OLIVER WYMAN

Tammy Tomczyk, FSA, MAAA

411 East Wisconsin Avenue, Suite 1600
Milwaukee, WI 53202-4419
1 414 223 7988 Fax 1 414 223 3244
tammy.tomczyk@oliverwyman.com
www.oliverwyman.com

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Ms. Alexandra Shafer
Assistant Director, Life & Health Division
Arizona Department of Insurance
2910 North 44th Street, Suite 210
Phoenix, AZ 85018-7269

Subject:

Effective Rate Review in Arizona's Individual Market

Dear Ms. Shafer:

The Arizona Department of Insurance (ADOI) has asked Mercer/Oliver Wyman to complete a review of current Arizona statutes/regulations to determine changes that would be necessary for Arizona to become an Effective Rate Review state in the individual market. Specifically, we compared the requirements of 45 CFR 154.301, Rate Increase Disclosure and Review Regulation, as issued by the Centers for Medicare & Medicaid Services (CMS) with current Arizona statutes/regulations and performed a gap analysis, identifying those areas where the current Arizona rules and regulations and level of rate review in the individual market are insufficient to meet the requirements outlined by CMS. As part of this review, we have addressed the specific criteria where CMS indicated that Arizona did not meet the requirements to be deemed an Effective Rate Review state, and provided our recommendations for changes that could be made to meet these requirements. While we make comparisons between current Arizona statutes/regulations and Federal regulations, we are not qualified to provide legal advice and nothing in this document should be considered to be such.

In addition we provide a discussion of the pros and cons related to revising Arizona statutes/regulations to specifically include each of the new requirements versus generally referencing the CMS regulation for rate increase disclosure and review. We have also provided a discussion of potential pros and cons associated with requiring the preliminary justification information be submitted for all comprehensive major medical filings in the individual and small group markets, as opposed to just those filings that meet the definition of a rate increase filing deemed "subject to review".

Background on Effective Rate Review Requirements Under 45 CFR 154

While Section 2794 of the Public Health Service Act (PHSA) requires CMS to establish a process for reviewing unreasonable rate increases, it does not specify what makes a rate increase unreasonable. Rather than predetermining the reasonableness of a proposed rate increase, 45 CFR 154 seeks to define a threshold for determining whether a rate increase is "subject to review." Only after a rate increase meets the "subject to review" standard will the review process seek to determine whether the increase is unreasonable. Rate increases that are reviewed and deemed unreasonable may still be implemented by the filing carrier, unless otherwise prohibited by state law.

The regulation sets an initial threshold for mandatory review in 2011 of any rate increase at or above 10 percent. Beginning in 2012, state-specific thresholds may be set based on "the cost of health care and health insurance coverage" in each state. CMS will publish any state-specific thresholds by June 1 of the preceding year, with the revised threshold being effective for the 12 month period beginning September 1 following the announcement. If no state-specific threshold is published for a state, the then current threshold remains in effect.

A rate increase that meets or exceeds the threshold described above is subject to further review to determine whether the rate increase is reasonable. If a state has an "Effective Rate Review Program" in place for the given filing type (e.g., individual HMO, small group non-HMO), the state will perform the review and determine the reasonableness. If the state does not have what CMS has deemed to be an Effective Rate Review Program in place, CMS will conduct the review for that filing type.

For a rate increase that is deemed "subject to review," the carrier must submit "preliminary justification" for the increase, regardless of whether CMS or the state will perform the review. Parts I and II of the preliminary justification must be submitted to both the state and CMS, and will be posted to the CMS website immediately upon receipt. The preliminary justification is intended to provide consumers with a thorough description of the rate increase, including the factors that the carrier asserts justify the increase. The posting will include a disclaimer that the rate increase is subject to review and has not been deemed unreasonable. Part III of the preliminary justification must be submitted only if CMS is performing the review. In addition, only information deemed non-confidential will be posted to the CMS website. The regulations include the following requirements:

- **Part I Justification – Rate Increase Summary** – Must include data and a quantitative analysis of the increase, including the following:
  - Historical and projected claim experience

- Trend projections related to utilization, and service or unit cost
- Any claims assumptions related to benefit changes
- Allocation of the overall rate increase to claim and non-claim costs
- Per-enrollee per-month allocation of current and projected premium
- Three-year history of rate increases for the product associated with the rate increase

This information is submitted in the form of the Rate Summary Worksheet as developed by CMS.

