



Product Filing Review Handbook

October 2018



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PRODUCT FILING REVIEW HANDBOOK

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INTRODUCTION

Overview

The Product Filing Review Handbook is intended to help insurance regulators provide speed to market for insurers while maintaining a high level of consumer protection by enforcement of state laws and regulations related to the sale of insurance products. One of the reasons that insurers complain about lack of timely review of their filings is that states, in the past, have used a wide variety of regulatory processes that might not be transparent to insurers. To address this concern, the Handbook is intended to add uniformity and consistency of regulatory processes, while maintaining the benefits of the application of unique laws and regulations that address the state-specific needs of the nation's insurance consumers.

Regulators have identified a need to have available for easy reference one source that compiles the latest NAIC speed-to-market filing tools along with instructions on their use and other related relevant information. The Handbook has been created to be that source. In addition, the Handbook will serve as a training tool for new product filing reviewers.

The Handbook provides basic information about the filing and review of rate, rule and form filings for all lines of insurance. It also explains basic ratemaking processes for those products that are subject to various forms of rate regulation. It provides guidance in the form of procedures that states can implement uniformly to make the filing process more transparent, to make it easier for insurers to achieve compliance and to benefit insurance consumers by assuring that appropriately priced, compliant insurance products are available to them in a timely fashion.

The System for Electronic Rate and Form Filing (SERFF) allows insurers, advisory organizations, and third-party filers to submit insurance product filings (typically rate, rule, and form filings) electronically to state insurance regulators. This is a true multi-state electronic filing system (licensed in all jurisdictions), has been tried and proven, and is explained in this Handbook. The Handbook reviews advantages of SERFF for the regulator, the filer, and for society. It outlines how the electronic filing system works and discusses future expectations for SERFF.

Using the Handbook

NAIC staff is available to answer any questions readers might have about the Handbook and the product development, filing, and review processes.

Handbook Revisions

Suggestions for improving or correcting information contained in the Handbook may be made via the Speed to Market Filing Suggestion Form. This form may be accessed from the NAIC website (www.naic.org) as follows:

- Regulators: Click on "Members and Regulators," then click on "Speed to Market Resources." Under "Rates and Forms Filing/Speed to Market," click on "Speed to Market Filing Suggestion Form."
- Industry: Click on "Industry Licensing and Filing." Under "Rates and Forms Filing/Speed to Market," click on "Speed to Market Filing Suggestion Form."

Suggested changes will be carefully considered by the Operational Efficiencies (EX) Working Group of the Speed to Market (EX) Task Force. Substantive changes made will be announced, while mechanical corrections (e.g., editorial or typographical changes) will be made without announcement in later editions.

CHAPTER ONE

A Brief History of Rate and Form Regulation

To help the reviewer understand why insurance is regulated as it is today, some historical perspective is provided.

Early World History

Since ancient times, insurance has evolved to satisfy the risk-bearing needs of society. With the advent of trade, shipping, and credit facilities in medieval Europe, insurance arrangements also appeared. A number of insurance, financial, and commercial centers developed in Antwerp, Amsterdam, London, and a number of Italian cities. Marine insurance, for example, appeared in Italian ports as early as the 12th century. These centers became more prosperous not only because they met commercial needs, but also because various government sanctions ensured the enforcement of contracts.

London had surpassed other insurance markets by the end of the 18th century. The Great Fire of London in 1666 helped lead the development of insurance in England and was to be replicated throughout the British Empire. Insurance in the United States developed from these roots.

Early U.S. History

The first U.S. insurance plans were based on membership in an organization. In 1736, the Friendly Society, operating under a Royal Charter from England, was formed as a mutual company in South Carolina. It covered the fire losses of its members, who contributed directly to a fund that paid claims.

Benjamin Franklin organized the first incorporated fire insurance company in colonial America in 1752, called the Philadelphia Contributionship. The insurer remains today the oldest mutual fire insurance company in business in America. Fire marks were used to identify the houses insured by the insurance company so that its fire-fighting brigade would know which dwellings they were to protect. The Philadelphia Contributionship selected as its fire mark four hands crossed and clasped, a form commonly known as “Hand-in-Hand.”

After colonial independence from England was achieved, insurance companies were chartered by individual states, thus beginning regulatory limitations on insurer activities and insurer investments. By 1824, the state of New York imposed a 10% tax on premiums written by fire insurance companies incorporated in other states. This practice was quickly adopted by many states.

