Adopted by the Executive (EX) Committee/Plenary
May 12, 2010

NAIC Response to Request for Information Regarding
Section 2794 of the Public Health Service Act

The questions below are from the Federal Register on April 14, 2010. Responses are in *italics*.

II. Solicitation of Comments

A. Information Regarding Regulatory Guidance

The Department is inviting public comment to aid in the development of regulations regarding Section 2794 of the PHS Act, and is especially interested in the perspectives of researchers, policy analysts, health insurance issuers, and States. To assist interested parties in responding, this request for comments describes specific areas in which the Department is particularly interested.

This request for comments identifies a wide range of issues that are of interest to the Department. Commenters should use the questions below to assist in providing the Department with useful information relating to the development of regulations regarding Section 2794 of the PHS Act. However, it is not necessary for commenters to address every question. Individuals, groups, and organizations interested in providing information relating to one or more of the topics discussed herein may do so at their discretion by following the above mentioned instructions.

General Comments:
The states regulate rates for many different types of health insurance, such as disability income, Medicare supplement, dental, fixed indemnity, accidental death and long-term care insurance. Some states have authority to disapprove rates or rate increases, while other states review rates and the justification, but do not have disapproval power, and some states do not review rates at all.

The rate is the cost per unit, while the premium is the total cost paid. Here is a hypothetical example: The rate offered by ABC Health Insurance Company to a small employer in Lake County with good claim experience whose coverage is effective from Jan. 1, 2010, through Dec. 31, 2010, for a $1000 deductible plan with 80% in-network coinsurance and 60% out-of-network coinsurance, with an out-of-pocket maximum of $3,000, on form number ABC345, for a particular PPO network, is $400 per month for a male single employee age 45 to 49. The rates are usually filed as a formula that describes how to calculate a rate for each person or family covered, based on the geographic location, the past claim experience, the coverage and copayments, form number, age, gender and number of dependents.

The premium is the dollar amount actually paid by the group or individual, which in this case could be a total of $24,000 for 30 employees, some with family coverage.

The PPACA addresses only health insurance that covers medical services provided by physicians, hospitals and other medical providers. The PPACA requires removal of limitations on annual benefits, and eventually coverage of "essential benefits." The PPACA does not specifically prohibit "mini-medical" insurance that covers medical services in a limited way, but the issuers of these plans may withdraw from offering these plans, because they are specifically designed to be low-cost limited coverage plans. For a different reason, student "blanket" comprehensive medical coverage might not continue, because students will either be covered on their parents' plans or will be required to purchase individual comprehensive coverage.

However, there are other types of medical insurance policies that will likely continue to be sold. These include fixed indemnity, dread disease and accidental injury insurance, which are often designed to be purchased in addition to comprehensive medical coverage, because they pay fixed amounts to cover the non-medical expenses associated with illness or accidents.

Specific Areas in which the Department is interested include the following:

1. Rate Filings and Review of Rate Increases

The Act requires the Secretary, in conjunction with States, to establish a process for the annual review of unreasonable increases in health insurance premiums. A justification for an unreasonable premium increase is also required.

The process should identify "potentially unreasonable" increases, with further review by states and/or the HHS Secretary to determine any mitigating or exacerbating factors and decide whether the increase is actually unreasonable. Any increase that is necessary to avoid a future financial loss on the block of business is usually considered reasonable, unless there are compelling reasons to determine that it is unreasonable. Rates that produce a financial loss can affect consumers by impairing the financial soundness of the insurer, reducing the insurer's incentive to provide good customer service, reducing the insurer's incentive to continue providing coverage and shifting costs to other blocks of business.

Here are some options for defining a "potentially unreasonable" increase:

- *The actuarial reasons and data provided are incorrect or incomplete.*
- *The average increase is higher than X% for a one-year period.*
- *The largest increase for any individual is higher than X% for a one-year period.*
- *The average increase is higher than the Medical CPI plus X% for a one-year period.*
- *The average increase is higher than the average of other rate increases in the market plus X%.*
- *It is likely to result in a loss ratio below the 80% or 85% MLR requirements.*
- *It does not appropriately reflect benefit changes.*
- *The resulting rates are unprofitable "loss leaders" for the company, and might force other carriers out of the market, followed by large rate increases.*
- *The rates include provision for excessive administrative expenses or profit.*
- *The rates include provision for unreasonable or wasteful administrative expenses.*
- *It results in significant part from egregious conduct by the insurer, such as providing false information in prior rate filings, failing to provide required annual filings or purposefully charging inadequate rates.*

Some practical considerations in choosing and implementing one or more of these or other options include the following:

Most states do not review or approve rates for large employers. Typically, the fully insured medical plans are negotiated based on the employer's past experience and the insurer's administrative expense for that employer. Self-insured plans are not subject to state authority.

Most states review rates separately for each licensed entity, even though affiliated insurers often operate as one organization, charging the same rates and even covering one group through two different licensed entities.

Stringent review of rate increases might lead to greater variability. Carriers often try to keep their rate increases stable over time, even though that means losing money in bad years and making more money in good years. If a rate increase is categorized as unreasonable, carriers might reduce it to meet the standard of reasonableness, resulting in the need for a higher increase the next year than would have been the case.

After the HHS Secretary determines a standard nationwide definition of "unreasonable" rate increases that must be reported by an issuer, the states will likely review their statutes and regulations and decide whether to add that definition to their standards for rate review and/or approval. If the standard is specific and objective, then the states will likely apply it consistently. Any subjectivity or generality would make the standard more flexible to apply to different circumstances, and arguably more equitable in its application, but would also likely lead to variations in application of the standard by the states that use it.

Those states that regulate rates usually review all rate increases, not just the ones that fail some test such as those listed above. Many states require annual rate filings for comprehensive health insurance, even if the rates are not changing. These requirements can provide a history of a company's rates, and help preclude rate "catch-up" when a company has neglected to increase the rates for a long period.

Many states use "prospective" regulation of rates, while others use "retrospective" regulation. Prospective regulation includes prior review and/or approval of rates, while retrospective regulation includes "file and use" where the rates go into effect, but the regulator can take action if the rates are later determined to be unreasonable under a standard such as one of the above. Retrospective regulation often relies on consumer complaints to indicate a problem with a company's rates.

Those states that require minimum loss ratios usually require companies to provide an actuarially valid demonstration that the future expected loss ratio is higher than the minimum. In contrast, another form of retrospective regulation is a guaranteed loss ratio, such as the requirement in the PPACA, either instead of (or in addition to) a review of rates. Under this method, refunds are required if the minimum loss ratio is not met. When a rate results in an actual past loss ratio lower than the minimum, the excess premium is rebated to the insured after the fact.

The rate review process is not a mechanical one, where a state can just check that a company's rates comply with specific requirements. Most states that review rates have qualified actuarial staff and/or consultants who apply technical knowledge of the health care market and professional judgment to review of health rate filings.

Some states have no regulation of comprehensive medical rates, although they might track and/or publish the rates or rate increases in the state.

Most states have different types of prospective or retrospective rate regulation for different comprehensive medical markets, such as individual, small employer, association group, employer-paid, blanket coverage, mini-medical coverage and state/local employee plans.

The requirements in the PPACA for the HHS Secretary's review of "unreasonable" increases by the HHS Secretary and the ensuring of "public disclosure" are also retrospective regulation, unless the interpretation of "prior to the implementation" is a 45-day or 60-day period to allow the HHS Secretary to persuade the company to reduce the level of increase. Because no enforcement mechanisms that would prevent use of the unreasonable rate increase appear in the PPACA for this provision, it does not appear to be intended as a prior-approval requirement.

The main advantage of prospective regulation is the prevention of harm to consumers by denying or reducing a proposed rate increase. Another advantage is that early regulation can effectively use lesser penalties, such as denial of a rate filing, and avoid such steps as large fines and cease-and-desist orders.

The main advantage of retrospective regulation of rates is lower cost to the state and to the company, and faster implementation of necessary changes. The cost is related directly to any non-compliance, and is not a burden on the compliant companies.

The competitive marketplace discourages excessive rates. With retrospective regulation, a state's market conduct or enforcement staff will intervene after state law has been violated. Sometimes the cost is minimal, while other times the cost can be large, but it can usually be charged to the insurer.

When effectively enforced, both types of regulation create a sentinel effect that incents companies to manage their rates. The public disclosure in this section of the PPACA might have a similar sentinel effect.

Reporting and auditing issues are critical to rate regulation. The NAIC has developed uniform nationwide reporting and auditing standards, which allow states to compare the information provided in rate filings by companies to the audited financial statement of those companies. State insurance regulators have found that oversight, reporting and verification of compliance with the law are critical to protecting the consumer.

Other consumer protections — such as clearly written policy forms, advance notice to consumers of rate increases and assistance to consumers with a complaint — are critical companions to rate regulation. Without these protections, prohibition of unreasonable rate increases is not effective in protecting consumers.

One complicating factor is the question of which state regulates rates for a policy that was issued in one state, but the insured resides in another state. The standard for most types of insurance is that the "state of issue" regulates a policy. However, due to the proliferation of group medical policies that purport to be issued in one state of situs, but that cover residents of other states, a number of states have adopted rate regulation for any medical policy that covers a resident of that state. This results in a situation where two or more states may be regulating the same policy.