- **Part II Justification – Written Description Justifying the Rate Increase** – A written description of the rate increase, the most significant factors prompting the rate increase, and the overall experience of the policy. The instructions for completing the preliminary justification indicate that the Part II justification must include:

  - Scope and range of the rate increase: Provide the number of individuals impacted by the rate increase. Explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premium).
  - Financial experience of the product: describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses and profit. Discuss how the rate increase will affect the projected financial experience of the product.
  - Changes in Medical Service Costs: Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes as well as any other relevant factors that are impacting overall service costs.
  - Changes in benefits: Describe any changes in benefits and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.
  - Administrative costs and anticipated profits: Identify the main drivers of changes in administrative costs. Discuss how changes in anticipated administrative costs and profit are impacting the rate increase.

- **Part III Justification – Rate Filing Documentation** – Specific, detailed documentation, sufficient for CMS to conduct a review to determine whether the rate increase is reasonable. CMS has indicated that their review should be consistent with reviews conducted by states with Effective Rate Review Programs. Therefore, if the carrier is also required to submit a rate filing to the state in connection with the rate increase under state law, CMS will accept a copy of the filing provided that the filing includes all of the information necessary for CMS to conduct its review. If the information included in the state filing is not sufficient for CMS

to determine whether the rate increase is an unreasonable increase, CMS will request additional information necessary to make its determination.

The scope of review would not include assessing the reasonableness of the requested rate increase itself, but rather would include assessing the reasonableness of the underlying rates and methods for determining the rates. Specifically, the review would determine whether the anticipated claim plus nonclaim expenses are reasonable in relation to the benefits provided. Therefore, a rate increase could be deemed unreasonable if it leads to premiums that are not reasonable in relation to the benefits provided. The rate increase would be deemed unreasonable if it results in rates that are excessive, unjustified, or unfairly discriminatory.

How Can Arizona Become an Effective Rate Review State in the Individual Market?

In an email to Ms. Kathy Zatari dated June 24, 2011, CMS indicated that Arizona does not currently meet all of the requirements necessary for an Effective Rate Review Program. CMS outlined five major criteria used for determining whether a state meets the requirements of an Effective Rate Review Program. In turn we explore each of the five criteria, as presented in CMS' response, and suggest actions that, in our opinion, the ADOI would need to take in order to meet these requirements and have their rate review program for individual filings deemed effective by CMS.

1. *§154.301(a)(1): The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in §154.301(a)(3). To meet this requirement, the State must* ***require*** *(not merely request) that the rate filings be submitted.*

   Our understanding is that current Arizona law requires carriers file with the ADOI each revision of rates for policies sold in the individual market, prior to the carrier implementing the rate change. Arizona's Cycle I grant application indicates that "Every initial rate filing and rate revision filing must include a schedule of rates, a compliance checklist, the items listed on the checklist, an actuarial memorandum and an actuarial certification of compliance." The Department's form P-124 for Form Rate filings and Rate filing (as revised 6/2011) requires the signature of a Qualified Actuary that certifies compliance with all Arizona laws and regulations. The forms also provide a list of items that the Actuarial Memorandum is to address.

   Current filing requirements are on a "file and use" basis. In other words, once the carrier files a rate revision they do not need to wait for approval from the ADOI prior to using the revised

rates. §154.301(a)(1) does not require that the State have prior approval authority over rates, only that the State have the authority to require the carrier submit sufficient information to conduct an examination of the rates as described in §154.301(a)(3), and in turn conduct the level of review described.

Recommendation: Arizona currently has the authority under AAC R20-6-607 to require carriers to submit rates prior to their use in the individual market, and as a result meets this portion of the requirement under §154.301(a)(1). However, in order to fully meet the requirements of §154.301(a)(1), the filing must contain data and documentation sufficient to conduct the examination described in §154.301(a)(3). Specifically, §154.301(a)(3) requires 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. One could reasonably argue that the "validity of the historical data underlying the assumptions" is addressed by AAC R20-6-607(F) and the "data related to past projections and actual experience" is addressed by AAC R20-6-607(D)(3) and AAC R20-6-607(E).