Insurance company financial examination began in New York in 1828. By 1853, New York law required that all companies incorporated in that state file prescribed annual reports, signed by officers under oath. This 1853 enabling law contained three sections (marine, fire, and life) and was widely imitated by other states. Insurance companies in the United States were, at that time, therefore limited to one phase of the business, while insurance companies in the other parts of the world were not restricted in this way.

As the United States gained its independence and progressed through the industrial revolution, insurance companies formed and became more active. By the mid-1800s, insurers were thriving in New England and developing their own customized fire insurance contracts. The absence of standard wording in these contracts presented many problems, however, in the interpretation of coverage. It became clear that a more uniform approach was desirable. Massachusetts adopted a standard form for writing fire insurance in 1873, followed in the next few years by several other states. The New York state legislature, in collaboration with the insurance industry, adopted a standard fire policy form in 1887, revised it in 1918, and by July 1, 1943, it had evolved into the “165 line form,” popularly referred to as the New York Standard Fire Policy. The 165 line form was soon approved by reference in most states, with some states during that period incorporating the exact wording into statute.

With economic growth came increasing awareness of the need for state government oversight of the insurance industry. In 1851, the first state insurance commissioner was appointed in New Hampshire. By 1870, many states had appointed officials to oversee insurance.

Paul v. Virginia

The question of whether the states or the federal government should regulate the business of insurance has been with us since the mid-1800s. To help clarify the matter, in 1869 the U.S. Supreme Court, in *Paul v. Virginia*, held that insurance was not commerce and was, therefore, not subject to federal regulation under interstate commerce laws. This quintessential case has shaped the regulation of insurance to this day.

The following paragraphs describe events and arguments related to *Paul v. Virginia*:

In May 1866 Samuel Paul, a resident of Virginia, was appointed the agent for a number of New York insurance companies. Earlier that year the Legislature of Virginia had passed a statute providing that no person shall, without a license authorized by law, act as agent for any foreign (other state) insurance company. The New York insurance companies were hoping to invalidate the Virginia statute through the court case.

Samuel Paul did not comply with all requirements of the Virginia statute for obtaining the required license, so it was disallowed. However, Mr. Paul subsequently sold a fire insurance policy in Virginia and was therefore convicted by the Virginia Circuit Court. The case ultimately was appealed to the United States Supreme Court on the grounds of writ of error, principally being that the judgment violated the Commerce Clause, which empowers Congress “to regulate commerce with foreign nations, and among the several states.”

The U.S. Supreme Court decision on *Paul v. Virginia*, read Nov. 1, 1869, upheld the Virginia court decision and added that such law does not conflict with the provisions of the Constitution—that Congress shall have power to regulate commerce among the several states. The Supreme Court justices further noted the following:

Issuing a policy of insurance is not a transaction of commerce. The policies are simply contracts of indemnity against loss by fire, entered into between the corporation and the assured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. Such contracts are not interstate transactions, though the parties may be domiciled in different states. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions governed by the local law.

Paul v. Virginia, therefore, was the reason that the states were initially charged to regulate the business of insurance. The National Insurance Convention of the United States was formed in 1871 in large part because of *Paul v. Virginia*. The National Insurance Convention of the United States provided the insurance commissioners with a national forum for discussion of common issues and interests that transcended the boundaries of their own jurisdictions (known since December 1935 as the National Association of Insurance Commissioners, or NAIC).

Antitrust Laws

A fundamental political question of the last quarter of the 19th century and first quarter of the 20th century in the United States pertained to trusts; i.e., combinations of business firms that attempted to dominate the market and typically control pricing. For example, the Standard Oil Trust established in 1879 combined the property of more than 40 petroleum refining and pipeline companies, representing approximately 90% of that industry. The market power of such combinations concerned consumers and led to political action. During the years 1887 through 1916, the following major legislation was passed by the U.S. Congress, reflecting a new business climate and new role for government: Interstate Commerce Act, Sherman Antitrust Act, Clayton Antitrust Act, and Federal Reserve Act.

The passage of these laws was intended to remedy trust abuses of economic power by outlawing collusion or conspiracy that restrained trade. Insurance consumers had hoped that state and federal antitrust laws would limit the ability of insurers to raise rates. However, the application of the antitrust laws to insurance proved to be a complicated matter.

