonableness of rates in accordance with federal or state standards. Therefore, many states require carriers to separately submit supplemental information in order to perform a thorough review.

The combination of the voluminous rate filing submissions to be reviewed in compressed time frames results in a less than optimal process in which regulators and carriers perform a circular three-step dance of review/request/submit additional information, which all ends when the music stops at the allotted end of the rate review season.

Everything associated with the current rate review process is so removed from the way we used to do things that even the familiar seems out of place. Vestiges of the Kansas that we came from are everywhere, but we can't discern that the URRT is an integral part of rate review any more than Dorothy could tell that the Tin Man is actually the farmhand, Hickory. Similarly, AV is no longer an indicator of pricing differences; the actuarial memorandum does not necessarily provide details of the development of the premium; the ACA version of composite rating for small group plans is almost unrecognizable; and a new plan is not necessarily a new plan under the federal uniform modification rules. Everywhere there are reminders of the old Kansas, but there are sufficient differences to keep us off balance, wondering where indeed this yellow brick road is leading.

Over time, the issues that cause the rate review actuary the most angst have changed. For the 2014 rate review season, lack of compliance with the single risk pool concept, inadequate documentation of the rate development process, and the impact of the 3Rs[7] were the focus of many animated discussions between regulators and carriers. For 2015, the appropriate calibration of the plan adjusted index rate and the correct application of the uniform modification rules brought new life to those discussions. The 2016 rate review season started with no sin-

gle obvious winner, but as it got underway, two issues surfaced to keep regulators off-balance. We found ourselves still unsure of the correct way to apply the uniform modification rules. Additionally, pricing actuaries are struggling to determine whether to revise 2016 rates (if allowed by the states) to reflect the final 2014 risk adjustment payment information which was released on June 30, more than a month after the 2016 rates were submitted to states for review. Similarly, rate reviewers need to determine if the new information is sufficient to justify an adjustment to the already filed rates for 2016.

ROLE OF THE RATE REVIEW ACTUARY

As the rate review process has become more complicated and stressful, the role of the state regulatory actuary has also expanded. In addition to the traditional role of technical expert, assuring compliance with state and federal law as well as the actuarial standards of practice, state regulators often have to come out of the backroom to educate and communicate with nontechnical audiences. More and more, actuaries are asked to provide information to state officials, consumer groups, the media and the general public to educate and facilitate effective policymaking decisions. Actuaries have to let go of their innate need for precision and accept that the "average rate increase" provided to the media is not really an accurate representation of the actual increase in rates that may be experienced by any one individual or even the average consumer in the state. There is no perfect

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measure that would be easy for the public to understand, so this is one example where "close enough" has to be "good enough."

The review of rates is now more often subject to public scrutiny from individuals who may not be fully fluent in "actuarialese," the official language of our version of Oz, but have learned enough to explain "adverse selection," "actuarial value" and "medical loss ratio" with relative ease to their less adventurous counterparts. Actuaries have learned not to cringe when the explanation is not exactly correct and to smile with pride at their students' accomplishments.

Paradoxically, even though the responsibility of the state regulatory actuary has increased, the actuary's sphere of control is smaller than ever before. What used to be a purely analytical exercise is now peppered with political overtones. The fact that a rate increase is actuarially justified may not mean that it is politically palatable. The carefully reviewed rates could be changed due to external pressures and the actuary has to meticulously document the results of the actuarial review in order to demonstrate compliance with the actuarial standards of practice if the adequacy or reasonableness of the final approved rates is ever questioned.

In many states, the rate review actuary is also the protector of the state's effective rate review status, which is granted by Oz of CCIIO similar to the medal of valor awarded to the lion. Transparency of rate filing information is one of the requirements of keeping the medal, but much of this information has historically been kept confidential in accordance with state law. Additionally, early release of proposed premiums could lead to a "race to the bottom," which may adversely impact the solvency of carriers, particularly the new entrants to the market—such as co-ops[8]—and ultimately lead to reduced competition.

UNCERTAINTY

State regulators are as curious and uncertain as anyone about where this yellow brick road will take us. We've been given one basic instruction: Follow it. The rest we've struggled to figure out for ourselves. We've all given up recreational reading so that we can instead review every proposed regulation, provide comments through the National Association of Insurance Commissioners (NAIC), and then digest the finalized regulation to discover the changes that we're expected to enforce for the coming year. Getting answers from the Wizard is challenging. There is a never-ending stream of conference calls to attend and sometimes the correct SMEs[9] are unable to attend.