However, AAC R20-6-607 does not appear to require carriers submit information that would allow the ADOI to assess the reasonableness of the assumptions used by the health insurance carrier. The draft Template for Actuarial Memorandum does include the requirement that an explanation of all factors used in the development of rates be included. Therefore, if this requirement is maintained in the final Template for Actuarial Memorandum, and the State has the authority to require all elements of this template be included with every filing, it is our opinion that the requirements of §154.301(a)(1) would be met.

2. *§154.301(a)(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.*

According to Arizona's Cycle I grant application narrative, the current rate review process in the individual market consists of an administrative completeness review only. Due to insufficient resources and expertise to assess the entire filing content, the ADOI relies on a checklist to determine whether the filing is complete and on an actuary's certification of compliance to determine whether the rates comply with the law.

Recommendation: In our opinion the current administrative reviews being conducted do not meet the requirements of §154.301(a)(2). In order to meet this requirement, we recommend the ADOI implement processes (described later in this letter) to review each of the data elements required in §154.301(a)(3) and §154.301(a)(4) for each filing deemed

"subject to review." Further, §154.301(a)(2) requires that these reviews must be conducted in a timely manner. However, 45 CFR 154 does not define what is considered "timely."

Currently, more than 30 states have rate approval authority over individual health insurance rates.[1] A large majority of these states also have deemer clauses associated with the rate filing. These deemer clauses generally range from 30 to 60 days, with two states having a deemer period of 90 days and one with a deemer period of 120 days.[2] We note that both North Carolina and South Carolina have 90 day deemer periods, and further that both of these states have rate review programs for the individual market that were deemed to be an Effective Rate Review Program by CMS. Therefore, we recommend that the ADOI establish a period of 90 days or less to conduct its reviews.

3. *§154.301(a)(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.*

As discussed above, the current rate review process in the individual market consists of an administrative completeness review only. In order to meet the requirement of §154.301(a)(3), the State would not only need to meet the requirements of §154.301(a)(1) and obtain the information necessary for these reviews, the ADOI would also need to conduct the reviews outlined in this requirement.

Recommendation: We recommend the ADOI implement processes to review the reasonableness of the assumptions used to develop the proposed rates, and the validity of the historical data underlying the assumptions for each filing deemed "subject to review." The validity of the underlying data should include a review of the credibility of the data relied upon, as well as the appropriateness of the data. In order for the data to be appropriate, it may require adjustment. For example, if nationwide data is used due to limited credibility of the State data, the data should be adjusted for any differences in demographics, benefits and historical rate increases.

Further, we recommend the ADOI review the issuer's data related to past projections and actual experience for these filings. AAC R20-6-607(D)(3) requires the carrier submit, if

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[1] http://www.statehealthfacts.org/comparetable.jsp?ind=887&cat=7

[2] Under a "deemer clause," if the state has not acted on a filing within the specified period, the rates are "deemed" to be approved. In practice, states will deny a filing if the deemer period is approaching and the filing has not been finalized. In some instances, the state still has the authority to retroactively deny a rate increase, even after the deemer period has passed, if the state discovers that the rate increase did not meet regulatory requirements.

available and appropriate, "the ratio of actual claims to the claims expected according to the assumptions underlying the existing rates." In our opinion, a review of this actual-to-expected analysis, along with the additional recommendations above, would satisfy this requirement.

4. *§154.301(a)(4): The examination must take into consideration the twelve factors described in §154.301(a)(4), to the extent applicable to the filing under review.*

   CMS specifies that the following 12 factors must be reviewed for each filing deemed "subject to review," where applicable:

   1. Medical trend changes by major service category
   2. Utilization changes by major service category
   3. Cost-sharing changes by major service category
   4. Benefit changes
   5. Changes in enrollee risk profile
   6. Impact of over- or under-estimating medical trends in prior years
   7. Reserve needs
   8. Administrative costs related to programs that improve health care quality
   9. Other administrative costs
   10. Applicable taxes, licensing and regulatory fees
   11. Medical loss ratio
   12. Carrier's capital and surplus level relative to national standards

   We note that the regulation does not explicitly define each of the items above. The ADOI's rate review program must include a review of each of these 12 items in order to meet the requirements of §154.301(a)(4).