Munn v. Illinois

A number of states passed laws in the 1870s to regulate rates charged by railroads and other private firms. These laws were challenged and appealed to the U.S. Supreme Court in the case of *Munn v. Illinois*. In that case the Supreme Court upheld the power of a state to regulate the rates charged by a private business, provided the regulated market was “affected with the public interest.” This decision was important as it resulted in a distinct set of legal principles for quasi-public or public

service companies. These firms, unlike corporations in general, were therefore obligated to provide universal service and uphold the public interest for the common good.

Life Insurance

While of little importance in the early history of the United States, life insurance companies, by the end of the 19th century, enjoyed spectacular growth, which turned them into dominant financial institutions with considerable influence.

The Armstrong and Merritt Committee Investigations

In the early 1900s, there were several abuses in the life insurance industry regarding sales practices, investment and several management practices by New York-based companies. The Armstrong Committee investigation, which uncovered numerous financial improprieties, began in New York in 1905 and shaped many insurance laws, including the prior approval insurance product and rate requirements that have been in place in some jurisdictions for more than a century. One important outcome of the Armstrong Committee investigations and subsequent legislation was in the area of policy language and provisions. The first insurance policy provision regulations, called the Uniform Standard Provisions Law, came into being in 1911.

The Armstrong investigation encouraged leading New York legislators to also call for investigations into the fire insurance industry, where they believed similar corruption or profiteering would be identified. The Merritt Committee, which met from 1910 and 1911, was formed through the New York state legislature for this purpose, but instead found that most fire insurance companies brought in only modest profits and concluded that cooperation among firms was often in the public interest.

The Merritt Committee did, however, suggest the licensing of agents, the admission of miscellaneous mutual companies, and a prohibition against rebating. Regarding rating, the committee endorsed schedule rating—which rating bureaus had developed to charge lower rates for buildings with sprinklers or construction that reduced the probability of fire damage. Schedule rating, however, would require insurance companies to cooperate through rating bureaus. The New York state legislature responded with a 1911 rating law that authorized four rating bureaus to operate in that state, provided each disclosed their procedures and submitted to examination by the state insurance department.

The ensuing laws following the Armstrong and Merritt Committee investigations mandated New York state review of rates to prevent discrimination. The laws also required insurance companies to submit uniform statistics on premiums and losses for the first time. Other states soon adopted similar requirements and, by 1920, more than half of the states had some form of rate regulation.

Development of Rating Bureaus

Insurance companies frequently had tried to organize the market to control rates. Early rating bureaus were privately owned—to avoid antitrust laws. As state rating bureau restrictions became reduced, more fire insurance rating bureaus were established in the states. Regional advisory organizations, with eventually inter-regional advisory organizations mostly replacing them, took control of the local fire bureaus due to the need for uniform approaches to ratemaking and form language. Separate rating bureaus also developed for other lines of insurance: inland marine, casualty, surety, workers' compensation, and multiple-line insurance. Bureaus today are commonly referred to as advisory organizations offering actuarial, statistical, underwriting, and standard policy language form services.

The Lockwood Committee Investigation

Another New York state legislative investigation, the Lockwood Committee, confirmed the continuance of insurance practice inequities. As a result, the New York Rate Law of 1922 was passed, which required that the New York State Insurance Department regulate insurance rates for all lines other than the following: life, marine, and accident and health. The New York State Insurance Department was to attempt to determine if the rates were “reasonable”; i.e., neither excessive nor inadequate. With this law change, casualty insurance companies in New York were now to be required to file a Casualty Experience Exhibit with the state. Other states also continued to expand their regulation of insurance, with rating bureaus becoming the preferred way to gather needed statistical data. The bureaus, therefore, began to impose considerable structure on the insurance industry.

United States of America v. South-Eastern Underwriters Association

In 1944, a landmark insurance case came before the U.S. Supreme Court. The *United States of America v. South-Eastern Underwriters Association* reversed the interstate commerce decision from *Paul v. Virginia* by declaring that insurance was interstate commerce subject to federal regulation. With this decision, the antitrust provisions of the Sherman, Clayton, and Robinson-Patman Acts applied to the business of insurance.