Some uncertainty in the market originated not from the law itself but from a line from a political speech.[10] The invention of transitional policies threw each state into a political quagmire. Is it better to allow some consumers to have a lower-cost plan with fewer benefits, or is it better to shore up the new market with these potentially "better" risks? The decision in some states was likely influenced by political alignment rather than introspection into the potential market effects. By the time the transitional population is integrated into the market, two of the three programs intended to help smooth the transition from a pre- to post-single risk pool will be unavailable. This is particularly worrisome for states with co-ops and other new entrants to the health insurance market that need a solid enrollment base (but not too much) and help from the 3Rs to get their feet under them.

The review of transitional and grandfathered rates is supposed to be back to the way things were, but it just isn't the same. Plans have to be checked to ensure that there are no benefit changes that void the grandfathered status. The accompanying actuarial memoranda now seem skimpy and uninformative compared to the voluminous Part III memoranda. It's difficult to separate out the

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market reform requirements and provide a consistent rate review analysis between pre- and post-ACA plans.

The 3Rs have not been the pillars of stability that they were intended to be. The 2015 notice of benefit and payment parameters, which establishes the pricing parameters for the year, sets a reinsurance attachment point of $70,000. Within a few months, the Centers for Medicare & Medicaid Services (CMS) released separate guidance indicating that the U.S. Department of Health and Human Services (HHS) "intended to propose changes to the reinsurance parameters for 2015," moving the attachment point to $45,000. This laid an unsure foundation for 2015 pricing because issuers were uncertain if they were allowed to price using the lower attachment point and regulators were uncomfortable allowing pricing based on an "intention." Additionally, state regulators had to determine if they would pick either $45,000 or $70,000 and only allow that level to ensure uniform pricing, or permit each carrier to choose the attachment point reflecting a company's rights to price according to its own understanding of the law.

Recent reports on risk corridor payments do not assuage regulators' fears that funds will be inadequate to cover receivables booked for 2014. Solvency has always been a regulatory concern. However, rate review regulators typically have not had to work intimately with solvency regulators when reviewing pricing assumptions. If a company files substantially the same plans each year with only a "trend" rate increase from 2014 to 2016, but is booking an enormous risk corridor receivable for 2014 that indicates that the 2014 rates were inadequate, should that be a red flag that the 2015 and 2016 rates may be inadequate? Certainly no company will explicitly price assuming a risk corridor receivable, but states are concerned that some companies are at least tacitly assuming this.

The permanent risk adjustment program has thankfully had the fewest surprise changes. Even so, the concurrent model poses timing difficulties. States are no more privy to individual company risk scores compared to the whole risk pool than the individual companies are. This complicates the task of evaluating year-end expected receivables and payables. Regulators have to decide how much scrutiny they will apply with regard to the accuracy of these booked values. A non-qualified opinion might bring up just as much uncertainty as to the credibility of the values as a qualified opinion.

One of the biggest challenges to thoroughly reviewing rates is the lack of credible post-ACA data. State regulators are chomping at the bit to review 2016 rates since that will be the first time that credible post-ACA experience data will be available. There will finally be a full year's worth of data to support or negate the reasonableness of key assumptions such as the morbidity of the newly insured and the impact of the 3Rs (although the final risk adjustment and risk corridor impact will not be known until the middle of the rate review season).

Just keeping up with all of the changes is physically and mentally exhausting. It would sure be refreshing to leave it all behind and go take a nap in a field of poppies.

LACK OF STATE CONTROL

Prior to the ACA, state regulators felt relatively comfortable making ultimate decisions on all aspects of rate filings. We had the backing of the McCarran-Ferguson Act and little in the way of superseding federal regulation to interfere with that confidence. Now, even benign questions like, "Can a company round their rates to the dollar?" have to be sent up to the great and powerful Oz[11] of CCIIO for a final determination.

Some state and federal laws directly conflict so that it is uncomfortable for states to sanction pre-eminence. The ACA requires posting of information in the actuarial memoranda that many states would consider proprietary and confidential. State regulators have struggled with trying to determine ways to meet the law's requirements without posting each company's "secret sauce" on the state and federal websites.

Accessibility to the wisdom of Oz has been frustrating for states. The timelines set by CCIIO give little room for back and forth, so when questions arise the answers are needed quickly. The process for regulators to get answers from CCIIO has changed over time. At first, states had no more direct method of contacting CCIIO than individual companies did. Then states were assigned a specific state representative through whom all questions were to be channeled. Now we are back to submitting questions to a general email address. With the changing process, it has been difficult to track down which questions have been asked and which answered. Rather than responding directly to the state, sometimes the answer will be posted to one of several websites (CALT, SERVIS, REGTAP, zONE) so regulators have to be familiar with these sites and check them frequently.