The Medicare Advantage and Medicare drug programs regulated by the U.S. Centers for Medicare & Medicaid Services (CMS) might offer useful information on the rate review process. The CMS process is known as desk review. Desk reviews of all bids are conducted annually by actuarial consulting firms that contract with CMS. The certifying actuary for each bid must answer desk review questions related to rate development and compliance with CMS rules. In addition, the programs rely on a comprehensive and easily used rate and benefit comparison tool available on the www.medicare.gov website, and

on a network of senior consumer counselors to help purchasers to compare rates and coverage. This has worked well to enroll millions of seniors efficiently. However, some companies have increased their rates significantly or have withdrawn from the market, forcing their customers to switch to another company with little notice. Also, at least one company has been ordered by CMS to cease and desist offering Medicare drug coverage due to its marketing methods.

a. To what extent do States currently have processes in place to review premium rates and rate increases?

Many states have prior review or approval of rates for comprehensive medical policies sold to individuals or to small employers to cover their employees. These policies usually offer family coverage. The details of the review process vary among states. The NAIC has prepared and attached a table summarizing the review process currently in place in each state, which is included in the Compendium of State Laws on Insurance Topics (Compendium).

The NAIC also has prepared and attached detailed descriptions of the rate review processes currently in place in Iowa, Minnesota, New York, Oregon and Pennsylvania.

i. What kinds of methodologies are used by States to determine whether or not to approve or modify a rate or a rate increase? What are the pros and cons of these differing methodologies?

The NAIC has several documents to provide guidance to the states in rate review, including the Health Policy Rate and Form Filing Model (#165), the Guidelines for Filing of Rates for Individual Health Insurance Forms (#134), and the Small Group Rating Compliance Manual. These documents are available to the Department of Health and Human Services on request.

Most states with rate review laws require that the company provide a qualified actuary's opinion that the rates are reasonable and comply with state law, as described in model #134. This allows the states to rely on the Code of Professional Conduct and the Standards of Practice that actuaries must follow. Here are links to the code and five standards that apply to rate filings.

- *Code: http://www.actuary.org/pdf/prof/code_of_conduct.pdf.*
- *Number 8—Regulatory Filings for Health Plan Entities, www.actuarialstandardsboard.org/pdf/asops/asop008_100.pdf.*
- *Number 23—Data Quality, http://www.actuarialstandardsboard.org/pdf/asops/asop023_097.pdf.*
- *Number 25—Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages, http://www.actuarialstandardsboard.org/pdf/asops/asop025_051.pdf.*
- *Number 26—Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans, http://www.actuarialstandardsboard.org/pdf/asops/asop026_052.pdf.*
- *Number 41—Actuarial Communications, http://www.actuarialstandardsboard.org/pdf/asops/asop041_086.pdf.*

ii. Are special considerations needed for certain kinds of plans (for example, HMOs, high deductible health plans, new policies, and closed blocks of business)? If so, what special considerations are typically employed and under what circumstances?

Companies that are new to a market or that have a small share of the market often receive special consideration. These companies might have start-up expenses and overhead to cover on a relatively small base, but these companies might serve a niche population such as farmers, high-risk industries or low-income individuals. Therefore, the rate review process might need to be adjusted to reflect the social advantage of having the company participate in the market. In addition, smaller or start-up companies might provide valuable innovation in a state, providing examples of ways to provide excellent coverage at a low cost.

Some large employers and associations are exempted by many states from rate review, because they negotiate the rates with the insurer based on their own experience, and have the ability to change insurers if they are dissatisfied. However, associations that provide individual or small employer coverage are often subject to review of the rates by states. A small employer that operates in more than one state should be subject to rate review only in the state that has the most resident employees.

Note that grandfathered plans are exempt from the rate review requirements, although not from the MLR and rebate requirements. It appears that state laws regarding rate review would stay in place, and apply to all plans, but that rate review information reported to the HHS Secretary would exclude grandfathered plans. Those states that do not have review authority for comprehensive medical rates might wish to add it, because the possibility of higher rate increases on

grandfathered plans than on non-grandfathered plans might cause concern. Also, the HHS Secretary might ask for information on grandfathered plans as background for the rate review process for non-grandfathered plans.

Regulation of rate increases is less needed in "guaranteed issue" markets where insurers are required to accept all applicants, such as small employer coverage in most states, or are likely to accept all applicants, such as for employer-paid large group coverage. If a premium rate is excessive, the policyholder can simply apply for coverage from another company with lower rates. However, even in guaranteed issue markets, effective prevention of unfair rate discrimination is needed. Guaranteed issue of coverage is not very useful if it comes with an unaffordably high premium rate for those with pre-existing conditions or the need for coverage, such as maternity benefits.

HMO premium rates are sometimes regulated by a separate state agency, such as the California Department of Managed Health Care or the Minnesota Department of Health. The Compendium contains a chart listing the separate agencies for each state. However, in most states, HMO rates are subject to the same rate review process as insurer rates. There are some differences in the structure of HMO rates, because of the close relationship between the medical care providers and the HMO.

For a relatively small closed block of individual comprehensive medical policies, a rate increase might in some circumstances be considered unreasonable even if it results in financial loss, if the company would still be financially sound. Although not desirable, sometimes the only alternative is to allow rates to increase to unreasonable levels for a few remaining customers who bought the policy in good faith. This is considered a special circumstance, and is usually considered on a case-by-case basis in state rate review.

b. Where applicable, do health insurance issuers currently provide actuarial memorandums and supporting documentation relating to premium rate calculations, such as trend assumptions, for all premium rates and rate increases that are submitted, and/or for all premium rates and rate increases that are reviewed?

Companies generally provide actuarial memorandums and supporting documentation relating to premium rate calculations, such as trend assumptions, only for premium rates and rate increases that are reviewed.

i. How is medical trend typically calculated?

Usually, "trend" is defined as the overall cost increase for a typical insured population in the state for a period, often expressed as an annual rate, including utilization changes and price changes — but not demographic changes that are reflected in the rates, such as age, gender or family size. For plans with a deductible, trend is adjusted for the impact of the fixed-dollar deductible, which makes the percent cost increase higher, especially for high-deductible coverage.

Some companies define trend as the historical increase in per-person cost for a particular block of business. While often appropriate, this can be unrealistically high due to anti-selective lapse (i.e., the tendency of healthier people to drop coverage), leaving higher average cost enrollees in the plan.

Historical trend is used for projecting future trend, after adjustments for known changes in conditions, such as aging of the population and changes in the typical benefits covered.

Some consulting actuarial firms publish their estimate of medical trend for the use of smaller companies that do not have statistically credible experience.

Although trend is considered a "safe harbor" for a rate increase, in some cases an increase equal to trend might be unreasonable. For example, if experience shows the rate to have been excessive in the recent past, a rate decrease might be the only reasonable action for the company to take.

ii. Are specific exhibits, worksheets or other documents typically required? If so, are these documents generally submitted to the State Insurance Department directly, and if so, in what format?

Most states specify the information that is required, but allow the company's actuary to provide the information in any reasonable format. Most states' requirements, including any worksheets, are accessible in the NAIC's System for Electronic Rate and Form Filing (SERFF) Web-based application.

iii. To what extent do issuers use the following categories to develop justifications for rate increases: cost-sharing, enrollee population including health risk status, utilization increases, provider prices, administrative costs, medical loss ratios, reserves, and surplus levels? Are there other factors that are considered?

Often, issuers combine the impact of cost sharing, population changes, utilization and pricing into a simple loss ratio calculation. Reserves or surplus levels are usually not directly used to justify rate increases, but may be implicitly incorporated in profit, risk, required rate of return or contribution to surplus.

Other justifications can include competitive analysis, anticipated changes such as new mandated benefits, the impact of health status loads/discounts, expected durational patterns in claim cost, or new taxes or fees.

c. What level(s) of aggregation (for example, by policy form level, by plan type, by line of business, or by company) are generally used for rate filings, rate approvals, and any corrective actions? What are the pros and cons associated with each level of aggregation in these various contexts?

Aggregation for rates is different from aggregation for loss ratio.

The states vary widely on aggregation requirements for rates. Some states impose limits on rate variations from a base rate (such as a 3:1 ratio for age factors, sometimes called "rate bands"). Those states might allow a different base rate for:

- *Different policy forms.*
- *Individual vs. group.*
- *Different sizes or types of groups.*
- *Different deductible levels or plan designs, such as health savings account (HSA) plans.*
- *Different marketing programs, such as Internet-based sales.*
- *Tobacco use.*
- *Wellness programs.*
- *Different provider networks.*
- *Different use of the network, such as point-of-service (POS) plans or exclusive provider organization (EPO).*
- *The dates that policies were issued (trend factors).*
- *The length of time since the policies were issued (durational rating).*

Generally, if the original rates were allowed to vary by certain categories, then rate increases may also vary by those categories. Conversely, if original rates were NOT allowed to vary by that category, then rate increases also may not vary by that category. However, most companies prefer to increase rates by a constant percentage, even if they could vary the percentage by categories. The advantages are simplicity, greater statistical credibility of the experience and moderation of exceptionally high increases.