   In what follows, we provide a brief description of each item along with a comparison of these requirements to the information required in the Part I and Part II preliminary justification, as well as the draft Template for Actuarial Memorandum for rate revision filings. We provide our recommendation for any action that the ADOI will need to consider in order to ensure it obtains the information necessary to review each of these required items.

   1. **Medical trend changes by major service category**
      CMS' Part I preliminary justification Rate Summary Worksheet requires the carrier to input the trend assumptions for the following categories: inpatient (facility only), outpatient (facility only), professional, prescription drug, other, and capitation. It appears that the medical trend assumptions are to include both components of trend –

cost and utilization. In addition, carriers are required in the Part II preliminary justification to describe how changes in medical service costs are contributing to the overall rate increase by discussing cost and utilization changes as well as any other relevant factors that are impacting overall service costs.

The ADOI's draft Template for Actuarial Memorandum requires that carriers provide a list of the factors used in the annual trend computation, such as inflation, utilization, change in medical costs, etc. for the following categories: inpatient, outpatient, professional, prescription drug, and other. In addition, the template requires carriers to include as Attachment A a description and support for the use of each factor, including a worksheet that exhibits the development and calculation of the annual trend for each item.

Recommendation: In our opinion, the Part I and Part II preliminary justification, along with the information required in item 4c of the draft Template for Actuarial Memorandum, would provide the ADOI with the information necessary to perform this review. However, we do recommend that item 4c of the draft template be revised to also include "capitation" in the list of trend categories, so that the ADOI receives support for changes in this component of claims.

2. **Utilization changes by major service category**
The CMS requirements for utilization changes are the same as for the medical trend changes requirements. However, in this case, the utilization-only trend is to be reported and supported.

The Part I preliminary justification does not require carriers to separately provide changes in utilization. The Part II justification requires carriers "describe how changes in medical service costs are contributing to the overall rate increase and discuss cost and utilization changes as well as any other relevant factors that are impacting overall service costs." While this justification does require a discussion of utilization changes, it does not appear to require this discussion be at the type of service level.

The draft Template for Actuarial Memorandum indicates that carriers must provide a list of the factors used in the annual trend computation, such as inflation, utilization, change in medical costs, etc. for the following categories: inpatient, outpatient, professional, prescription drug, and other. In addition, the template requires carriers to include as Attachment A a description and support for the use of each factor,

including a worksheet that exhibits the development and calculation of the annual trend for each item.

Recommendation: The draft Template for Actuarial Memorandum does not appear to specifically require that utilization-only trend be reported. By using the phrase "such as" it may be argued that it leaves it up to the carrier to decide which components of trend are required to be included. We recommend using stronger language such as "a list of the factors used in the annual trend computation, including but not limited to inflation, utilization and other changes in medical costs." As noted previously we recommend the draft template also include "capitation" in this list of trend categories.

3. **Cost-sharing changes by major service category**
   CMS requires that changes in cost-sharing and the resulting impact on premium rates be reviewed. We interpret this to mean that the current and proposed benefit factors for the cost sharing element that is changing should be reviewed. Additionally, support, which may include actual experience, should be provided for the benefit factor changes.
   The Part I preliminary justification Rate Summary Worksheet requires carriers report allowed and net claims for the base period from which cost sharing dollars in aggregate and per member per month are calculated. It also requires carriers report projected cost sharing as a percent of allowed claims for projection period. In addition, the draft Template for Actuarial Memorandum requires that the impact and disclosure of cost-sharing changes by major service category be provided.

   Recommendation: In our opinion, the requirements of the Part I preliminary justification in combination with the draft Template for Actuarial Memorandum may provide the ADOI with sufficient information to conduct this review. However, support for the impact of cost-sharing changes by major service category should also be required and may not be included in the filing given the current wording of the draft Template for Actuarial Memorandum. Therefore, we recommend revising Section 4(b)(3) of the draft Template for Actuarial Memorandum to read "Provide the following information *and associated support for*…."

4. **Benefit changes**
   CMS requires that changes in benefits, such as newly mandated benefits or elimination of a benefit, and the resulting impact on premium rates be reviewed. Based on a review of the Instructions for Completing the Preliminary Justification, we interpret this to mean that the current and proposed benefit factors and/or base

rates that are impacted by the change(s) should be reviewed. Additionally, support, which may include actual experience, should be provided for the benefit factor and/or base rate change(s).