A dissenting justice vote expressed the following sentiment:

For 150 years Congress never has undertaken to regulate the business of insurance. Therefore, to give the public any protection against abuses to which that business is peculiarly susceptible, the states have had to regulate it. The states began nearly a century ago to regulate insurance and state regulation—while no doubt of uneven quality—today is a successful going concern. The Court’s decision at very least will require an extensive overhauling of state legislation relating to taxation and supervision. The whole legal basis will have to be reconsidered. What will be irretrievably lost and what may be salvaged no one now can say, and it will take a generation of litigation to determine. Certainly the states lose very important controls and very considerable revenues.

McCarran-Ferguson Act

The *United States of America v. South-Eastern Underwriters Association* created a flurry of activity among insurance companies and insurance regulators alike, which led to heavy lobbying of the U.S. Congress to reverse the U.S. Supreme Court decision. The next year, out of the turmoil came the McCarran-Ferguson Act (Public Law 15) that protects the insurance industry from federal antitrust laws to the extent that the states would actively regulate insurer conduct. Once again, under McCarran-Ferguson, state insurance regulation was dramatically changed. The following are excerpts from Public Law 15 (approved by the U.S. Congress March 9, 1945):

The Congress hereby declares that the continued regulation and taxation by the states of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the states. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

The threat of federal intervention brought state insurance regulators together in support of Public Law 15. Since its passage, the states have shown more interest in enacting legislation that follows more closely with NAIC-adopted model laws and regulations.

The All-Industry Bill

The NAIC held extensive hearings after the passage of the McCarran-Ferguson Act to determine a best framework for state-based insurance regulation. The NAIC hearings, under the leadership of New York State Insurance Superintendent Robert Dineen, then NAIC president, resulted in proposed legislation called the All-Industry Bill, which was adopted by the NAIC as a model law in 1946. By 1948, every state had enacted a rate regulatory law, typically patterned after the All-Industry Bill, to meet the provisions of the McCarran-Ferguson Act, thereby allowing insurance to be exempt from the federal antitrust laws. This served to further entrench the bureaus—who made the rates—with deviations and independent filings being the exception.

Insurance Lines

As early as 1871, the New York state insurance superintendent proposed to the National Convention of Insurance Commissioners that life insurance companies should not be allowed to write any accident or casualty insurance. States generally followed the New York example, with its corporate state law restricting the underwriting authority of insurance companies. Therefore, when a new insurer applied for a corporate charter, it had to specify its business type as either that of fire, marine, or life. This not only separated life insurance from other insurance forms, but also precluded any single insurer from writing both property and casualty insurance. To overcome these restrictions, U.S. insurers organized groups of companies writing different lines but owned in common.

This New York practice of restricting an insurance company to underwriting limited lines prevailed nationwide because of the so-called Appleton Rule (promulgated by New York State Insurance Superintendent H.D. Appleton). The Appleton Rule,

which by 1940 had been incorporated into the insurance law of New York, required all insurance companies licensed in the state of New York to accept this limitation wherever they operated. Because most major insurance companies wanted to operate in New York, they accepted this separation-of-business-lines rule.

There were some critics of the Appleton Rule, however, who believed it led to undesirable consequences. For example, it was perceived that the Appleton Rule might create a vacuum where some serious hazards could find no U.S. protection, resulting in protection through foreign (i.e., alien) insurance markets. In 1943, the NAIC formed the Diemand Committee, which recommended that fire, marine, casualty, and surety companies be permitted to write any kind of insurance except life outside the United States and to accept reinsurance for the same lines within the United States. It also recommended that insurance companies be permitted to write comprehensive automobile policies, comprehensive aviation policies, and personal property floaters. The NAIC adopted the Diemand Committee's recommendations in June 1944 and referred them to the states.

In 1949, New York authorized full underwriting powers to fire and marine, and casualty and surety insurance companies—proving to be a turning point for all other states to enact similar legislation. These changes permitted insurance companies to operate as multiple-line companies by combining different types of coverage into a single policy.

Consumer Influence

The fundamental issues that concerned consumers tend to involve insurance policy rating. Rates that are adequate, but not excessive or unfairly discriminatory, are often difficult to determine and subject to contention. This problem was at the center of consumer unrest regarding the insurance marketplace throughout the 20th century. High insurance rates could lead to consumer protests, but the lowering rates could lead to insurer insolvency—both of which ultimately harm the consumer.