Less aggregation for rates can lead to unfair discrimination — such as lower rates for newly issued business, high lapses for older business and rate spirals, which occur when a rate increase leads to relatively healthy people dropping their coverage, which leads to another rate increase and so on. More aggregation can lead to high lapses for customers who are paying more than the expected costs for their category.

For loss ratio purposes, companies generally prefer more aggregation because a block of business with a loss ratio that is lower than the minimum can be averaged with another block with a higher loss ratio. Less aggregation means that a company might be paying refunds or reducing rates on one block of business while losing money and trying to increase rates on another block.

Companies also prefer more aggregation for loss ratio calculations because greater size leads to greater statistical credibility and more consistency of results.

d. What requirements do States currently have relating to medical trend and rating calculations? What are the pros and cons of these different requirements, and what additional requirements could potentially be set?

Most states rely on actuarial expertise and professionalism in the calculations. Calculations are based on experience or statistical studies. Rating calculations must be actuarially sound, and the burden of proof is on the company.

i. Do States generally allow enrollees under the same policy form to be further subdivided for purposes of calculating medical trends and rates?

Yes, but only for categories such as benefit plan, age and geographic area that were already subdivisions for rating purposes. Also refer to the above answer.

ii. Do States generally allow enrollees under different policy forms to be grouped together for these calculations, and if so, how?

Yes, states often allow greater aggregation. The state may or may not consider it unfair to pool together policies with different risks and use the average. It is considered unfair discrimination to charge different rates to policies with identical risks.

2. Defining Unreasonable Premium Rate Increases

The Act provides that the initial and continuing rate review process under Section 2794 is only to be undertaken for unreasonable premium rate increases.

a. In States that currently have rate review processes, are all rates or rate increases generally reviewed? If so, for what markets and/or products? If not, what criteria do these States typically use when determining which rates or rate increases will be reviewed? To what extent do States require that these reviews take place before the proposed rate increases can be implemented?

As discussed above, those states that review rates usually review all rate increases. The particular market(s) or product(s) regulated and the review criteria vary significantly by state. See the chart from the Compendium and the attached detailed descriptions of sample states' review processes.

b. To what extent have States developed definitions of what constitutes a premium rate increase warranting review?

Most states either review all rates in a product line, such as individual comprehensive medical, or no rates in a product line. There are some exceptions, such as Alaska, which reviews rates only for their Blue Cross plan.

3. Public Disclosure

The Act requires that health insurance issuers prominently post the justification for an unreasonable premium increase on their Internet Web sites prior to implementation of the increase.

a. To what extent is information on premium rates and premium rate increases, and related justifications, currently made available to the public?

This varies significantly by state. See the attached table of public availability by state with links to state websites.

i. To what extent are annual summaries of premium rate increases currently made available to the public on State or consumer Web sites, and/or made available by request? Where available, to what extent is this information generally provided by policy form, type of product, line of business, or some other grouping?

This varies significantly by state. See the attached table of public availability by state with links to state websites.

ii. To what extent are rate filings with actuarial justification and supporting documentation generally made available to the public? In what format(s) are rate filings currently made available to the public?

This varies significantly by state. See the attached table of public availability by state with links to state websites.

What format(s) would be most useful to the public?

This question is difficult to answer in a fragmented market, where a person might not know if he or she is in a government plan, an ERISA self-funded employer plan, an association plan, a small group employer plan or a large group plan. Most consumers are interested in practical questions of affordability and the availability of switching to other coverage, not the technical details of rate review.

iii. What kinds of supporting documentation are necessary for consumers to interpret these kinds of information?

This is a difficult question that might be answered over time after the initial portals are established and consumers provide feedback. The portal must be able to screen for eligibility for public programs, high-risk pools, employer coverage and affordable individual coverage. It is difficult for consumers to compare value when coverage can vary extensively. Consumers need simple information on benefits and cost for coverage that is available to them.

b. What kinds of information relating to justification for an unreasonable premium increase could potentially be made available?

The information required in current rate reviewing states, or the information published by states now, could be a starting point. Companies should be allowed to add any additional information that would be useful in justifying a rate increase.

4. Exclusion From Exchange

For plan years beginning in 2014, States receiving grants in support of the rate review process must make recommendations, as appropriate, to the State Exchange about whether particular insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

a. To what extent have States developed definitions of what constitutes an excessive or unjustified premium rate increase and/or a pattern or practice of such increases? How could a pattern or practice of excessive unjustified premium increases be defined in this context, and what are some of the pros and cons of the various approaches that are available?

The states' definitions vary widely. Some states apply their definitions during rate review, while other states generally deal with problems on a case-by-case basis. A pattern or practice of such increases could be defined in a specific way — such as "two or more within a five-year period" or "two or more affecting at least 1,000 people each" — or could be defined more generally, such as "in the judgment of the Commissioner of a state or of the HHS Secretary." A specific, objective definition is easier to apply, but is arguably less equitable than a more general, subjective definition.

b. What criteria could be established to determine whether insurers have engaged in a pattern or practice of excessive or unjustified premium increases?

Criteria could include the number of people affected, the size of the excessive or unjustified increase, or the supporting justification or lack thereof.

5. Grant Allocation

The Act directs the Secretary to allocate $250 million in grant money to States to carry out the rate review process.

a. What factors could be considered in grant allocation?

- *Size of the state's population.*
- *Number of companies operating in the state.*
- *Number of languages in widespread use.*
- *Number of rate filings submitted in an average year.*
- *The state's ability to provide realistic estimates of the cost of specific deliverables.*
- *A state's past rate review process or lack thereof should not be a factor in determining the amount of the grant.*
- *The state gives specific, measurable deliverables and deadline dates that address the goals of rate review, including:*
    - *Develop legislative proposals for state law changes to improve rate regulation.*
    - *Set up ongoing collection of information about the medical insurance market.*
    - *Use checklists or other standard criteria for rate filings.*
    - *Establish deadlines for prompt state review of filings.*
    - *Consult with companies about efficient review.*
    - *Provide assistance to prospective purchasers of coverage.*
    - *Provide rate and benefit comparisons.*
    - *Establish standards for rates and rate filings.*
    - *Establish effective enforcement mechanisms..*
    - *Establish consumer advocate programs.*
    - *Establish consumer outreach programs for education, including websites.*

b. What weighting could be given to different factors and why?

Consideration should be given to the state's willingness to provide a binding commitment to specific measurable goals and deadline dates, and to commit to cost estimates for those deliverables. The amount of money granted to a state should be related to the amount of work that will be performed by the state.

B. Information Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of Section 2794 of the PHS Act will be economically significant. A rule that has an annual effect on the economy of $100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and issuers and, in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many ``respondents'' will be required to comply with any ``collection of information'' requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $135 million.

The Department is requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What policies, procedures, or practices of health insurance issuers and States may be affected by Section 2794 of the PHS Act?

Rate review procedures of some states might be affected significantly. Health insurance issuers should answer this question and the following ones relative to their policies, procedures and practices.

a. What direct or indirect costs and benefits would result?

Costs to the states should be covered by the grant program. The states and their residents will benefit from a more transparent and efficient health insurance market, with the assurance that health insurers participating in the Exchange will have their rating practices monitored by the states and that insurers that violate rating practice standards will be excluded from the Exchange.

b. Which stakeholders will be impacted by such benefits and costs?

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

2. Are there unique costs and benefits for small entities subject to Section 2794 of the PHS Act?

a. What special consideration, if any, is needed for these health insurance issuers or plans that they sell?

b. What costs and benefits have issuers experienced in implementing requirements relating to rate review under State insurance laws or otherwise?

3. Are there additional paperwork burdens related to Section 2794 of the PHS Act, and, if so, what estimated hours and costs are associated with those additional burdens?

This is currently unknown.

These responses represent the views of the National Association of Insurance Commissioners and the data is based on surveys of state departments of insurance. The information on state regulatory activities does not include those performed by other state regulatory agencies.

Iowa Individual Health Insurance Rate Increase Testing
May 2010

This paper attempts to shed some light on how individual accident and health (A&H) rate increase filings are reviewed in the state of Iowa. This applies to product lines such as major medical, Medicare supplement and any other individual lines of business subject to minimum loss ratio requirements. For these lines of business, insurance carriers are required to file and receive approval from the Commissioner's Office before they can change the premium rates on any policy. Rate increase requests should contain the following information:

1. A cover letter or general description that summarizes the request; i.e., x% increase proposed, a description of the policy forms affected, the proposed effective date, etc.

2. An actuarial memorandum — this is an integral part of any rate filing. The actuarial memorandum should describe in detail 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, etc. The memorandum should also demonstrate compliance with the loss ratio standards.