The Part II preliminary justification requires that carriers "describe any changes in benefits and explain how the benefit changes affect the rate increase." Finally, the draft Template for Actuarial Memorandum requires that the impact and disclosure of benefit changes be provided.

Recommendation: In our opinion, the requirements of the Part II preliminary justification and the draft Template for Actuarial Memorandum may provide the ADOI with sufficient information to conduct this review. However, corresponding support for the impact of benefit changes should also be reviewed and may not be included in the filing given the wording of the Part II preliminary justification requirements and the current draft Template for Actuarial Memorandum. Therefore, as previously noted, we recommend revising Section 4(b)(3) of the draft Template for Actuarial Memorandum to read "Provide the following information *and associated support for*…."

5. **Changes in enrollee risk profile**
   CMS requires that changes in enrollee risk profile be reviewed. Changes in enrollee risk profile will typically be measured by the change in the average morbidity and duration of the policies. The Instructions for Completing the Preliminary Justification indicate that in its reviews CMS will require that information on assumptions related to morbidity, mortality and persistency be included in the Part III preliminary justification.

   Neither the Part I nor Part II preliminary justification requires the carrier to provide information related to changes in the enrollee risk profile. The draft Template for Actuarial Memorandum does require that the impact and disclosure of changes in enrollee risk on the rates be provided.

   Recommendation: In our opinion, the draft Template for Actuarial Memorandum meets the requirements of this criterion, given the State has the authority to require this information be submitted with all filings deemed subject to review.

6. **Impact of over- or under-estimating medical trends in prior years**
   CMS' Part I preliminary justification Rate Summary Worksheet requires carriers to provide both the prior estimate and the current estimate of the "current" rate. The

"current" rate is defined as the rate in effect 12 months prior to the proposed effective date of the rate increase. This comparison effectively provides an actual-to-expected ratio of net claims, and therefore any over- or under-estimation of trend.

In addition, the draft Template for Actuarial Memorandum requires that the impact and disclosure of any overestimate or underestimate of medical trend of prior years related to the rate increase be provided.

Recommendation: In our opinion, the information included in both the Part I preliminary justification Rate Summary Worksheet and the draft Template for Actuarial Memorandum meets the requirements of this criterion.

7. **Reserve needs**

CMS requires that the reserves be reviewed for reasonableness. In reviewing the Part III preliminary justification reporting requirements included with the Instructions for Completing the Preliminary Justification, it appears CMS' intent for this requirement is to include a review of both claim reserves and contract reserves. We note that comprehensive major medical policies are almost exclusively priced on an attained-age basis and, as a result, contract reserves rarely develop.

The draft Template for Actuarial Memorandum requires that carriers provide the "impact and disclosure of changes in reserve needs." The requirement does not appear to require support for the change or specify how carriers are to report the change (i.e., the dollar amount of reserves needed or the change in reserve needs as a percent of the incurred claims estimate). Changes in reserve would be most efficiently reviewed by examining the needed reserves as a percent of incurred claims. If reserve needs are instead reviewed in dollar terms, additional information related to changes in the underlying population would be needed.

Recommendation: In order to ensure the ADOI receives the information necessary to perform the required review of reserve needs, we recommend that the ADOI require carriers to submit claim reserve needs as a percent of incurred claim estimates, as well as support for any changes in this percentage. Further, we recommend that any applicable contract reserve needs be reported. While this may be the intent of Section 4(b)(3)(v) of the draft Template for Actuarial Memorandum, we recommend making clarifying revisions. For example, the requirement could be split into two where the first reads "impact and disclosure of changes in claim reserve needs, stated as a percent of incurred claims" and the second reads "impact and disclosure of changes in contract reserve needs, if any." Support for these changes

should also be required, and if our previous recommendation to revise Section 4(b)(3) to read "Provide the following information *and associated support for*…." is implemented, we believe the requirement to provide this support would be satisfied. Therefore, if the State has the authority to require the information required in the draft Template for Actuarial Memorandum, with the revisions noted, be submitted with all filings deemed subject to review, it is our opinion that this criterion will be met.

