Rate Filing Disclosure Form
Background and Project Summary
December 2010

Background

State insurance regulators were asked to assist the Department of Health and Human Services in developing a form that could be used to meet the requirement in Section 2794 of the Patient Protection and Affordable Care Act that specifies insurers must provide a justification for any rate filing request that meets an 'unreasonable' threshold. This justification is to be filed with HHS, the state regulator and posted on the insurer's website. Based on Section 2794, the justification is intended to provide consumers with more information regarding their insurance premiums.

Project Summary

The initial form was drafted by a small group of regulator actuaries, as a starting point, and then was presented to the Speed to Market Task Force for further consideration. The Task Force began its deliberations in May of this year, holding numerous public conference calls and two face to face open meetings at the NAIC Summer and Fall National Meetings. During these open forums, the Task Force received and discussed comments from regulators, insurance industry representatives and consumer representatives. In addition, HHS staff has been consulted, thus has had the opportunity to provide input. Throughout this process, it was consistently and openly acknowledged that HHS had not yet provided a definition of 'unreasonable' nor did HHS provide feedback regarding the suggestion that an alternative form would likely be more appropriate for the large market. In addition, it should be noted that on May 12, the NAIC provided a very lengthy response to Federal Register questions issued on April 14, specifically related to rate review. In those comments, the NAIC was very clear that HHS should consider the term 'potentially unreasonable' rather than 'unreasonable' and cautioned HHS in developing an arbitrary standard since there are many valid reasons for rate increases and that the development of a simple standard could arbitrarily identify a rate request as unreasonable, when, in fact, it is actuarially justified.

With regard to this form, the statutory role of the NAIC is not defined in the law as it was with the Medical Loss Ratio issue. The law simply states that HHS should consult with the states on the development of a justification for 'unreasonable' rate requests. This has been interpreted such that the NAIC is simply providing input and HHS has the authority to accept, reject or modify anything recommended by the NAIC. Furthermore, the form was developed with the knowledge that not all parties receiving the justification would have access to the rate filing. Therefore, while the form may appear to contain information that is already contained in the rate filing, the justification recognizes that some rate filing documentation and some insurer financial information may be useful in reviewing a rate request and may need to be submitted as part of the justification.

Given the NAIC has deliberated for several months in a very open and transparent process, acknowledging HHS has not disclosed their definition of unreasonable nor has HHS provided any feedback on how to address large groups, and recognizing that HHS has been very involved in the process and has indicated an intent to use some of the work of the NAIC, but has also indicated strong interest in collecting even more detailed information than is being recommended in this form and has requested the NAIC move forward with a recommendation, it was determined that the form was in as final a format as could be developed.

The Task Force adopted the form at the NAIC Fall National Meeting and the Health and Managed Care (B) Committee adopted the form (with a few additional changes) in a call on November 9.

Adoption of this form is not intended to be considered an endorsement of any definition of unreasonable that HHS may ultimately develop and the form clearly states it does not apply to the large group market. In addition, it is acknowledged that no instructions have been developed at this point, but if requested, the NAIC could consider providing additional input of this nature. Furthermore, as the members learn more about how HHS is planning to approach "unreasonable" rate filings, or if HHS provides further direction regarding large groups for example, the NAIC may want to consider providing additional guidance to HHS.

RATE FILING DISCLOSURE

The following three sections apply to those premium increases that meet the "unreasonable" test under Section 2794 of the Public Health Service Act. Health insurance issuers are required to submit the information required under these three sections and a complete rate filing which includes a justification for the premium increase to the Secretary and the relevant state prior to the implementation of the increase.