3. The experience; i.e., loss ratios of the policy forms to which the rate increase applies. The company is required to use a special template (Exhibit 1) to report the experience. The template includes the following columns: Calendar Year, Earned Premiums, On-Level Earned Premiums, Incurred Claims (including a claim reserve column), Life-Years Exposed, Pure Premium, Average Premium, Incurred Loss Ratio, Cumulative Los Ratio and On-Level Loss Ratio. The template also has a section for the projection of experience and assumptions used, calculation of the lifetime loss ratio with interest and the rate increase history for Iowa and for the nationwide block. The Division can also request an actual to expected demonstration via Exhibit 2. This template assists the Division in assessing how the current experience compares to what was anticipated using original pricing assumptions.

4. An actuarial certification signed and dated by a qualified actuary.

5. The revised rate sheets

We consider the review of health insurance rate increase proposals a two-step process, each with unique considerations and goals, but bound together by loss ratio requirements. I will start with a few main bullet points about each step, and then expand on these items separately in more detail starting on Page 2 (not included with this e-mail).

Step 1 Main Points:

- Analyze carrier experience, claim trends, and assumptions to determine if the rate increase proposal is actuarially justified. An internally developed rate increase model/template (the Iowa model) will be utilized to gauge the validity of the proposal
- If the Iowa model does not confirm the carrier proposal, a lower increase will be proposed. Thirty-five to forty percent of all A&H rate increase filings are negotiated to a lower amount. This is normally accomplished via email exchanges and/or conference calls with the company actuaries.

Other Considerations:

  - What kind of justification did the carrier submit for the assumptions utilized?
  - Are the actual to expected factors greater than 1.0?

Step 1's overarching goal is to determine if the carrier's proposal is reasonable and justified. It involves a short term projection which is typically from the mid-point of the chosen experience period to the mid-point of the proposed rating period. It should be noted that while the Iowa model has developed over the years, the basic foundation of it has not changed.

The simplest form of the model can really be boiled down to this formula:

On-level loss ratio (for chosen experience period) x (1 + Trend Factor)^x
---
Expected (target) pricing loss ratio (for the next year)

===> (where x=mid-point of the experience period to the mid-point of the proposed rating period in years and "on-level" means that the earned premiums have been restated to the current rate level)

Step 2 Main Points:

- Confirm that the lifetime loss ratio calculation will satisfy the state's minimum loss ratio requirements; the proposed rates must be used in the projection
- Lifetime means accumulated value of all past experience plus the present value of future anticipated experience

  Other Considerations:

  - Did the carrier use reasonable assumptions in the projection of experience?
  - Did the carrier use interest in the projections?

The lifetime loss ratio calculation will normally involve long-term projections (such as 10-years) or much longer for business such as long-term care insurance. The formula for the lifetime loss ratio calculation is shown below.

(Accumulated [past] incurred claims + P.V. of [projected] incurred claims)

(Accumulated [past] earned premiums + P.V. of [projected] earned premiums)

Minnesota Rate Filing Procedures for Major Medical Insurance

Julia Philips

May 10, 2010

All health insurance rates must be filed through the System for Electronic Rate and Form Filing (SERFF), the NAIC electronic filing gateway. In the SERFF instructions, there is a link to the "checklists" that give detailed guidance for form and rate compliance. Here are the information requirements that appear in the checklists for Individual and Small Group major medical insurance rates.

Minnesota Statutes 62A.65, Subd 3
Premium Rate Restrictions Apply to Individual Coverage

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year.
(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.
(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent.
(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use.
(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and
(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.
(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.
(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Checklist of Items to be included in Rate Filings For Individual Health Plans New Rate Sheets

1. Include **all** information needed to determine all rates charged.
2. Include details on proposed effective date or dates, and how implemented.

General Policy Data

1. Number of Minnesota policyholders and national policyholders.
2. Description of the type of policy, benefits, and general marketing method.

Premium Rate Restrictions

1. Demonstration that the premium restrictions of 62A.65 are met.
2. List of all individual health plan policy forms and date of most recently approved rate filing.

Experience Data

- Premium and claim experience for the last five years in Minnesota, as well as aggregate experience to date for the lifetime of the block. Include earned premiums, incurred claims, and earned/incurred loss ratios. Both Minnesota only and nationwide experience must be provided, if the Minnesota experience is not credible.

Rate Increase History

1. Dates that increases actually became effective since 1992.
2. If more than one date per increase, give detail and number of policies affected. 3. Documentation of compliance with annual filing requirement. [62A.021, Subd 1 (c)]

Rate Increase

1. Scope and reason for rate revision.
2. Relationship of proposed rates to current rates, especially noting maximum increase to be seen by any policyholder.
3. Verification of at least 12 months time between rate increases to any policyholder.
4. Support for anticipated claim cost trend.

Loss Ratio Standards

1. The anticipated future loss ratio for the period that rates will be effective, and a description of how it was calculated, including monthly or quarterly projected earned premiums and incurred claims.
2. A demonstration that the loss ratio standards of Minnesota Statutes 62A.021 are met. Such demonstration may include consideration of:

- The anticipated distribution by policy duration, with expected selection factors.
- Credibility of the Minnesota experience.
- Where credible experience is not available, calculation of expected claim cost based on other sources of credible data.

Certification

Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

Burden of Proof

The party proposing the rate has the burden of proving by a preponderance of the evidence that it does not violate Minnesota Statute 62A.02, Subd. 3.

Minnesota Statutes, Section 62L.08
Premium Rate Restrictions Apply to Small Employer Coverage

Health carriers may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

Restrictions Relating To Premium Rates – Checklist of Items to be included in Rate Filings for Small Employer Health Benefit Plans

I. New Rate Sheets, including all information needed in determining the rates charged.

II. General Policy Data
   A. Number of Minnesota Policyholders.
   B. Brief description of the type of policy, benefits, general marketing method and issue age limits.

III. Premium Rate Restrictions
   A. Demonstration that the premium restrictions of Minnesota Statutes, section 62L.08, are met.

IV. Experience Data
   A. Premium and claim experience for the last five years in Minnesota. Include earned premiums, incurred claims, and earned/incurred loss ratios. Both Minnesota only and nationwide experience must be provided, if the Minnesota experience is not large enough to be credible.

V. Complete history of all past rate increases since July, 1993 on small employer insurance *that were effective in Minnesota including the exact effective date.*

VI. Rate Increase
   A. Scope and reason for rate revision including a statement of whether the increase applies only to new business, only to in- force business, or to both.
   B. Descriptive relationship of proposed rate scale to current rate scale, especially noting maximum increases if different than averages.
   C. The description of the derivation of the rate increase **must** address the considerations required in the determination of reasonableness.

VII. Loss Ratio Standards
   A. The anticipated future premiums and claims by month for the period that rates will be effective, and a detailed description of how they were calculated.
   B. A demonstration that the loss ratio standards of Minnesota Statutes, section 62A.021, are met. Such demonstration may include consideration of:
      1. The concentration of experience at early policy durations where select morbidity (low claims from healthy insureds) is applicable and where loss ratios are expected to be substantially lower than at later policy durations. (Expected durational selection factors must be provided.)
      2. Credibility of the Minnesota experience.
      3. Where credible experience is not available, calculation of expected claim cost based on other sources such as experience in other states, consultant data, government data, and so on.

VIII. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

Health Insurance in New York

Except for those covered through public programs, most people are covered through employer-sponsored insurance. The New York insurance market consists of large group market (groups over 50), small group market (groups of 2-50) and individual direct pay market.

New York has considerably greater consumer protection compared to other states, including pure community rating and open enrollment. Community rating and open enrollment apply to the individual direct pay market, small group market and the large group HMOs. For the community-rated groups and individual direct pay policyholders, rate adjustments are put into effect under a file-and-use methodology and subject to only limited post-implementation regulation via a back-end minimum medical loss ratio (MLR) testing process using loss ratio reports with potential refunds or credits to the small group and direct pay policyholders.

The Healthy New York Program (small groups and individuals) and the Individual Direct Payment Health Insurance Program receive state-funded stop-loss subsidies.

New York Rate Review Process

Prior Approval: New products and initial rates, including changes to benefits and rate adjustments for non-community rated products, are submitted under the normal prior-approval process.

File and Use: For HMOs (individual, small group and large group), Article 43 corporations (not-for-profit HMDIs – individual and small group) and insurance companies (individual and small group), rate adjustments are submitted under an alternate procedure called "file and use." For health plans/insurers that use this procedure, all that is required prior to implementation of a rate adjustment is 30 days' notice to the policyholder, and a certification by an actuary or designated qualified person that the expected medical loss ratio meets the indicated minimum loss ratio (75% for small groups, 75% for individual policies issued by for-profit insurance companies, 80% for individual policies issued by HMOs and not-for-profit insurance companies and 65% per Regulation 62 for large groups). A loss ratio report is to be submitted the following year. If the actual loss ratio is below the required MLR, premiums refunds/credits to affected small group and individual policyholders are to be made.

Experience Rating: Except for HMOs, the large group market is experience rated. Only groups larger than approximately 400 lives (varies by company) are fully experienced rated with a credibility factor of 1.00. Groups with less than the specified number of lives are assigned a credibility factor of less than 1.00 and the premiums are calculated based on a combination of its own experience and the manual rates.

For the experience-rated group, the experience rating formulas are required to be filed with the New York State Insurance Department and approved before use.