8. **Administrative costs related to programs that improve health care quality**
PPACA permits the inclusion of administrative costs for quality improvement in the numerator of the loss ratio calculation, for the purposes of meeting the minimum medical loss ratio (MLR). As such, carriers may want to include these costs in their claims for purposes of making any demonstrations of compliance with federal MLR requirements.

   The draft Template for Actuarial Memorandum requires carriers to provide justification for an increase in administrative costs related to programs that improve health care quality. In addition, information could be obtained from the new Supplemental Health Care Exhibit included with the NAIC statutory statement for assessing the reasonableness of these changes.

   Recommendation: We note that the Federal regulations clearly indicate that a review of all 12 items must be conducted, however, only where applicable. Since adjustment for administrative costs related to programs that improve health care quality are not required in demonstrating compliance with the loss ratio requirements of AAC R20-6-607(H) and neither current State nor Federal regulations require filings to include a demonstration of anticipated future compliance with the Federal MLR requirement, it is our opinion that this review is not applicable for Arizona. However, the draft Template for Actuarial Memorandum does include the requirement that carriers provide justification for an increase in administrative costs related to programs that improve health care quality, and it may be beneficial to maintain this requirement in the case that CMS feels a review of these costs should be conducted for other reasons.

9. **Other administrative costs**
CMS requires that the administrative cost assumptions (other than those for quality improvement) be stated and supported. This support may include a comparison to recent financial results and support for any changes.

The draft Template for Actuarial Memorandum requires carriers to provide justification for an increase in administrative costs.

Recommendation: In our opinion, the requirements included in the draft Template for Actuarial Memorandum meet this criterion.

10. **Applicable taxes, licensing and regulatory fees**
    CMS requires that the amounts assumed in the filing for taxes, licensing, and regulatory fees be stated and supported. We note that these items are deducted from earned premiums in the calculation of the MLR for the federal MLR requirements.

    The draft Template for Actuarial Memorandum requires carriers to provide justification for an increase in applicable taxes, licensing and regulatory fees.

    Recommendation: In our opinion, the requirements included in the draft Template for Actuarial Memorandum meet this criterion.

11. **Medical loss ratio**
    CMS requires that the projected loss ratio be reviewed for compliance with any applicable State requirements. Under AAC R20-6-607(H), the State has the authority to require carriers demonstrate that the future and lifetime loss ratio tests under AAC R20-6-607(G) are anticipated to be met.
    We note that while CMS will also review the projected loss ratio in relation to the applicable Federal standard in making its determination of whether the requested increase results in rates which are unreasonable in relation to benefits, §154.301(a)(5) only requires that states with Effective Rate Review Program make their determination of whether a rate increase in unreasonable based on a standard set forth in state statute or regulation. We note that we are familiar with several states that were deemed to have an Effective Rate Review Program and apply a loss ratio test different than the Federal standard by which CMS will perform its review.

    Recommendation: In our opinion, the current requirements under AAC R20-6-607(G) and AAC R20-6-607(H) meet this criterion.

12. **Carrier's Capital and Surplus Requirements**
    CMS requires that the carrier's capital and surplus requirements be reviewed for reasonableness. The draft Template for Actuarial Memorandum requires that carriers justify any "changes in capital and surplus with company provision description for any consideration of impact these may have to the rate increase."

Recommendation: In our opinion, the requirements included in the draft Template for Actuarial Memorandum meet this criterion.

Overall, it is our opinion that the requirements of AAC R20-6-607, the information required in the draft Template for Actuarial Memorandum with the modifications noted above, and the Part I and Part II preliminary justification would provide the ADOI with the information necessary to review each of the 12 items described above, as applicable. It is important that carriers are required under Arizona statute or regulation to submit all of the information included in the draft Template for Actuarial Memorandum for filings deemed "subject to review" in order to ensure that all of the required information is obtained. We recommend that the ADOI implement processes to include a review of each of the 12 items listed above, as applicable. If these recommendations are implemented it is our opinion that the ADOI will meet the requirements under §154.301(a)(4).

5. *§154.301(b): A State with an Effective Rate Review Program must have a mechanism for receiving public comments on those proposed rate increases.*

   In addition to satisfying the provisions in §154.301(a), a state with an Effective Rate Review Program must provide access from its website to the Part I and Part II preliminary justification and have a mechanism for receiving public comments on those proposed rate increases.