In 1947, New York enacted an insurance “guaranty fund” law. The law assessed all insurance companies in that state a percentage of premiums written for a guaranty fund to pay unsatisfied claims against insolvent insurers. All other states enacted similar laws to establish their own guaranty funds.

Beginning in the late 1960s and continuing through the following two decades, many states replaced their prior-approval laws (where rates must be filed and approved by the state insurance department before use) with some type of open competition law (e.g., modified prior approval, flex rating, file and use, use and file, or no file). By 1987, some type of competitive rating laws were in effect in most states.

However, there was some movement away from open competition. In a number of states insurance companies were required to roll back rates. Perhaps the prime example of this was the 1988 passage of Proposition 103 in California. Among the Proposition 103 requirements placed on insurance companies was the reduction of most insurance rates 20% below the level that existed Nov. 8, 1987.

Prospective Loss Cost

During the NAIC 1988 Winter National Meeting, a working group was formed to look into the proper role of advisory organizations (also variously known as rating or rate service organizations) in preparing and filing final rates. After holding a number of meetings, the working group concluded that advisory organizations should be prohibited from preparing and distributing final rates for subscribing company members. The working group recognized that statistical and administrative advantages exist for having a central agent collect and analyze loss data, however. For competitive reasons, though, the working group believed insurance companies should develop their own expense and profit-loading factors.

Reacting to this working group recommendation and from pressures to limit insurers' antitrust exemptions due to perceived anticompetitive rating practices, advisory organizations such as the Insurance Services Office (ISO) and the National Council on Compensation Insurance (NCCI) made a break with tradition in the late 1980s and early 1990s by announcing that they would no longer be preparing and filing rates for their members. Instead of filing final rates on behalf of members, they would only file the loss component of rates (termed “advisory prospective loss costs”) and leave it up to member companies to reflect their company operating and underwriting expenses and profits.

Notable State Uniformity Efforts in Recent Years

- Terrorism Model Bulletins

The drafting and implementation of terrorism model bulletins represents a fine example of the states working well together. A model bulletin addressing insurance coverage for acts of terrorism was first adopted by the NAIC members Nov. 26, 2002. The model bulletin provided voluntary filing procedures for property/casualty insurers writing commercial lines coverage to help them obtain expeditious compliance with the provisions of the Terrorism Risk Insurance Act of 2002 (TRIA). Through diligence of the insurance commissioners, the model bulletin was adopted on the very same day that President George W. Bush signed TRIA into law. The model bulletin has greatly assisted the states through helping their insurance companies implement the provisions of the federal program. This was subsequently followed up with the extensions of TRIA in 2005 and 2007, whereby the insurance commissioners and their staffs quickly adopted revised model bulletins, procedures, and disclosure forms for insurers to use in the filings they made and for the proper treatment of their policyholders.

- **Speed to Market Initiatives**

Among the especially notable speed to market initiatives of the NAIC are SERFF and the Interstate Insurance Product Regulation Commission (IIPRC).

SERFF has experienced tremendous growth since first formed through collaborative efforts by regulators and industry in 1997. Today all 50 states, District of Columbia, and Puerto Rico accept rate and form filings via SERFF. More than 3,000 insurance companies, third-party filers, advisory organizations, and other companies make filings electronically through SERFF to the individual jurisdictions. SERFF processed 527,139 filings in 2009. SERFF will be more fully discussed in Chapter Eight.

The IIPRC establishes a central filing point for select life and health insurance products, thereby enhancing the speed and efficiency of regulatory decisions. It operates through uniform national standards for insurance products developed by the participating states. The IIPRC allows companies to compete more effectively in the modern global financial marketplace, while continuing to provide protection for consumers. The IIPRC started receiving and reviewing product filings by mid-2007 and currently has more than 35 member states, representing more than half of the insurance premium volume in the United States.

Today

Insurance regulation has become an increasingly significant political issue in the United States. Insurance regulators are increasingly being challenged to create sophisticated methods for supervising this complex business to protect consumers and reduce insolvencies. Interests range from advocating more effective state regulation to proposals for federal regulation of insurance. In a competitive economy these tensions between free enterprise and consumer protection continue to exist.