April 30, 2010

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Department of Consumer and Business Services
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Health Insurance Rate Review in Oregon

Background: The Oregon Department of Consumer and Business Services, through its Insurance Division, must approve rates for individual, small group, and portability health insurance markets. In recent years, amid annual double-digit increases in rates, state policymakers and insurance regulators increased public access to rate filings and armed regulators with additional tools to curb rate increases.

Process: The department has sought legislation bringing transparency and stronger standards to its rate review process since 2007. The 2007 Legislature passed a bill making rate filings public and requiring the department to post the filings on its Web site. In 2009, as part of a large bill on health care reform, the Legislature made several additional improvements to the rate review process, which are described below. The department completed rulemaking to implement the law in February 2010, following a public hearing and after receiving input from an advisory committee of small-business, insurer, and consumer representatives. All aspects of the revised process are effective with rate requests filed on or after April 1, 2010.

Goals: While health care costs must be controlled before Oregonians will see significant changes in access to and affordability of health insurance, these changes are intended to promote competition among carriers, curb excessive rate increases, provide accurate data on factors driving insurance costs, and generally allow the public to participate in and understand the health insurance rate review process. In addition, the rate review rules clarify and standardize what constitutes a rate filing with the intent of simplifying the filing process for both the division and industry.

Key features of Oregon's rate review process:

- The department posts rate filings for individual, portability, and small-employer plans on its Web site once they are deemed complete. All information submitted as part of an insurance company's rate request is posted. The department has 10 days from receipt of a filing to determine if the filing is, in fact, complete.

- A required feature of the filing is a plain-language summary highlighting the insurer's request and its five-year history of rate increases for that line of insurance.

- The posting of the filing on the Web site triggers two key timelines:
  - A 30-day public comment period. Policyholders sign up on the department's Web site to receive an e-mail when their insurer files a rate request and again when the department makes a decision. Comments are posted to the Web site.
  - A 40-day timeline for the division to review the filing and issue its decision. The department must issue a decision within 10 days of the close of the public comment period.

- The department has explicit authority to consider factors such as an insurer's investment income, surplus, and cost containment and quality improvement efforts when reviewing a

rate filing. It may also consider an insurer's overall profitability rather than just the profitability of a particular line of insurance.

- Insurers must separately report and justify changes in administrative expenses by line of business and must provide more detail about what they spend on salaries, commissions, marketing, advertising, and other administrative expenses. The department established a worksheet specifying what should be reported and requires a five-year history of these expenses.

- Because every rate change tells its own story, the department files a plain-language summary on the Web site listing key factors underlying each rate filing decision.

Learn more about rate review:
The rules, required plain-language summary, and other documents and links to testimony for and against the department's rate review rules:
http://insurance.oregon.gov/rules/recent_admin_rules.html

Key consumer rate page: http://tinyurl.com/ORHealthRates

E-mail notification to sign up for rate filing alerts:
https://service.govdelivery.com/service/multi_subscribe.html?code=ORDCBS&custom_id=276

Oregon transparency efforts: Besides making rate filings public, Oregon has taken many steps to provide consumers with more information about health care costs to help them make informed decisions.

- Health insurers are required to provide their members with out-of-pocket cost estimates for common medical procedures, through either an interactive Web site or toll-free phone number, as a result of legislation passed in 2007. For more information, go to http://tinyurl.com/ORcostestimates.
- The Department of Consumer and Business Services publishes an annual report called "Health Insurance in Oregon," which provides financial and market data about Oregon's major health insurance companies. The report draws on additional information insurers have to report as a result of legislation the Governor signed in 2005, and is available online at http://tinyurl.com/OrHealthIns2010
- The state hosts a Web site that compares hospital costs at http://www.oregon.gov/OHPPR/RSCH/comparehospitalcosts.shtm. Information about hospital quality and evidence-based data on prescription drugs is also available at http://www.oregon.gov/OHPPR/index.shtml.
- As part of health reform legislation passed in 2009, the state will create a database of all health care claims by all medical providers, providing even more cost information to Oregonians.

Pennsylvania Rate Review Procedures

Data Required for a Rate Review

A rate filing must include an actuarial memo justifying the proposed rate change.
The memo should include the following:

- a brief description of the type of forms included, benefits provided, rating method used (attained or issue age),
- renewal provisions,
- insurer's NAIC number, the month and year that the rate revision is scheduled to be implemented,
- a statement declaring whether this is an open block of business or a closed block of business,
- the name, address, and telephone number of an insurance company representative who will be available to answer questions relating to the rate revision should be included in the actuarial memo or an accompanying cover letter,
- written and earned premiums, paid and incurred claims, the change in claim reserves, the change in active life reserves, and the incurred loss ratio,
- earned premium recalculated at the current Pennsylvania rate level and incurred loss ratios based on the recalculated earned premium,
- if the basis for determining reserves has changed over the life of the policy,
- national and Pennsylvania data shown separately. Data should be submitted in 12-month blocks; partial year data is generally not acceptable. All policy forms included in the data should be identified by their approved Pennsylvania policy form number. Data should be submitted separately for each policy form. Data can be grouped if policies have similar benefits, similar premiums, similar rate adjustment histories, and an actuary has certified that the forms are actuarially equivalent,
- the rate history for Pennsylvania (i.e. month, year, and percentage amount of all previous rate revisions) and show the nationwide rate history (i.e. the average rate change for the entire U.S. and the average implementation date),
- the number of policies in force and the average annual premium both in Pennsylvania and the entire U.S.

The methodology of the revised rate calculation must be explained. The memo should discuss the insurer's minimum guideline loss ratio, the trend factor used, the experience period used, the rating period used, and any credibility weighting of national and state data. The memo should show the percentage rate changes, the maximum and minimum change, and the aggregate change. The filing should provide the revised rate table in duplicate along with one copy of the current approved rates. The rate tables should clearly indicate the company name, form name and number, whether the rates are issue age or attained age, any applicable policy fees, and any factors used to determine the final gross rates (i.e. area factors, smoking factors, etc.).

The review period is 45 days, with an extension period of an additional 45 days. If the Department does not approve or disapprove the filing, it will deem into use at the conclusion of the review period.

The Department has adopted a practice of publishing all individual and small group filings to the Web to give the public a 30 day period to review the proposed change and comment on its impact. In these cases, the review period is delayed until the comment period ends. The public posting includes the entire filing, including memoranda from consulting actuaries, except where the company or consulting

actuary indicates that certain portions are proprietary trade secrets. Practices vary among companies and actuaries, with some claiming no such protections and others claiming broad protections.

Web posting has made the filings much more readily available than the Department's prior procedure, which was to make filings available in a public reading room at the Department's offices in Harrisburg. The new process has been used by individual consumers, though the dominant users are analysts representing a broad array of industry, consumer, employer, and other interests with the resources to review technical information and make it understandable to diverse audiences.

All approved rate filings and the supporting documentation are made available for public access on the Department's website: http://www.insurance.state.pa.us/dsf/rf_filings.html

Summary of State Public Access to Rates and Rate Filings

5/10/2010 **Julia Philips, Minnesota Dept of Commerce**

Note that almost all states that review rates make filings available if you come to the Department in person and ask for one

STATE	Publish Filings	Publish List	NOTES	LINKS
ALABAMA AL	At department	No		
ALASKA AK	At department	No		
ARIZONA AZ				
ARKANSAS AR				
CALIFORNIA CA				
COLORADO CO	At department	Internet	Can search for filings	http://www.dora.state.co.us/pls/real/Ins_RAF_Report.main
CONNECTICUT CT	At department	Only if hearing	Look in 2009 for Anthem Order	http://www.ct.gov/cid/cwp/view.asp?q=289000&cidNav=|48775|
DELAWARE DE				
DIST OF COLUMBIA DC				
FLORIDA FL	Internet	Internet	Can search, includes 0%	http://www.floir.com/DataReports/DataReports.aspx#Life%20and%20Health%20-%20Data
GEORGIA GA				
HAWAII HI				
IDAHO ID				
ILLINOIS IL	At department	Internet	Individual rate increase summary	http://www.insurance.illinois.gov/Reports/Report_Links.asp
INDIANA IN				
IOWA IA				
KANSAS KS	At department	No		
KENTUCKY KY				
LOUISIANA LA				
MAINE ME	Internet	Internet	Posts filing if have hearing	http://www.maine.gov/pfr/insurance/filings/filings.htm
			Brochure with individual rates	http://www.maine.gov/pfr/insurance/consumer/indhlth.htm#6
			Market summary	http://www.maine.gov/pfr/insurance/consumer/financial_results_health_insurers.htm
			Brochure with small employer rates	http://www.maine.gov/pfr/insurance/employer/smallemp.htm
MARYLAND MD				
MASSACHUSETTS MA				
MICHIGAN MI				
MINNESOTA MN	At department	No		
MISSISSIPPI MS				
MISSOURI MO				
MONTANA MT				
NEBRASKA NE	At department	Internet		http://www.doi.ne.gov/lh/filings/filing_index.htm
NEVADA NV	At department	No		
NEW HAMPSHIRE NH				
NEW JERSEY NJ	At department	Internet	All rates for individual coverage	http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm
			Examples of rate increases	http://www.state.nj.us/dobi/division_insurance/ihcseh/sehrates.htm
NEW MEXICO NM				
NEW YORK NY				
NORTH CAROLINA NC	Internet	No	Can search SERFF public portal	http://infoportal.ncdoi.net/filelookup.jsp?divtype=3
NORTH DAKOTA ND				
OHIO OH	At department	Internet	Sample open enrollment rates	http://insurance.ohio.gov/Consumer/Documents/Open%20enrollment%20sample%20premiur
OKLAHOMA OK				
OREGON OR	At department	Internet	Summary and search available	http://www.oregoninsurance.org/insurer/rates_forms/health_rate_filings/health-rate-filing-sear

