# Ruling on 2015 Golden Rule Rate Filing (Pre-Affordable Care Act Individual Major Medical Rate Proposal -- FACT Group Master Contracts G258102009, G25HS12009, G25CPY2009, and G25SVR2009

The Iowa Insurance Division (IID) received Golden Rule's individual medical rate filing on October 21, 2014 via SERFF, a rate and form filing system [website] hosted by the National Association of Insurance Commissioners. Golden Rule's proposal calls for an average rate increase of 19% to be effective beginning April 15, 2015. It is the Division's policy to review the rate filing proposal via internal actuarial staff, as well as having an independent external review to give the public additional confidence that the proposal is reasonable and justified. Therefore, the filing will undergo an actuarial review within the IID as well as an independent analysis from Lewis and Ellis (Overland Park, KS). Lewis and Ellis has performed a number of reviews for the Insurance Division over the last several years.

Before the results of our review are summarized, it might be useful to provide a brief summary of the filing process in Iowa:

1. Insurance carriers are required to request and receive approval from the Iowa Insurance Division before health insurance premium rates can be changed. All major medical and hospital surgical rate filings will receive additional outside review. If a rate increase proposal exceeds a certain threshold (6.1% for 2014/15), a public hearing is scheduled as required by Iowa Code section 505.19(1). A hearing was held December 6, 2014 at 10 AM. Furthermore, if a rate increase proposal is above 10%, the carrier is required to file certain information with the federal government (CMS).

2. The carrier's actuaries and attorneys submit the rate change proposal to the IID which includes the following information:

   - A general filing description that summarizes the request, i.e., x% increase proposed, a description of the policy forms affected, and the proposed effective date

   - An actuarial memorandum – this document describes the methodology and assumptions used to determine the amount of the rate increase, i.e., medical inflation, lapse rates, increases in the frequency and severity of claims, higher than expected loss ratios, and other relevant factors. The memorandum also demonstrates compliance with loss ratio standards under the law. Loss ratio means the ratio of claims to premiums.

   - The experience of the policy forms subject to the rate change proposal, i.e., loss ratios of the policy forms to which the rate increase applies.

   - An actuarial certification signed and dated by a qualified actuary

3. The Division's actuarial staff (and its consultants) then analyze the carrier's claims experience (loss ratios), claim trends, rate increase history, and other assumptions to determine if the rate increase proposal is actuarially justified.

4. If the Division's staff and its consultants cannot confirm the carrier proposal, a lower (or no increase) could be proposed. This is normally accomplished via email exchanges, face-to-face meetings at the Division's office, and/or conference calls with the company actuaries.

## Recommendation based upon internal and external reviews

I have received the results of the internal review as well as the independent actuarial report from Lewis and Ellis. Both reviews suggest that the carrier proposal of 19% is justified based upon past and projected experience. Both reviews assumed an 80% target loss ratio (amid other assumptions for the projection) which generated a range of increases consistent with a 19% increase. The 80% figure is also consistent with the Federal loss ratio requirement for individual medical policies under the ACA.

However, this review was complicated by the existence of another Golden Rule rate filing under review at the same time. In that particular review, we were unable to fully justify the carrier proposal of 6.1%, and after several discussions with the carrier and our consultant, a 2.5% proposal was agreed upon. Against that backdrop, the 2.5% proposal for that block of business actually affects the company's 19% proposal because it would violate Iowa Code section 513C.5(1)(e) which states that the maximum rate increase differential (between blocks) can be no more than 15%. In other words, if one block receives 2.5% -- the most any other block can be increased is 17.5%, i.e., 2.5% + 15% = 17.5%. Consequently, the maximum base rate increase that can be approved at this time is 17.5%.

Final statements

Please note there is an additional layer of protection (beyond regulatory review) provided for under the ACA. If all parties (the Division's review, the consultant's review, and the company's review) are wrong about this rate increase proposal to the extent that the loss ratio standards are not satisfied, the carrier will be forced to pay rebates to policyholders using a retrospective formula under federal law. Given the experience submitted, we view the chance of a Federal rebate to be small.