

## **Issuer Module 2: Technical Instructions for Completing the Preliminary Justification Webinar**

### **Transcript**

My name is Keith Powell. I am an actuary at HHS. I will be talking you through our slides on preparing the Preliminary Justification. I suggest that you follow the slides with the relevant sections in the user manual, starting around page 11.

Part I is a one-page Excel work sheet. The user should complete the shaded and bolded areas. The remaining values will be calculated. We will go through Part I, by section, beginning with Part A.

Notice that in the manual there is a brief description of the categories of health care services, while we recognize that different definitions are possible, we need you to use these particular definitions in your preparation.

In section A, the base period is the experience period that is the basis for the issuer's work in doing the projections for the rate increases. Notice that the member months in the base period must be the same for all service categories. Also, allowed claims should include estimates of claims incurred but unpaid.

And you now see before you an example of a completed section A with the material that the user will complete bolded and highlighted.

Section B shows the projection periods. B2 is the one-year projection period beginning with the effective date of the proposed rate change. B1 is the period one year before the projection period.

Trend adjustments are used to go from the base period to period B1 to period B2. And, here is a picture of a completed section B1 and B2.

Section B3 covers the medical trend breakdown. Everyone uses a different approach to trend. Some people use none at all. Some use a single aggregate number. Others use utilization and unit cost only. Others get quite a bit more complex. I've seen some presentations with as many as 10 components of trend. One component that is often used in addition to utilization and unit cost is mix of services, the portion of the trend arising from the cell of more expensive services, rather than just a larger volume of services.

Because trend is an important cost driving assumption, we need to see a breakdown along the lines presented here, showing utilization, unit cost and one item for other factors that takes everything else into account.

Section C shows the current and future rate components. The current rate is the rate in effect twelve months prior to the proposed rates, based on the filing that established that old rate. It's important to note that the rate increase shown in section C is the same as the rate increase used to test the threshold for a CMS review.

Section D shows the rate increase history and the range and scope of proposed increases. The rate increase history covers three calendar years and should address both the requested and the implemented levels. Obviously, the number of individuals has to be estimated. Please be certain to include the minimum and maximum values of proposed increases.

There are internal tests underlying this section of the Preliminary Justification that are intended to avoid errors. There may be some situations in which they could actually keep you from completing the work sheet. For example, a negative claim number will not be accepted, yet under certain conditions you might have negative claims for one component, one service category. Should that happen, should you find that to complete this part of the Preliminary Justification accurately, you're being blocked by an internal check on this Excel Worksheet, please contact us and we will help you get through this section.

Here is a picture of the final section of the Excel worksheet.

Part II of the Preliminary Justification is an explanation of the rate increase. This should be in brief, nontechnical language oriented to consumers. You will need to explain the scope and range of the increase, the number of people impacted, and how the rate increase varies. There is always lots of interest in the highest percentage increase actually delivered, so the variation in the rate increase is a very important item. It is also very important to show a summary of historical revenue, claims, expenses, and profits on the product and how the rate increase should impact that in the future. Please try to explain clearly the linkage between the historical experience and the estimated future experience in a non-technical way oriented toward the consumers.

The other items that should be addressed are how provider costs and utilization contribute to the need for the rate increase, the impact of legally-required benefits, if any, and how administrative costs and anticipated profits contribute to the need of a rate increase.

Part III is needed only when CMS is reviewing the rate increase. Please follow the section of our slides with the material in your manual on this section which I believe starts at around pages 18 and 19. We are trying to be very flexible with respect to the format that you choose in presenting this material. Most of the material can be found in the standard actuarial memorandum and we strongly recommend that you submit such a memorandum as part of your filing.

The first category of information listed in the manual with items A through K are meant to identify the issuer and the particular filing. Clearly this is meant to distinguish you from other

issuers and this particular filing from any other filing that you might have. There should be no difficulty in providing this information.

Category 2 goes into a description of the product that is the basis for the filing. We know that this is going to be a comp major medical product, but please provide some additional details on the nature of the product (i.e., restricted providers, consumer driven high deductible product) information such as that. Please also provide a summary description of the benefits that can be used by the actuary reviewing your filing. I suggest you do this in one page with a good summary. This should not be just a copy of material from the text. For individual business, it is important to specify the renewability in the product. We need to know the strength of the rate guarantee because this is what engages the NAIC model for reviewing individual rate increases. We need to know and have you state clearly whether this is a non-cancellable product, guaranteed renewable, collectively renewable or optionally renewable. Please give us some information on the general marketing method used. Is this a commission product? Do you sell within house people or do you use outside sales? Please disclose the underwriting method. Is this an underwritten product or not? In the case of individual, please discuss the premium classification. Is this an issue age or a ten day age rated product? And if it is an issue age rated product in particular, what is the issue age range?