PENNSYLVANIA PA	Internet	No	Notices and search available	http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276
RHODE ISLAND RI				http://www.ohic.ri.gov/2010%20RateFactorReview.php
SOUTH CAROLINA SC				
SOUTH DAKOTA SD				
TENNESSEE TN				
TEXAS TX				
UTAH UT				
VERMONT VT				
VIRGINIA VA	At department	No		
WASHINGTON WA				
WEST VIRGINIA WV				
WISCONSIN WI	Internet	No	Individual filings	https://ociaccess.oci.wi.gov/Companyfilings/jsp/rfsearch.oci
WYOMING WY				

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

The date following each state indicates the last time information for the state was reviewed/changed. 2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
AL (2/09)	§ 27-14-8; Ins. Reg. 482-1-024	Prior approval (30 day deemer)		Filing required for informational purposes only.	Accident & Health
AK (2/09)	§§ 21.42.120, 21.42.123, 21.42.125, 21.09.270, 21.39.040, 21.39.210 Order 83-1(exempts certain forms)	File and use with 30 day waiting period with compliance certificate; Prior approval (30 day deemer) without compliance certificate.	Retaliatory	Prior approval; file and use if change is no greater than 10%.	Each Insurer
AZ (2/09)	§ 20-1110 Reg. 20-6-607	Prior approval (30 day deemer)		Filed for review (HCSO and group health forms are not filed).	Individual Health
AR (2/09)	§ 23-79-109; AR Ins. Rule & Reg. 57	Prior approval (30 day deemer)	$50 policy, rider, application, per submission; $20 for each rider, application or endorsement filed separately; $20 for corrections in previously filed forms. $50 for each rate filing.	Prior approval (30 day deemer)	Individual Health

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
CA (2/09)	Ins. §§ 795.5, 10290, 10236.13; Ca. Admin. Code tit. 10 § 2202	Prior approval (30 day deemer)	Indiv./Group Health, Long Term Care: $580 Policy; $130 Rider; $130 New Issue Rate; $170 Rate Increase. Medicare Supp.: $330 Policy; $60 Rider; $130 Rates; $130 Rate Increase.	File Prior Approval	Individual Health and Group Health, Medical Supplement, Credit Health Long Term Care
CO (2/09)	§§ 10-16-107, 10-16-107.2, 10-10-109; Ins. Reg. 1-1-6; 4-2-11, 4-4-2; CO Bulletin B-4.18 § 10-16-321; Ins. Reg. 4-3-1	Prior approval	Included in general fee for services.	Prior Approval (60 day deemer); no need for approval if no increase requested (file and use). Prior Approval (30 day deemer)	All Health including Long Term Care and Credit Life and Disability. Medicare Supplement

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
CT (2/09)	§§ 38a-182, 38a-183, 38a-474, 38a-481, 38a-513; Reg. 38a-652; Reg. 38a-481-1 to 38a-481-4	Prior approval	Retaliatory	File and use Prior approval (45 days) Prior approval (30 day deemer)	Group LTC credit HMOs, med. supp., credit health Individual health except as noted above.
DE (2/09)	tit. 18 §§ 701, 2504, 2712, 3333	Prior approval (30 day deemer)	$50 policies, riders applications, endorsements $50 rate changes	File and use (45 days)	All Health including Med Supp., LTC, HMOs, Health Service Corps.
DC (2/09)	§§ 31-4712, 31-3508 § 31-3109	Prior approval (30 day deemer)		Prior approval (30 day deemer) File and Use (60 day review) Prior approval (90 day deemer)	Individual Accident and Sickness Hospital & Medical Services Subscriber Contracts Health products with mental illness benefit; drug or alcohol abuse
FL (2/09)	§ 627.410	Prior approval (30 day deemer)		Prior approval (30 day deemer)	All Health

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
GA (2/09)	§ 33-24-9, 33-8-1, 35-57-5; Reg. 120-2-10-.06, Reg. 120-2-25 (specifies limited exemptions from filings); § 33-57-5; GA Bulletin L&H-2	Prior approval (90 day deemer but could be extended for additional 90 days)	$25 form $75 rate	Information filing required for any rate increase or new program; increases must also be filed with Consumer's Insurance Advocate.	All Health
HI (2/09)	§§ 431:10A-113, 431:10A-309 § 431:14G-105	File—individual health Prior approval—med. supp.	$20 per form $50 per rate filing $20 for form and rate filing	Annual compliance filing Prior approval	Approved plans All managed care plans
ID (2/09)	§§ 41-1812, 41-2136; Ins. Reg. 18.01.44 §§ 011, 040	File and use, certification required	For rate and form filings not filed with SERFF and in excess of 10 per calendar year, $20 for each rate or form.	File and use, certification required.	Individual Health
IL (2/09)	215 ILCS 5/143, 5/355, 5/408; Reg. tit. 50 § 916.40	Prior approval	$50 per form; $200 per form for advisory and ratings orgs.	Rate filing shall be submitted with policy form filing.	Individual Health; Group Medicare supplement; Individual and Group Long Term Care

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
IN (2/09)	§ 27-8-5-1 § 27-13-7-11 §§27-13-20-1 to 27-13-20-2 § 27-1-3-15	Prior approval (30 day deemer) Prior approval (30 day deemer) Prior approval	$35 $35 $35	File and use (30 days) Prior approval (30 day deemer) Prior approval	Group Health Individual Health HMOs
IA (2/09)	§§ 514A.13; Reg. 191-30.5, 191-36.9	Prior approval (30 day deemer and 60 days prior to effective date)		Prior approval (30 day deemer and 60 days prior to effective date)	All Health
KS (2/09)	§§ 40-216, 40-2215	Prior approval (30 day deemer)		File and use	Individual and Group Health
KY (2/09)	§§ 304.14-120, 304.17-380, 304.17-383, 304.17A-095; Reg. 806 KAR §§ 14:007, 15:150, 4:010	Prior approval (60 day deemer)	$100; $5 all other forms	File and use	All Health

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
LA (2/09)	§§ 22:211, 22:620, 22:972; Reg. 78; §10107 (37:XIII.10107)	Prior approval (45 day deemer)	$100 per company per product for insurance policy filings	File and use (30 day deemer)	All Health
	§ 22:1078, Reg. 33 §545 and 550 (37:XIII.545 and 550)	Prior approval (45 day deemer)	Rates - $100 per company per type of standard benefit plan		
	Reg. 46 § 1917 and 1937 (37:XIII.1917 and 1937)	Prior approval (45 day deemer)	No filing fees required for rate for Long Term Care	Prior approval	Long term care
ME (2/09)	tit. 24-A §§ 601, 2412, 2736, 2802, 5004, 5011, 5075-A; Ins. Reg. ch. 940, 755, 275, 425, 140; Bulletin 146, 325, 326 and 337	Prior approval (30 day deemer)	Cannot exceed $20 per rate or form filing	File and use (60 days)	All Health, except individual, med supp., LTC, small group non-electing guaranty loss ratio option
MD (2/09)	Ins. §§ 12-203, 12-205, 2-112; Reg. 31.10.01.02, 31.10.01.02A, 31.04.17	Prior approval (60 day deemer)	$125 per form and rate	Prior approval (90 days for changes)	All health
MA (2/09)	§ 175:110; Reg. 801 CMR 4.02	No filing required	$75 per form $150 per rate	No filing required	Health group
	§ 176J: 3; Reg. 211 CMR 66.13	File and use		No rate filing, actuarial certification required	Small group
	§§ 176:4 to 176:5; Reg. 211 CMR 41.00	Prior approval (standard plan)		Prior approval	Non-group

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
MI (2/09)	§§ 500.2236, 500.2242(a), 500.3474 Reg. 500.801 to 500.806; Order 97-010-M	Prior approval (30 day deemer)	None	File and use	Individual Health
MN (2/09)	§§ 62A.02, 60A.14 § 62A.02, Subd 2(b)	Prior approval (60 day deemer)	$90 per rate or form filing; $75 per form or rate if filed electronically	Prior approval (60 day deemer) File and use	All policies Rates related to accident & sickness as defined in §62A.01. Does not include Medicare-related coverage.
MS (2/09)	§ 83-9-3; Ins. Reg. A&H 73-4	Prior approval	$15 policy $10 rider, endorsement $10 application	Prior approval Filed for review and acknowledgment	Med. Supp. and LTC Other Health
MO (2/09)	§§ 376.405, 376.777.7, 354.150, 354.495; Reg. tit. 20 § 400-8.200	Prior approval (60 day deemer)	$50	No provision	
MT (2/09)	§§ 33-2-708, 33-2-709, 33-1-501; MT ADC 6.6.508A, 6.6.1107	Prior approval (60 day deemer) Prior approval for Medicare Supplement	No fees for filing forms or rates	Prior approval for rates higher than those established. Rates must be accepted prior to use.	Credit insurance Med. Supp.