CHAPTER TWO

The Filing Process

The insurance filing process is a cooperative effort between the filer and the regulator. In this process, the proposed product is presented by the filer to the regulator for review and/or approval. The product must comply with state laws and/or regulations. The contract language should be clear and, within regulatory judgment and/or law, “readable” as required. The pricing and wordage of the product, therefore, must be consistent with statutory and regulatory requirements.

The Filing

What is a “filing?” Webster’s New World Dictionary defines “filing” broadly; i.e., “a collection of information arranged in order.” In general, however, an insurance filing—whether submitted electronically or through other means—may be said to be a mechanism for an entity to use in seeking to meet certain requirements of a regulatory authority to obtain eligibility, or some other form of status or approval. In particular, an insurance filing might require the submission and evaluation of large amounts of complex information. This information is central to the regulatory process. For the best answer to this question, however, you should become familiar with how the term “filing” is defined in your state.

Insurance filings are made by several kinds of entities. Filings are made by, for, or on behalf of, risk-bearing entities; i.e., insurance companies. Filings can be made individually by each insurer or insurer-group—either by its own staff or by a contracted third-party filer. Advisory organizations such as the American Association of Insurance Services (AAIS), Insurance Services Office (ISO), National Council on Compensation Insurance (NCCI), and Surety and Fidelity Association of America (SFAA) are entities authorized under each jurisdiction’s laws to make insurance filings on behalf of their members and subscribers; e.g., insurance companies.

What is to be filed? Different state filing requirements may be applicable to each product category (i.e., rates, rating rules, policy forms, underwriting rules, etc.) and to different categories of filers (i.e., advisory organization filings may be subject to different rules from that of insurer filings). For example, a filing might be as simple as submittal of an insurers range selected from statutorily approved criteria (e.g., flex rating), in which case the filing might simply be approved when received by the regulatory authority. However, other filings might be quite complex, especially for some new programs, such as those requesting approval to write new commercial package policies. Such complex filings might entail actuarial analysis of its rating plans and even legal review of proposed contract language.

While filings are made when a company develops and implements a new program, most filings are modifications to existing programs, and thus will not contain all the elements of an insurance program. The origins of such filings can be diverse, including responses to newly enacted legislation, regulations or court cases, market research, or a desire to simplify or enhance an existing program. Such revisions can range from short, simple, straightforward submissions, to complex documents as previously mentioned. In addition, some filings will pertain to an insurer’s response to material filed on its behalf by the company’s advisory organization.

Rate filings are generally made by insurers on a regular basis in response to updated experience, as discussed in later chapters. Rate revisions might be filed in response to legislation, regulation, court cases, or other changes in the underlying program. Rate filings might also be precipitated by a loss cost filing made by an insurer’s advisory organization.

While in most states member and subscriber insurers may authorize their advisory organization to make filings in their behalf, some advisory organization customers may not give their advisory organization filing authority. These insurers may file to adopt the advisory organization material at another time, either with or without modifications, or not adopt a specific revision at all. Insurers that have given their advisory organization “file on behalf” authority may, however, choose at any time to make a simple filing notifying the regulator of their non-adoption of the advisory organization’s filing. Similarly, they may make simple filings that merely change the effective date of the material that has been filed on their behalf by their advisory organization.

For property/casualty lines of business, loss cost filings are a subset of rate filings and are made only by advisory organizations. These entities do not file final rates or effective dates for their loss costs. Rather, they file advisory prospective loss costs, which are defined as all the loss-related elements of a rate. Please refer to Chapter Three to gain a basic understanding of how the loss cost filing process works.

Insurers that wish to use their advisory organization's loss costs as the basis of their rates file a "Reference Filing Adoption" that specifies a provision (usually a loss cost multiplier) that comprises the insurer's expense and profit provision to be applied to the adopted loss costs, along with any modifications to the loss costs that are appropriate for its book of business or marketing strategy, and naming an effective date. In most jurisdictions, this filing can specify that the filed multiplier will remain on file to be automatically applicable to future updates filed by the advisory organization.

The Filer

The party making the filing (e.g., insurance company, advisory organization, or third-party filer) is referred to as the "filer." The steps in the insurance product development cycle that an insurer or advisory organization might take to bring a new insurance product before the regulator will now be examined.