It turns out that the great and powerful wizard behind the curtain is neither omniscient nor omnipotent, but is a regular, fallible Kansan[12] like the rest of us. Folks at CCIIO are given the charge to answer questions and interpret the law simply by virtue of arriving in Oz a few months earlier than we did. Answers are not immediately forthcoming because there hasn't been time to contemplate all of the questions being asked.

States have been given opportunities to take back some of the control, but often there is a lack of political will, funding or time. All of these opportunities (state-based exchanges, risk adjustment, reinsurance, AV calculator continuance tables, merged markets) take time to consider. It's far easier to punt to the federal government when you already feel overwhelmed with current implementation issues that you can't reassign. States also need data to make some of these decisions and they don't have it. Many states

are now establishing all-payer claims databases (APCDs) so they'll be better prepared to assess these options.

ROAD AHEAD

As much as we may long for the comfort of the old ways, regulators aren't clicking their heels together just yet. The road so far has been challenging and unexpected, and time will only tell where it will lead.[13] We certainly haven't reached the end of the rainbow.

King v. Burwell evokes a sense of déjà senti; the unnerving feelings from the summer of 2012 were back in 2015. While that decision is now behind us, could a 2017 summer sequel appear to potentially upend the market again? These long-running cases along with short filing timelines put state regulators in the unpalatable position of reviewing rates multiple times and in an abridged time frame. Should states allow companies to submit multiple sets of rates depending on decisions beyond their control?

As the full reality of the market reforms applicable to the small group market hits, state regulators have to evaluate the merits of self-funding alternatives that allow employers to avoid the ACA market reforms. Traditionally, small employers were too small to absorb the risks associated with self-funding their health benefit plans and wanted the security of a fully funded rate. Now insurance companies are offering very low specific and aggregate attachment points for small employer plans that create a self-funded rate where much of the risk is ceded to a stop-loss insurer. It is unclear how much risk needs to be retained by the employer in order for a small employer plan to be governed by ERISA[14] rather than state insurance law. Since self-funding of health plans is most attractive to those employers with historically favorable experience, regulators are concerned that if too many small employers go the self-funded route, the fully insured small group market may become a field of poisoned poppies with premium rates spiraling out of control. For that reason, some state regulators are contemplating, or have already made changes to their stop-loss laws to raise the attachment points in an effort to maintain the integrity of the fully insured small group risk pool.

Insurance agencies are also looking for self-funded solutions for their clients. Leveraging the captive insurance markets, agencies establish relationships with their groups through a captive and negotiate stop-loss rates for the conglomerate. The distinction between this type of state-regulated group captive and a Multiple Employer Welfare Arrangement (MEWA) is not well-defined. As more of these arrangements are proposed, regulators in each state must determine the parameters around which these new arrangements will be allowed.

For state regulators the epithet of "there's no place like home" has little comfort because there is no "home" to return to. Rating practices and rate review have changed too much and they're more likely to change again than to stay the same. The political winds could shift, and we could be blown out of Oz down a rabbit hole with other decisions to make as we gingerly handle a bottle that says, "Drink me." ■

ENDNOTES

1. 45 CFR 154.215(b)(1), Unified Rate Review Template (pronounced "hurt" without the "h").
2. 45 CFR 156.135 Actuarial Value Calculator.
3. The Supreme Court of the United States (SCOTUS).
4. On June 28, 2012, in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court upheld two of the main provisions of the ACA—the individual mandate and Medicaid expansion.
5. The Center for Consumer Information and Insurance Oversight (CCIIO).
6. 45 CFR 154.301.
7. Transitional reinsurance, risk corridor and risk adjustment programs created per Sections 1341, 1342 and 1343 of the ACA.
8. Consumer Operated and Oriented Plans established in accordance with Section 1322 of the ACA.
9. Subject matter expert (pronounced "smee").
10. "If you like your health care plan, you'll be able to keep your health care plan." President Barack Obama, Green Bay, Wisconsin, June 11, 2009.
11. One other commonality between CCIIO and the Wizard of Oz is an inexplicable affinity for acronyms. The wizard's real name is Oscar Zoroaster Phadrig Isaac Norman Henkle Emmannuel Ambroise Diggs, which he shortened to OZPINHEAD, and ultimately to just "OZ" for obvious reasons.
12. This is not a direct reference to the Kansan Kathleen Sebelius.
13. We are personally hoping to see a flying monkey.
14. Employee Retirement Income Security Act of 1974, as amended.

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