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
NE (2/09)	§ 44-710; Reg. tit. 20 ch. 009 §44-4501; Reg. tit. 210 ch. 46 Reg. tit. 210 ch. 36 NE Bulletin CB-50	Prior approval Prior approval Prior approval	Retaliatory	Rate schedules shall be filed with policy forms. Prior approval	All other Health Long Term Care Med. Supp.
NV (2/09)	§§ 680B.010, 687B.120, 689A.360, 680B.010; NV ADC 687B.229	Prior approval (45 day deemer)	$25 rates and policy $10 rider or endorsement	File and use Prior approval	Individual Health Medicare Supplement
NH (2/09)	§§ 415:1, 415:18, 400-A:35; Reg. Ins. 401.02, 401.03	Prior approval (30 day deemer)	Retaliatory	Prior approval (30 day deemer) File and use (30 days)	All individual health, group med supp., LTC, small employer medical, hospital or surgical All other group health
NJ (2/09)	§§ 17B:26-1, 17B:27-25, 17B:27-49, 17B:27E-11, 17B-27-74; Reg. 11:4-16, 11:4-18, 11:4-40	Prior approval (60 day deemer. Re-submission - 30 day deemer) Option to file and use available for certain forms		Prior approval (60 day deemer. Resubmission – 30 day deemer)	Individual Health, LTC
NM (2/09)	§§ 59A-18-12, 59A-18-13, 59A-6-1	Prior approval (60 days)	$30 policy package $15 incidental forms $50 rate filing	Prior approval (60 day notice to policy holder)	All Health

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
NY (2/09)	Ins. Law §§ 3201, 4308, 4235(h); 11 NYCRR 52.40	Prior approval (90 day deemer)	None	Prior approval	Individual health and group and blanket forms where jurisdiction applies
NC (2/09)	§§ 58-6-5, 58-51-85, 58-51-95, 58-65-40, 58-68-45, 58-67-50	Prior approval (90 day deemer) HSCO – Prior approval (within reasonable time)	None	Prior approval (all individual rate revisions, group med. Supp., medical service corp. rates)	All Health
ND (2/09)	§§ 26.1-11-06, 26.1-30-19 to 26.1-30-20	Prior approval (60 day deemer)	Retaliatory	Prior approval (60 day deemer)	All Health
OH (2/09)	§§ 3923.02, 3923.021; OH ADC 3901-1-57	Prior approval (30 day deemer)	$50 forms; no fee for rate filings	Prior approval (30 day deemer)	All Health
OK (2/09)	tit. 36 §§ 321, 3610, 4402, OK ADC 365:10-5-63, 365:10-5-47.1	Prior approval (30/60 day deemer depending on type of filing)	$50 policy or retaliatory if higher $25 rider or retaliatory if higher	Rates filed with form.	All Health, Credit Life and Health

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
OR (2/09)	§§ 742.003, 746.005, 743.018, 743.730(17)(27)(28), 743.737, 743.760; Reg. 836-010-0011	Prior approval (30 day deemer)		Prior approval	Individual and groups, except groups with more than 25 lives
	§ 836-052-0114	Prior approval		Prior approval	Medicare supp., except specific groups under Reg. 836-052-0114(5)
	§ 836-060-0043			Prior approval (for deviations from prima facie)	Credit life and health
	§ 836-060-0026 to 836-060-0031			File and use (for statutory prima facie)	Credit life and health
	Reg. 836-052-0510	Prior approval			Long term care individuals and groups

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
PA (2/09)	§§ 40-18-3809, 40-18-3803; 49 P.S. § 50	Prior approval (30 day deemer)	Retaliatory	Prior approval (45 day deemer)	All Health; some group exempt if meet requirements
RI (2/09)	§§ 27-18-8, 42-14-18, Reg. R27-23-1101 to R27-23-1102, R27-23-1106 to 27-23-1107	Prior approval (60 day deemer)	$40 policy and related forms filed together; $25 revised rate or form; retaliatory on fee-by-fee basis.	Prior approval (60 day deemer)	All Health
SC (2/09)	§§ 38-71-310, 38-71-720; Reg. 69-46; Bulletin 2-93	Prior approval (30 day deemer)		Prior approval (90 day deemer)	Individual Health, Group Med. Supp.
SD (2/09)	§§ 58-11-12, 58-11-17, 58-17-4.1	Prior approval (30 day deemer)		File and use (30 day deemer)	Individual health
TN (2/09)	§§ 56-26-102; Reg. ch. 0780-1-20	Prior approval (30 day deemer)		Prior approval (30 day deemer)	All health except experience rated groups
TX (2/09)	Reg. 28 TAC 3.1, 3.4; Ins. §§ 11153.051, 1701.051 to 1701.054	File and Use with certificate of compliance; Prior Approval without certificate (60 day deemer).	$50 exempt from review; $100 not exempt.	File and Use	Individual Health, Long Term Care, Credit Life, Accident and Health, Med. Supp.
UT (2/09)	§ 31A-21-201, 31A-3-103, 31a-3-108; Reg. R590-220	File and use	Included in annual fee	File and use	Individual health, med. Supp., long term care, health benefit plans

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
VT (2/09)	Ins. Reg. 93-5: tit. 8 §4062	Prior approval (30 day deemer)		Prior approval (30 day deemer)	All health
VA (2/09)	§ 38.2-316; Reg. 14 VAC 5-100-10 to 5-100-80; Reg. 14 VAC 5-130-10 et. seq.; 14 VAC 5-170-120, 14 VAC 5-200-77; 150 and 153	Prior approval (30 day deemer)		File and receive acknowledgment Prior approval	Group health Individual health, all med. supp.
WA (2/09)	§ 48.44.020 § 48.46.060 §§ 48.18.100, 48.18.010, 48.19.010, 48.20.025, 48.21.045, 48.66.035, 48.44.017, 48.44.023, 48.46.062, 48.46.066	File and use File and use Prior approval (30 day deemer)	No fee No fee No fee	Prior approval (60 day deemer) Prior approval (60 day deemer) Prior approval (30 day deemer) File and use (informational only) File and use (subject to disapproval)	Healthcare service contractor, large group HMO large group Small group health plan rate changes, med. supp Individual health plan All other health
WV (2/09)	§§ 33-6-8, 33-6-34, 33-16B-1; 114 CSR 26-3 § 33-6-8(b)(2)	Prior approval (60 day deemer) File and use (30 day disapproval)	$50 per form $75 per rate	Prior approval (60 day deemer); Rate filings required for new products or rate changes; rate filings shall be filed with forms.	All health Mass-marketed Health

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

2/09

STATE	CITATION	FORM FILING REQUIREMENT	FEE	RATE FILING REQUIREMENT	RATE FILING APPLIES TO:
WI (2/09)	§§ 625.13, 631.20; WI Bulletin 4-28-2008; Reg. § INS 6.05	Prior approval (30 day deemer); May file and use with certification; does not apply to long-term care or Medicare Supplement.	None	Use and file (30 days)	Individual health
WY (2/09)	§§ 26-15-110, 26-18-135	Prior approval (45 day deemer)	No fee	File and use	Disability

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the statutes and regulations cited should be consulted. The NAIC attempts to provide current information; however, readers should consult state law for additional adoptions.

FILING REQUIREMENTS
HEALTH INSURANCE FORMS AND RATES

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
AL (5/09)	§§ 27-21A-1 to 27-21A-32	Insurance Department (licensing, financial statements, investments, complaints, examinations, solvency)	Department of Public Health (licensing, complaints, examinations)
AK (5/09)	§§ 21.86.010 to 21.86.900	Insurance Department (licensing, rates, financial statements, complaints, examinations, solvency)	Department of Health and Social Services (licensing, complaints, examinations)
AZ (5/09)	§§ 20-1051 to 20-1078	Insurance Department (licensing, examinations, financial statements, solvency, assets transfer, disclosure forms)	Department of Health Services (examinations)
AR (5/09)	§§ 23-76-101 to 23-76-132	Insurance Department (licensing, solvency, rates, financial statements, complaints, investments, examinations)	Department of Health (licensing, financial statements, complaints, examinations)
CA (5/09)	§§ 1340 to 1399.64	Department of Managed Health Care (solvency, rates, examinations, financial statements, fraud, licensing, disclosure forms, advertising)	Insurance Department (consultative)
CO (5/09)	§§ 10-16-102, 10-16-401 to 10-16-427	Insurance Department (licensing, solvency, complaints, investments, examinations)	Department of Public Health and Environment (licensing, complaints, examinations)
CT (5/09)	§§ 38a-175 to 38a-194	Insurance Department (licensing, rates, solvency)	Department of Public Health (clinics)
DE (5/09)	§§101-106, 301-334, 501-535, 701-714, 901-915, 1101-1118, 1301-1332, 1501-1514, 1701-1723, 2101-2112, 2301-2318, 2501-2534, 2701-2755, 3301-3357, 3401-3410, 3501-3578, 3601-3608, 5001-5015, 5901-5944, 6401 to 6420	Insurance Department (solvency, licensing, financial statements , rates, examinations, investments, contracts, advertising, disclosure)	

