Glossary: **Health Plan Rate Review**

Health insurance rates have traditionally been regulated, or at least reviewed, by state insurance departments. This glossary contains some of the terms that consumer advocates might encounter as they seek to understand the process, review the filing and possibly challenge unjustified rate increases. More materials can be found at: ConsumersUnion.org/ratereview.

Term	Definition
Actuarial Memorandum	Main part of a **rate filing**: includes Exhibits setting forth the data, assumptions, estimates, and calculations on which the rate increase is based.
Administrative Expenses	These expenses include agents' commissions, general administrative expenses, taxes, licenses and fees. These do not include profit, **reserves** or **surplus**.
Annual Statement	Like the **rate justification**, this filing discloses total general administrative expenses, expenses for commissions and total premiums. Annual statements are filed with state insurance departments and the **NAIC** by March 1st each year, and can be found at https://eapps.naic.org/insData/.
Authorized Control Level or ACL	The legal minimum **surplus** an insurer must hold to do business.
Contingencies	An extra amount included in the rate that will enable the insurer to earn a reasonable profit even if the insurer ends up insuring people whose health is far worse than average.
Deductible Leveraging	When an insurer's payment to a provider increases but the policy deductible does not increase, the insurer's costs go up by a greater percentage than indicated by the provider's payment increase.

Term	Definition
Deemer (As In 30 Day Deemer)	The prescribed time period that the state insurance commissioner has to approve or disapprove a rate. If the Commissioner does not act within this time period, the rate is approved.
Duration	Aka *Underwriting Wear-Off*. The effect on claims costs of once-healthy people who develop more medical needs after they are insured under the policy for a while. This will no longer be allowed as a rate justification.
Effective Rate Review	HHS released regulations in 2011 classifying states as either having effective rate review programs or not. In states without an effective program, HHS will review rate filings when rate increases exceed a certain threshold, but HHS cannot disapprove the rate. The criteria for an effective program is listed at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html
Experience Period	To develop projected revenues and costs, insurers adjust actual revenues and costs from a recent historical time frame, called the *experience period*, based on anticipated changes.
File and Use	A regulatory approach that permits an insurer to file rate increases before or on the effective date, and implement them without having received state approval first. But, state regulators may conduct a retrospective review and take corrective action if rates are found to be excessive or not in compliance with state laws and regulations.

Term	Definition
Investment Gains	Insurance company investment gains can be split into two sources: investment gains on **reserves** and investment gains on **surplus**. Investment gains on reserves result from the time lag between when the insurance company receives the premiums to the time when claims and expenses are paid. This generates the investment gains on reserves. Investment income on surplus results because insurance companies must have a positive surplus position in order to operate. These surplus funds are held in various financial assets, which generate investment gains on surplus.
Medical Trend	The rate at which claims are expected to increase for the future rating period. Its two most important elements are (1) unit cost trend (price inflation) and (2) utilization and mix of services. Sometimes identified in rate filings as the "claims trend," "trend factor," "rent assumption" or "loss trend."
National Association Of Insurance Commissioners Or NAIC	A private organization of the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories that establishes standards and best practices, conducts peer review, and coordinates their regulatory oversight. www.naic.org
Rate Filing	Submitted by an insurer to state DOI or HHS, the rate filing contains the information justifying, or purporting to justify, the rates the insurer seeks to charge.
Prior Approval	A regulatory approach where insurers must file rate increase requests with state regulators and rates must be approved before they go into effect. In most prior approval states, the requested rates are "deemed" approved if the Insurance Commissioner or other agency official does not affirmatively approve or deny them within a certain time frame, usually 30 or 60 days.
Provision For Adverse Deviation (PFAD)	An insurer may increase a claims projection to account for "uncertainty." This item may actually be a disguised extra profit margin.

Term	Definition
Rate	The average an insurance company charges for a defined package of insurance plans. The amount consumers actually pay every month (the premium) — may be higher or lower than the rate due to rating factors or a group's specific claims experience.
Rating Period	The future period of time for which revenues and costs are being projected, and during which the new rates will be in effect.
Rating Year	Informal term referring to the year for which the rates are being proposed.
Reserves	Reserves are a category of funds set aside for known liabilities such as incurred but unpaid medical claims, future medical claims, and pre-paid premiums. This is not the same as surplus.
Risk-Based Capital Or RBC Ratio	The percentage of **Authorized Control Level** (ACL) surplus held by an insurer is called its Risk-Based Capital or RBC ratio.
Second-Mover Advantage	Insurers entering the market for the first time in 2015 – a second mover – are likely to attract a disproportionate number of healthy individuals who are likely to switch based on price.
Selection/Deterioration	The effect on claims costs of healthy people dropping coverage or switching to other policies, leaving mostly those with higher medical costs in the block of business. Refers to the pre-2014 effect of sicker people staying on policy. This should no longer be allowed as a rate justification.
Surplus	The amount insurers hold over and above what they project they need to pay claims. Not the same as **reserves**.

Term	Definition
SERFF	The **NAIC**'s System for Electronic Rate and Form Filing (SERFF). This is a cost-effective method for facilitating the submission, review and approval of product filings between regulators and insurance companies. http://www.serff.com/about.htm
Trade Secret	A secret, commercially valuable plan, formula, process, or device that is used for the making, preparing, compounding, or processing of trade commodities and that can be said to be the end product of either innovation or substantial effort. There must be a direct relationship between the trade secret and the productive process.
Underwriting Wear-Off	Aka *Duration*. The effect on claims costs of once-healthy people who develop more medical needs after they are insured under the policy for a while. This will no longer be allowed as a rate justification.
Unit Cost Trend	Aka *price inflation*. This is the increase (or decrease) in the prices the insurer pays to doctors, hospitals, and other health care providers. (This is one of the two most important elements making up **Medical Trend**.)
Utilization & Mix Of Services	A measure of changes in the number of services, the intensity of services, and the number of treatable conditions. (This is one of the two most important elements making up **Medical Trend**.)