The insurer or advisory organization would identify a need for the insurance product. This step is followed by drafting the contract language, including the main policy form, the coverage page or declarations and any endorsements that might be used to amend the policy. Actuaries would price the product and develop rating rules or actuarial memoranda. The insurer or advisory organization would develop underwriting rules to guide marketing and underwriting staff in deciding whom to accept as a policyholder and whether other coverage limitations are required.

Once a contract has been drafted and priced, the insurer or advisory organization needs to determine whether it needs to be filed with the insurance regulator. Ideally, during the development phase, the insurer or advisory organization would review applicable product standards and filing requirements to assure that the submitted filing is complete and compliant so a final approval/acceptance disposition would be anticipated. The filing process is a two-way street. It is relatively easy for state insurance regulators to process a complete and compliant filing. Delays occur when the filer has not taken the time during the product development process to correctly identify the state-specific product regulatory requirements. The availability of the speed-to-market operational efficiency tools described in Chapter Eight, makes this process easier and more transparent.

Below is a more complete explanation of the typical steps applied in the product development process for a new insurance product. Many or all of these same steps may also be applied in regards to making a revision to a current product filing or in meeting other product needs of the filer requiring regulatory approval/acceptance.

- **Analysis:** This phase involves identification of risk faced by individuals, families and businesses. Once risks have been identified, appropriate treatment of the risk is needed. Treatment of risk may be accomplished in a number of ways, such as through risk financing transfers (e.g., insurance) and non-insurance risk financing transfers (e.g., hold-harmless agreements). However, this text will focus on the development of insurance products to meet the nation's financial risk transfer needs. The product development staff must assess whether its prototype is an appropriate risk transfer device and figure out whether the product being contemplated is marketable. Analysis may also involve modeling.
- **Development:** During this phase, appropriate contract language is drafted and evaluated. It is incumbent upon those developing the product to consider the statutory and regulatory requirements for the insurance contract and draft policy language that is consistent with these laws and regulations. Use of speed to market tools should make this process simpler and straightforward. In addition to contract language, rating rules and rates may need to be developed for the new product. Underwriting rules will also need to be developed. Often underwriting rules, that help determine eligibility for the product and itemize any restrictions that might be used to limit coverage available to certain individuals, will be developed at the same time. In some states underwriting rules must be filed with the regulator.
- **Submission Requirements:** During this phase, the product is converted from its developmental stage into a filing proposal for submission; i.e., a filing. Most often the filing would be submitted electronically (e.g., via SERFF). The filer would additionally have available various Speed to Market Tools, which enhance uniformity in the filing process.

To accomplish this task, the filer would begin by reviewing the state's filing requirements for that particular insurance product - whether it is a property/casualty or a life and health insurance product. Today the filer would be encouraged by the regulator to locate the applicable Product Requirements Locator on the NAIC website (www.naic.org), if available for the type of business to be filed in the state. The Product Requirements Locator can be a helpful speed-to-market tool for filers to quickly locate the product rate, rule, and form filing requirements needed by each state. Should the state not be listed in the Product Requirements Locator, the filer could:

- Click on the Industry tab on the NAIC homepage. Under “Rate and Forms Filing/Speed to Market,” click on “State Filing Review Requirements.” A map of the NAIC jurisdictions is displayed and a filer can click on a state to obtain the insurance regulatory agency website needed to provide filing requirement information for that product.
 - Click on the link located on the NAIC home page titled “States & Jurisdiction Map.” This map will allow the filer to click on a state to obtain the insurance regulatory agency website for locating product filing requirement information.
 - SERFF also includes state filing submission requirement information.
- Transmittal Document: Now that the filer is knowledgeable regarding the state filing requirements for the product to be submitted to the regulator(s), the filer will need to complete all necessary information contained in SERFF and/or any other transmittal documents as required, including any required transmittal documents when submitting a hardcopy filing.
 - Transmission: Once the filer has completed the transmittal document and feels confident the filing is prepared properly and will be in compliance with state law(s), it then may be submitted via SERFF or other electronic filings systems or the mail for consideration by the regulator.