   Whether CMS or the state performs the review, CMS will post on its website at http://companyprofiles.healthcare.gov/ the information from the Part I and Part II preliminary justification. In the comment and response section of the final rule for 45 CFR 154, CMS indicates that states could meet this requirement to provide website access either by directly posting the relevant Part I and Part II justification on its own website or by posting a regularly updated list of the relevant Part I and Part II justification with a link to the CMS website where they can be found. In our experience working with other states, we note that most intend to satisfy this requirement by including a regularly updated list of the relevant Part I and Part II justification with a link on their state website to the CMS website where the information can be found.

   To meet the requirements of §154.301(b) states must also have a mechanism in place for receiving public comments on proposed rate increases. In the comments and response section of the final rule for 45 CFR 154, CMS indicates that states could choose to accept public comments through the mail, their websites, public hearings or by some other means. While some states, such as Oregon, have very robust bulletin board discussion areas included on

their website where the public may leave comments, most states do not. Having such a bulletin board would require staff to regularly monitor the site and ensure that any inappropriate comments are removed in a timely manner. In our experience working with other states on their implementation of Effective Rate Review programs, we found that most plan to accept comments via email through their website while also allowing the option to submit comments via mail for those without internet access.

Recommendation: We recommend that the ADOI implement the necessary changes to its website, such that a mechanism is in place to provide access to the Part I and Part II preliminary justification, and receive public comments on rate filings. We believe the easiest way to meet these requirements is to post a regularly updated list of the relevant Part I and Part II justification with a link to the CMS website where they can be found, and allow for consumers to submit comments via email or regular mail.

While 45 CFR 154 requires that a review of the items outlined in §154.301(a)(3) and §154.301(a)(4) be performed for rate increase requests deemed "subject to review," the regulation does not specify the process that must be used. In addition, while a credentialed actuary may be best qualified to perform a review of the 12 items included in §154.301(a)(4), the regulations do not explicitly require an actuary perform the review.

In our experience, there is a variety of approaches taken by other states. In some states all filings are referred to an actuary for review while in others standardized tests are performed by a non-actuary examiner and only those that fall outside specified ranges are referred for actuarial review. In cases where only certain filings are referred for actuarial review, the level of the requested rate increase is typically one of the factors considered in determining whether to forward the filing for review. We anticipate that in these states all filings that meet the threshold to be deemed "subject to review" under their Effective Rate Review Program include some level of review by a credentialed actuary.

Some states have actuaries on staff that perform the actuarial reviews, while others use an outside consulting actuary to perform the reviews. If an examiner at the state performs a portion of the review, it is important that the examiners receive training on basic rating concepts to ensure a robust review. It is also recommended that a rate review manual which documents the process to be used in reviewing each of items included in §154.301(a)(3) and §154.301(a)(4) be utilized. In addition to providing a reference for reviewers, it will promote consistency among reviewers.

Should Arizona Keep Its Current Regulations in Place and Adopt the Federal Regulation for Excessive Rate Increases?

As described above, it is our opinion that the requirements of AAC R20-6-607, the information included in the draft Template for Actuarial Memorandum with the modifications noted, and the Part I and Part II preliminary justification would provide the ADOI with the information necessary to review each of the 12 items described previously. However, in order to meet the requirements of an Effective Rate Review Program in the individual market, the State will also need to revise either current statute or regulation. In making these revisions, there are two options for doing so:

1. The statutes/regulation can be revised to specifically include all of the new requirements under Federal regulation in combination with the existing Arizona statutes. This would yield a merged or blended set of regulations that could require different filing criteria based on whether a filing is "subject to review" or not.

2. The statues/regulation can be revised to state that, in addition to current regulations, all rate increases deemed "subject to review" must include any additional requirements as defined in the Federal regulation.

There are pros and cons to specifically including all of the new CMS requirements in Arizona's statutes/regulation. These are discussed below.

Pros to Developing a Merged Set of Requirements

The advantage of merging or blending the new CMS requirements with Arizona's current statute/regulation is that carriers would only have to review one set of legislation/regulation when preparing filings in the State, rather than comparing State and Federal regulations to determine whether both sets of requirements are satisfied. This should result in more complete initial filings (i.e., all required information is included in the first submission) and may result in potential administrative savings for the ADOI as the need for additional review of follow-up information may be minimized.