Category 3 is the scope and reason for the rate increase. Again please be sure to have not only the average rate increase, but the range from minimum to maximum.

Category 4 is the average annual premium before and after the rate increase. Please be sure to include rate increases in the recent past, back from 2008 or later, even those that have only been partially implemented to date and give implementation details including the initial effective date, the range of effective dates and the method of implementation. For example, is this implemented on policy anniversaries? Please show the proposed increase in a dollar amount as well as a percentage.

Next section, category 5 covers past experience and any other alternate or additional data used in preparing the rate increase. How many people are covered? How many policy holders if this is a group? How many groups? What is the written premium for a recent period? There are some circumstances under which a projection is prepared using information other than historical experience. If that is the case, please be sure that you show all relevant historical experience used to prepare the projections, but also go into details as to the other material used and why you had to use sources other than actual experience. Please present the details of your own work involving credibility in this filing. Please show details that will support your work, for example the number of people covered if you wish to support a certain credibility factor. I would like to make several comments about presenting historical claims that addresses claim reserves and contract reserves. We need to see the incurred claims presented separated by claims that have been paid through a recent date and you should disclose that paid through date and in addition for each incurred year, we need to see the claims that you believe were incurred in that year, but

remain unpaid as of that recent paid through date. If you are including contract reserves, please go into details as to why the reserve is needed, whether it is required by law or not, tabular basis if relevant, and the reason why you think that contract reserve is appropriate. For example, with an issue age product you might well feel that it's appropriate to deal with the built in cost increases accounted to the issue age rating structure. Contract reserves, if present, should be presented in a separate column and not included in the incurred claims.

Category 6 concerns details that the issuer used to determine the rate increase. This will be a great place to show the three expense items that may be used to modify the branch of the review that focuses on the federal MLR. These are expenses for quality improvement, regulatory costs and taxes. You will need to show those numbers for both the market, which is defined as the line of business in a state, and this particular block that is the subject of the filing if that is different. If you wish to take into account these three expense items, it's important that you present historical experience that the reviewing actuary can examine to test your assumptions for reasonables. Please show the impact of the proposed premium inquiries as a percentage and in dollar terms. We will need to see details on the methodology and all relevant actuarial assumptions. Methodology should include, in the case of individual, elements such as the projection period and the trending period. We are not going to ask you to show every imaginable actuarial assumption, but it is important to show the major assumptions so that they can be tested as part of the review. To try to illustrate this distinction, consider the case of persistency assumptions with individual filings. It is common to sweep mortality into the lapse assumption. If you choose to do this, it is not necessary for you to break out in detail mortality assumption to show all the increments, all you have to do is say that the lapse assumption presented includes mortality.

Category 7 requests the cumulative loss ratio and a description of how it was calculated. This should be used for individual business only. Please confirm that you are showing the detail, that is, the premiums and claims by year since inception, showing the early values clearly with and without the interest adjustment.

For category 8, we need you to present the projected future loss ratio. This is a one year projection beginning at the effective date of the rate increase and you should describe how it is calculated including all the major assumptions. This is not the adjusted federal MLR.

Category 9 requests the projected lifetime loss ratio combining the cumulative and the future experience with a description of how it is calculated. This is for individual business only. It should show details by year, premiums and claims used in preparing this lifetime loss ratio. The issuer should provide this information in a manner that will allow for testing associated with the applicable state lifetime loss ratio calculation. Absent such a state requirement, the issuer should do a presentation that will allow testing under the NAIC's model for testing individual rate increases.

Category 10 discusses the federal medical loss ratio requirement. Issuers must provide a 12 month projected loss ratio, including the premiums and current claims that gave rise to that, for the period beginning with the effective date of the rate increase. This should be provided separately for the market and for the block of business that is the subject to this filing if the two are different. Again, the market is all of the issuers line of business either individual or small group, in the particular state. If the issuer wishes, this is the point at which the three MLR expense components; expenses for quality improvement, for regulatory costs and for taxes, should be included. These numbers should be prepared at the market level and if the block of business that is the subject of this filing is different from the market, you should show the details of the allocation down to the level of the block of business. You should also give sufficient information so that the reviewing actuary can determine if a test for the federal MLR standard is passed at the market level when the requested inquiry is implemented on the individual block.

Given below is an example of the kind of material that we think is ideal for presenting the summary of the individual lifetime loss ratio. It is important to show the experience for each year from and including the inception date of the form, historical totals, totals for the projected period, future and lifetime results.

This concludes our discussion of the preparation of the Preliminary Justification. If you have questions, please submit your questions about this training to [RateReview@hhs.gov](mailto:RateReview@hhs.gov). Submitted questions will be answered during the CMS Rate Review User Group calls. User Group calls will take place in August and September. And you can get more details in the training confirmation email.