SECTION 1 — OVERVIEW OF THE RATE FILING

A. Issuer Information and Type of Plan

1. Health Insurance Issuer ▶ _____
   Insurance company submitting the rate change request.
2. NAIC Company Code ▶ _____
   Unique indentifier assigned to the insurance company.
3. State ▶ _____
   State where rate filing is required to be filed.
4. Type of Plan — Select one ▶
   - ☐ Individual
   - ☐ Small Group
   - ☐ Conversion
5. SERFF Tracking Number ▶ _____
   Unique identifier assigned by the SERFF system to identify the filing.
6. State Tracking Number ▶ _____
   Unique identifier assigned by the state to identify the filing.
7. Policy Form Number(s) ▶ _____
   Unique identifier related to the policy forms associated with the rate filing.
8. Plan Name(s) ▶ _____
   Name given to the plan by the insurer
9. Product Type — Select all that apply ▶
   - ☐ HMO - Health Maintenance Organization
   - ☐ PPO - Preferred Provider Organization
   - ☐ POS - Point of Service
   - ☐ HSA - Health Savings Account
   - ☐ HDHP - High Deductible Health Plan
   - ☐ FFS - Fee-For-Service
   - ☐ EPO - Exclusive Provider Organization
   - ☐ Other
10. Description of Deductible, Copayment and Coinsurance ▶ _____
11. Block of Business Status — Select one ▶
    - ☐ Open
    - ☐ Closed

B. Rate Request

1. Proposed Effective Date ▶ _____
2. Number of Covered Persons in this State ▶ _____
3. Number of Covered Persons under the Plans Nationwide ▶ _____

B. Rate Request (cont.)

	Increase/(Decrease) (from one year earlier)	Previous PMPM[2] (from one year earlier)	Proposed PMPM[2]
4. Proposed Average Rate Increase/(Decrease)[1]	%	$	$
5. Minimum Increase/(Decrease) for any Policyholder	%	$	$
6. Maximum Increase/(Decrease) for any Policyholder	%	$	$

[1] Premium rates for an individual insured/policyholder can increase or decrease for many reasons, many of which are part of general rating characteristics in an existing rate table/manual (e.g., age, family status, etc.) and beyond the scope of a filing. The minimum/maximum rate increase for any individual/policyholder represents the range of increases consistent with proposed changes in the rate table/manual.
[2] Per Member Per Month

C. Components of the Average Rate Increase/(Decrease) and Basis for Rate Request

Break down the "Proposed Average Rate Increase/(Decrease)" into the following components of rate changes (in percentage):

	% Change
1. Medical** Utilization Changes	%
2. Medical** Price Changes	%
3. Medical** Benefit Changes Required by Law	%
4. Medical** Benefit Changes Not Required by Law	%
5. Changes to Administration Costs	%
6. Insufficiency of Prior Rates Continuing losses that need to be covered by additional rate – not a recovery of previous losses, but a projection of continued shortfall from target.	%
7. Other Reasons for the Rate Request	%
8. Overall Average Rate Increase/(Decrease) Provide a Simple Calculation of how the Average Rate Increase/(Decrease) is derived based on the above components of rate changes	

**Medical includes Prescription Drug

D. Earned Premiums, Incurred Claims, and Underwriting Gain/Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing and for Nationwide if the plans are available in other states

	This State	Nationwide
1. (a) Reported 12-Month Period	From:	To:
(b) Member Months		

	This State (PMPM)	Nationwide (PMPM)
2. Earned Premiums Excluding Federal and State Taxes and Licensing or Regulatory Fees	$	$
3. Reimbursement for Clinical Services Provided to Enrollees	$	$
4. Activities That Improve Health Care Quality	$	$
5. Federal and State Taxes and Licensing or Regulatory Fees	$	$

D. Earned Premiums, Claims Costs, and Underwriting Gain/Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing and for Nationwide if the plans are available in other states (cont.)

	This State (PMPM)	Nationwide (PMPM)
6. Administrative Costs Allocated or Assigned to the Plans Reported in this Filing, Excluding Items 4 and 5 Above and by the Following Categories:		
a) Total annual compensation of the ten highest paid officers or employees	$	$
b) Total annual compensation for staff other than ten highest paid officers or employees	$	$
c) Agents or brokers fees and commissions	$	$
d) Other General and Administrative Expenses	$	$
e) Total = a + b + c + d	$	$
7. Underwriting Gain/(Loss) (Line 2 – (Lines 3 + 4 + 6))	$	$

E. Projected Results of the Proposed Rates

	This State		Nationwide	
	% calculated in Section 1.D	Proposed %	% calculated in Section 1.D	Proposed %
1. Reimbursement for Clinical Services Provided to Enrollees as a Percentage of Premiums[3]	%	%	%	%
2. Activites That Improve Health Care Quality as a Percentage of Premiums[3]	%	%	%	%
3. Federal and State Taxes and Licensing or Regulatory Fees as a Percentage of Premiums[3]	%	%	%	%
4. Administrative Costs as a Percentage of Premiums[3]	%	%	%	%
5. Underwriting Gain/Loss as a Percentage of Premiums[3]	%	%	%	%

[3] For purposes of calculations in Section 1.E, premiums mean earned premiums excluding federal and state taxes and licensing or regulatory fees.

F. Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

	Calendar Year	Requested This State	Implemented This State	Implemented Nationwide
1. Past Year		%	%	%
2. Past Year		%	%	%
3. Past Year		%	%	%

SECTION 2 — DETAILED DESCRIPTION OF A RATE FILING

A. Issuer Information and Type of Plan

Provide a description of the issuer and type of plan.

B. Rate Request

Provide a brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of the assumptions and projections made, and the rating requirements specifically required by this State. If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are applied in order to derive the rate projection. List the average number of covered persons during the experience

period for this state and for nationwide, and the average proposed rate change. Provide the description of the calculation for the average rate increase/decrease and the minimum/maximum rate change for any policyholder, including built-in trend factors, duration factors, age, geography, family size, industry, health status and other rating factors used to calculate the average rate increase/decrease or the minimum/maximum rate change. Include a detailed description of how the average rate increase/decrease and the minimum/maximum rate change are translated into the increase/decrease per member per month (PMPM). Provide an illustrative example if necessary. List the rating requirements (such as adjusted community rating) and citations of the rating requirements specifically required by this state.

C. Components of the Average Rate Change and Basis for Rate Request

Provide a detailed description of each component of rate changes listed in Section 1.C and the calculation of the overall average rate increase/decrease derived from these components. List benefits changes required by law, and not required by law, including changes to deductible, copayment, coinsurance and essential health benefits defined under Section 1302(b) of the Patient Protection and Affordable Care Act. Provide reasons for any benefits changes not required by law.

D. Earned Premiums, Claims Costs, and Underwriting Gain Loss

Provide each item listed in Section 1.D for the 12-month experience period from this state and nationwide. List and explain in detail all adjustments in earned premiums, such as state assessments, collections or receipts for risk adjustment and risk corridors, and payments of reinsurance. List all activities that improve health care quality.

E. Projected Results of the Proposed Rates

Include detailed calculations of each item listed in Section 1.E. Provide all justifications of any adjustments used to calculate these projected results.

F. Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Provide an explanation of how these calendar-year rate changes in Section 1.F were translated from past rate filings.

G. Additional Comments

Provide additional comments from an officer on the reasons for the proposed rate change, including the following topics:

1. Whether certain benefits have been reduced or enhanced in order to steer members towards more effective and more cost-effective services.
2. Any efforts toward cost containment and quality improvement, especially those inaugurated since the insurer's last rate filing.
3. Description of how rate changes can vary depending on rating factors, including examples.

SECTION 3 — DOCUMENTATION REQUIRED FOR A RATE FILING

Each rate filing should include the following information and documents:

(Some states may consider certain information confidential and subject to regulator only review)

1. A description of the health insurance issuer's rate-making methodology, including a description of the benefit plan and any changes to the benefit plan design, identification of the data used and the kinds of assumptions and projections made, and the rating requirements specifically required by this State. If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are applied in order to derive the rate projection.

2. The number of covered persons for the plans included in this filing. These numbers must be shown for each month of the experience period and the prior two (12-month) periods by plan and in aggregate if two or more plans are included in the rate filing.

3. Earned premiums for each month of the experience period and the prior two (12-month) periods by plan and in aggregate if two or more plans are included in the rate filing.

4. Incurred claims for clinical services provided to enrollees as referenced in Section 2718 of the Public Health Service Act for the plans included in this rate filing for each month of the experience period and the prior two (12-month) periods, and breakdown by the following categories:

a) Inpatient Hospital,
b) Outpatient Hospital,
c) Physician,
d) Pharmacy,
e) Laboratory,
f) Imaging,
g) Emergency Room, and
h) Others

5. A breakdown of the health insurance issuer's expenses allocated or assigned to the plans included in this rate filing for the experience period and the prior two (12-month) periods at least as detailed as the categories listed below. Provide the documentation and justification of the assignment or allocation of the expense to the plans included in this rate filing.

a) Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act,
b) Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act ,
c) Total annual compensation of the ten highest paid officers or employees,
d) Total annual compensation for staff other than ten highest paid officers or employees,
e) Agents and brokers fees and commissions, and
f) Other General and Administrative Expenses.