Cons to Developing a Merged Set of Requirements

It is our understanding that it may be administratively difficult to change an Arizona statute. Additionally, the CMS requirements may – and most likely will – change in the coming years. For example, the level that defines a rate increase which is "subject to review" will undoubtedly be revised in the future. With this in mind, it may be easier to simply reference these requirements rather than specifically defining them in Arizona's statutes, so that when changes do occur, the statutes would not need to be revised. Alternatively, if strictly enforceable the

ADOI may wish to consider specifically calling out the new requirements via regulation or bulletins, which, as we understand it, may be easier to revise in the future.

Should Arizona Require Preliminary Justification for All Filings, Regardless of the Amount of Rate Increase?

CMS regulation only requires the preliminary justification be provided for rate increases that are deemed "subject to review." However, there is nothing preventing the State from requiring this information be submitted by all carriers, for all filings, regardless of the level of rate increase. We outline the pros and cons to the ADOI doing so below.

Pros to Requiring Preliminary Justification for all Filings

One purpose of collecting the Part I and Part II preliminary justification for all filings may be to provide an enhanced review for all filings. The advantages of doing so are that it would provide equity to all Arizona consumers in the individual and small group markets. Simply because a rate increase is below the applicable threshold does not mean that it is by default reasonable. This approach could also improve the ease of workflow for the Department by applying consistent processes and procedures for all filings, regardless of the level of rate increase requested.

Other states we work with are considering whether to require this information be provided for all filings not because they plan to apply the enhanced review for all filings, but rather with a focus on consumer disclosure. One may argue that efforts to increase consumer disclosure should not be dependent upon the level of the rate increase requested, and that all consumers should have available to them information on the rate increases they are being asked to accept, regardless of level. It would be a straightforward process to develop a simple application to convert the information in the Rate Summary Worksheet into a consumer friendly rate summary page that could be posted for public viewing. However, we note that the preliminary justification and any consumer friendly rate summary would need to be placed on the ADOI's website, since it will not be posted to CMS' website when the rate increase is not subject to review.

Cons to Requiring Preliminary Justification for all Filings

The most obvious disadvantage of requiring all carriers to submit the preliminary justification for every filing is the time, resource, and expense burden that will be placed on the carrier. The State may especially receive pushback from carriers that are requesting relatively small annual increases (e.g., less than 5%). We note that during consumer focus groups conducted in Maryland consumers indicated they would like access to this information, and our report to the Maryland Insurance Administration recommended they consider obtaining this information for all filings so that consumer friendly notifications could be easily developed and posted on their website. During a public hearing in which we presented these recommendations, carriers

indicated that they were opposed to being required to submit this information for rate increases below the required threshold.

Further, if the preliminary justification is required for all filings, any incentive for carriers to propose a rate increase slightly below the excessive rate increase threshold in order to avoid providing the justification would be removed. This could work to increase the average annual rate increase across all carriers, since the advantage of reduced oversight and administrative burden associated with filing for smaller rate increases is removed.

Caveats and Limitations

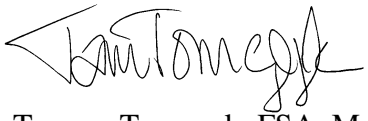
The above information was prepared exclusively for the Arizona Department of Insurance. All decisions regarding the implementation or use of advice or recommendations contained in this letter are the sole responsibility of the ADOI. While we have made comparisons between current Arizona statutes/regulations and Federal regulations, we are not qualified to provide legal advice and nothing in this document should be considered to be legal advice. There are no third-party beneficiaries with respect to this analysis, and Mercer/Oliver Wyman shall not have any liability to any third party in respect of this letter or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this letter. I am not aware of any direct or material indirect financial interest or relationship, including investments or other services that could create a conflict of interest, or that would impair the objectivity of my work.

If you have any questions related to this letter, please call me directly at (414) 223-7988.

Thank you.

Sincerely,



Tammy Tomczyk, FSA, MAAA

Copy: Rebecca Donsky, Arizona Department of Insurance
Kevin Lurito, Mercer
Branch McNeal, Mercer
Ron Betz, Mercer