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
DC (5/09)	§§ 31-3401 to 31-3431	Insurance Department (licensing, solvency, forms, investments, complaints, examinations	Department of Health (licensing)
FL (5/09)	§§ 641.17 to 641.3923	Insurance Department (licensing, financial statements, examinations, solvency, fraud, rates, forms, investments, advertisements)	Agency for Health Care Administration (licensing)
GA (5/09)	§§ 33-21-1 to 33-21-29	Insurance Department (licensing, solvency, complaints, investments, forms, financial statements, examinations)	Department of Community Health (licensing, examinations, health standards)
HI (5/09)	§§ 432D-1 to 432D-27	Insurance Department (licensing, solvency, financial statements, investments, examinations)	
ID (5/09)	§§ 41-3901 to 41-3940	Insurance Department (licensing, financial statements, examinations, rates, forms, complaints, solvency)	
IL (5/09)	125/1-1 to 125/5-9	Insurance Department (licensing, solvency, financial statements, contracts, investments, complaints, advertisements, rates, forms, examinations)	Department of Public Health (licensing)
IN (5/09)	§§ 27-13-1-1 to 27-13-43-2	Insurance Department (licensing, solvency, forms, financial statements, complaints, investments, rates, examinations)	
IA (5/09)	§§ 514B.1 to 514B.33	Insurance Department (licensing, solvency, powers of organization, rates, financial statements, complaints, investments, examinations)	Department of Public Health (licensing); Attorney General (incorporation)
KS (5/09)	§§ 40-3201 to 40-3235	Insurance Department (licensing, forms, examinations, financial statements, investments, solvency, complaints)	

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
KY (5/09)	§§ 304.38-010 to 304.38-230	Insurance Department (licensing, forms, rates, financial statements, investments, examinations, solvency)	
LA (5/09)	§§ 22:241 to 22:272	Insurance Department (licensing, investments, financial statements, solvency, examinations, complaints, forms)	Department of Health and Hospitals (financial statements)
ME (5/09)	tit. 24-A, §§ 4201 to 4252	Insurance Department (licensing, investments, solvency, financial statements, complaints, examinations)	Department of Health and Human Services (licensing, complaints, examinations)
MD (5/09)	§§ 19-702 to 19-735	Department of Health and Mental Hygiene (quality standards, complaints, licensing, examinations)	Insurance Department (complaints, licensing, solvency, rates, forms, financial statements)
MA (5/09)	§ 176G:1 to 176G:30	Insurance Department (advertisements, examinations, financial statements, licensing, rates)	
MI (5/09)	§§ 500.3501 to 500.3580	Insurance Department (licensing, quality standards, rates, financial plan, examinations, solvency)	
MN (5/09)	§§ 62D.01 to 62D.30	Department of Health (licensing, investments, financial statements, complaints, advertisements, examinations, solvency)	
MS (5/09)	§§ 83-41-301 to 83-41-365; 83-19-51	Insurance Department (licensing, quality assurance, solvency, investments, forms, financial statements, complaints, rates, examinations)	State Health Officer (licensing, financial statements, complaints, examinations)
MO (5/09)	§§ 354.400 to 354.551; MO. CODE REGS. tit. 20, §400-7.110	Insurance Department (licensing, solvency, financial statements, complaints, investments, examinations, advertising)	

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
MT (5/09)	§§ 33-31-101 to 33-31-405	Insurance Department (licensing, merger/consolidations, financial statements, investments, solvency, forms, complaints, examinations)	
NE (5/09)	§§ 44-3292 to 44-32,180	Insurance Department (licensing, exercise of power, solvency, forms, financial statements, investments, complaints, rates, examinations)	Department of Health and Human Services (licensing, financial statements, complaints, examinations)
NV (5/09)	§§ 695C.010 to 695C.350	Insurance Department (licensing, solvency, exercise of power, investments, forms, disclosures, financial statements, complaints, examinations)	Board of Health (licensing, financial statements, examinations)
NH (5/09)	§§ 420-B:1 to 420-B:26	Insurance Department (licensing, forms, rates, advertisements, financial statements, examinations, complaints, investments)	State Health Planning and Development Agency (licensing) Department of Health and Human Services (financial statements)
NJ (5/09)	§§ 26:2J-1 to 26:2J-47	Department of Health and Senior Services (licensing, financial statements, complaints, investments, quality, quality/delivery, examinations, forms/filing, advertising)	Department of Banking and Insurance (licensing, forms, rates, financial statements, investments, solvency, financial/market conduct examinations)
NM (5/09)	§§ 59A-46-1 to 59A-46-49	Insurance Department (licensing, solvency, quality of service, forms, financial statements, complaints, investments, rates, examinations)	Department of Health (licensing, examinations)
NY (5/09)	§§ 4400 to 4414	Department of Health (licensing, complaints, solvency, examinations, fraud)	Insurance Department (forms, licensing, solvency, examinations, fraud)

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
NC (5/09)	§§ 58-67-1 to 58-67-185	Insurance Department (licensing, investments, changes to articles of incorporation, forms, advertising, solvency, rates, financial statements, examinations)	
ND (5/09)	§§ 26.1-18.1-01 to 26.1-18.1-25	Insurance Department (licensing, changes affecting financial soundness, investments, solvency, quality of care, forms, financial statements, complaints, rates, examinations)	
OH (5/09)	§§ 1751.01 to 1751.89	Insurance Department (licensing, rates, complaints, advertising, investments, forms, financial statements, examinations, solvency, quality of care)	Department of Health (licensing, financial statements, examinations)
OK (5/09)	§§ 6901 to 6936	Insurance Department (licensing, quality of care, forms, exercise of power, financial statements, investments, complaints, solvency, rates, examinations)	Department of Health (licensing, quality of care, complaints, general rulemaking, examinations)
OR (5/09)	§§ 750.003 to 750.095	Insurance Division, Dept. of Consumer & Business Services (capitalization, solvency)	
PA (5/09)	§§ 1551-1567; PA. CONS. STAT. §§ 40-83-101 to 40-83-119	Insurance Department (licensing, examinations, rates, financial statements)	Department of Health (licensing)
RI (5/09)	§§ 27-41-1 to 27-41-54 (2009)	Department of Business Regulation (licensing, exercise of power, solvency, rates, financial statements, complaints, investments, examinations)	Department of Health (licensing, financial statements, complaints, examinations)
SC (5/09)	§§ 38-33-10 to 38-33-325	Insurance Department (licensing, exercise of power, financial statements, complaints, investments, advertisements, examinations)	

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
SD (5/09)	§§ 58-41-1 to 58-41-119	Insurance Department (licensing, rates, financial statements, investments, advertising, examinations, solvency)	Department of Health (licensing, examinations)
TN (5/09)	§§ 56-32-101 to 56-32-138	Commerce and Insurance Department (licensing, solvency, forms, rates, exercise of power, financial statements, complaints, investments, advertising, examinations)	Department of Health (licensing)
TX (5/09)	§§ 843.001 to 843.464	Insurance Department (licensing, solvency, complaints, forms, rates, standard of care, financial statements, examinations)	
UT (5/09)	§§ 31A-8-101 to 31A-8-502	Insurance Department (licensing, examinations, solvency, quality of care)	Department of Health (licensing, quality of care)
VT (5/09)	§§ 5101 to 5115	Insurance Department (licensing, complaints, insolvency, forms, rates, examinations, financial statements)	
VA (5/09)	§§ 38.2-4300 to 38.2-4323	State Corporation Commission (licensing, solvency, forms, rates, financial statements, investments, advertising, examinations)	Department of Health (financial statements, examinations)
WA (5/09)	§§ 48.46.010 to 48.46.920	Insurance Department (licensing, forms, financial statements, complaints, examinations, solvency)	Department of Social and Health Services (licensing, quality of care)
WV (5/09)	§§ 33-25A-1 to 33-25A-35	Insurance Department (licensing, exercise of power, solvency, quality of care, forms, rates, financial statements, complaints, investments, advertisements, examinations)	Department of Health and Human Resources (examinations)

DEPARTMENTAL REGULATION OF HMOs

8/09

STATE	CITATION	PRIMARY REGULATOR	SECONDARY REGULATOR
WI (5/09)	§§ 609.001 to 609.98	Insurance Department (licensing, quality of care, complaints, examinations, forms)	
WY (5/09)	§§ 26-34-101 to 26-34-134	Insurance Department (licensing, exercise of power, solvency, forms, rates, financial statements, complaints, investments, examinations)	Department of Health (licensing, quality of care, financial statements, complaints, examinations)

DEPARTMENTAL REGULATION OF HMOs