6. A detailed calculation and documentation of the proposed rate change including but not limited to the following:

a) Earned premiums for the experience period, premiums adjusted to the current rate level, and the projected earned premiums.
b) Incurred claims for the experience period, and the projected claims.
c) Trend factors and detailed development.
d) Impacts on claims due to benefit changes.
e) Projected breakdown of the expenses as a dollar amount and as a percentage of projected earned premiums by the following categories:
    - Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act,
    - Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act ,
    - Total annual compensation of the ten highest paid officers or employees,
    - Total annual compensation for staff other than ten highest paid officers or employees,
    - Agents and brokers fees and commissions,
    - Other General and Administrative Expenses,
    - Any credit from forecasted investment earnings on claim reserves or other similar liabilities, and
    - A reasonable provision for projected profit, contribution to surplus, contingency charges, or risk charges. For the purposes of this section, "projected profit, contribution to surplus, contingency charges, or risk charges" means the portion of the "projected earned premiums" not associated directly with the "claims" or "expenses."

f) Factors used to derive the projected rate change and the specific rate for any individual, employee, or employer including built-in trend factors, duration factors (such as durational loss ratio), age, geography, family size, industry, health status and other applicable rating factors.
g) Documentation and justification for the credibility factors used in the rate projection if the experience of the plans included in the rate filing is not credible.
h) Changes to the rating factors from prior rate filing to this rate filing and the impacts on the rate projection. Health insurance issuer must provide a justification for the changes to the rating factors. For example, if the age factors are modified from the prior rate filing, the issuer must show that the revenues projected before and after changing the age factors are the same.
i) Base rates and plan relativities if two or more plans are included in the rate filing. For the purposes of this section, base rate means the rate for any plan prior to the adjustment for any rating factors. The plan relativities mean the relative values of the benefit plan.

j) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, including the minimum and maximum rate change for any individuals or covered persons, the range of rate change by the distribution of members or groups. The methodology must be detailed enough to allow the reviewer to replicate the calculation of premium rates if given the necessary data.

7. Provide the documentation and calculations of the overall average rate increase and each component of rate change as described in Section 1.C. Efforts should be made to break down the medical utilization and price changes consistent with the data required under this section and into the following categories: inpatient hospital, outpatient hospital, physician, pharmacy, laboratory, imaging, emergency room, and other.

8. A certification by a member of the American Academy of Actuaries that rates for the plans included in this filing are reasonable in relation to the benefits provided.

9. The requirements of subsections (2) through (7) may be modified by the health insurance issuer if a reasonable explanation is provided. For example, if the rate filing involves capitation contracts that would make it difficult to breakdown the categories as required by subsection (4), the issuer may modify the categories for the purposes of reporting.

10. Since the rate filing cannot be understood without a wider understanding of the company, the health insurance issuer's most recent Annual Financial Statement and related supplemental filings may be accessed at the following website: https://eapps.naic.org/insData/. The following pages or exhibits from an insurer's annual statement filings provide information that can be helpful in understanding the insurer's financial position:

- Assets
- Liabilities, Capital, and Surplus
- Statement of Revenue and Expenses
- Analysis of Operations by Line of Business
- Underwriting and Investment Exhibit—Analysis of Expenses
- Exhibit of Net Investment Income
- Exhibit of Capital Gains (Losses)
- Enrollment by Product Type for Health Business Only (Exhibit 1 of the Health Annual Statement Blank)
- Summary of Transactions with Providers (Exhibit 7 of the Health Annual Statement Blank).
- Notes to Financial Statements
- General Interrogatories
- Five-Year Historical Data
- Exhibit of Premiums, Enrollment, and Utilization
- Management's Discussion and Analysis
- Accident and Health Policy Experience Exhibit
- Supplemental Compensation Exhibit
- Supplemental Health Care Exhibit (now being developed by E Committee)

(Note: The data included in the annual statement filings is companywide information and reported on a calendar year basis. The data submitted in the rate filing is information assigned or allocated to the plans referenced in the rate filing and may not be on a calendar year basis.)

Definition and Glossary of Terms: Some items mentioned throughout these three sections are yet to be determined. (For example, what kind of activities can be classified as activities that improve health quality?) It is recommended that a link to the Definition and Glossary of Terms be included.