The Reviewer

Once the state insurance regulatory agency receives the filing, the filing may be assigned a tracking number for ease in identification and then sent to a reviewer. A typical process is outlined below:

- Filing Clerk: The filing clerk receives the new filing and performs a cursory check for its completeness. If the filing is found to be complete, it is then sent to the reviewer handling that type of insurance. If it is found to be incomplete, the filing clerk may reject the filing or may contact the filer to obtain the missing information. If the filer fails to promptly supply the missing information, the filing is disapproved or not accepted.
- Reviewer: The reviewer analyzes the filing for completeness, compliance with laws and regulations, and any other factors applicable for the type of insurance. In so doing, the reviewer will rely on various operational efficiency tools such as the NAIC speed-to-market tools, which includes the Product Coding Matrices and Review Standard Checklists. If the filing is found to be in compliance, the reviewer will approve/accept the filing or recommend approval/acceptance (if required) to the filing manager. If the filing is found not to be in compliance, an objection letter will be generated. An objection letter is a formal correspondence from the insurance department to the filer explaining filing deficiencies. Some states include a statement in the objection letter that until the deficiencies are remedied the filing is disapproved and may not be implemented. The letter may also specify the filer’s legal remedy to challenge the disapproval; most often, this would be that the filer could request a hearing. Some states specify the timeframe within which the deficiencies are expected to be remedied. Such remedies may take the form of an amendment to the filing or the submission of additional supporting information. Inadvertent approval/acceptance of a form that has omitted a statutorily required policy provision generally does not negate the filer’s responsibility for abiding by the required provision.
- Filing Manager: This position is generally filled by a senior reviewer who holds this or a similar title and is delegated authority by the commissioner regarding certain product filings. If the filing is complete, in compliance with applicable laws and regulations, then the filing is approved or accepted by the filing manager, or it may be recommended to a higher regulatory authority for disposition (e.g., approval or rejection).
- Insurance Commissioner: The insurance commissioner and/or other designated state official(s) may make the final decision regarding whether designated filings should be approved/accepted, rejected, or possibly have additional information requested. Note that in many states this higher decision is often delegated to the filing manager or the reviewer.

The scenarios presented for the filer and reviewer provide examples of how these processes generally work. A filing can be handled more expeditiously if it is complete initially and processed with less time spent sending and receiving communications. While this is the goal, much time has been lost waiting for correspondence to be sent between the filer and the reviewer. Therefore, it would be in the interest of both filer and reviewer, when correspondence is necessary, to exchange information with courtesy, promptness, and clarity. When the filer is asked to respond, a specific reasonable deadline should be provided for that response to ensure timely handling of the filing.

CHAPTER THREE

The Basics of Property and Casualty Rate Regulation

Introduction

Review of rate filings is not an easy task because there are many regulatory goals that need to be considered and what might be appropriate in one circumstance is not necessarily appropriate in another. This chapter provides an overview of rate regulation for property/casualty lines of business, including information about typical state rating laws and rate standards, ratemaking data, methods, and common regulatory issues. This should not be viewed as a step-by-step process to the development of rates but rather an outline of the potential process and issues.

Some calculations are provided throughout the chapter to aid understanding of subjects, but not all regulatory reviewers are required to understand the mathematical or actuarial aspects of these calculations. To be prepared for actuarial review of rate filings, additional actuarial training is needed.

Rating Laws

Each state legislature has enacted state insurance rating laws¹, some of which are based on the following NAIC property/casualty model rating laws and guidelines:

Guideline #1780:	<i>Property and Casualty Model Rating Law (Prior Approval Version)</i>
Guideline #1775:	<i>Property and Casualty Model Rating Law (File and Use Version)</i>
Model #777:	<i>Property and Casualty Commercial Rate and Policy Form Model Law</i>

Other laws are still from the All-Industry Bills of 1947, prior to publication of the NAIC model laws.

Each state regulator adopts the regulations needed to implement the state insurance rating laws. You will need to become familiar with both your state rating laws and related regulations².

Rating laws are often classified as prior approval, file and use or use and file (competitive), no file (open competition), or flex rating. The terms of the classification can vary by state, but generally, the following definitions are used:

- Prior approval rating laws are those where rates must be filed with and approved by the state insurance department before they can be used. Approval can be by means of a deemer provision, which indicates approval if rates are not denied within a specified number of days (e.g., 30 days).
- Competitive rating laws typically allow use of rates so long as they are filed. Two variations of competitive rating laws are 1) file and use; and 2) use and file.
 - File-and-use rating laws are those where the rates can be introduced into the market at the same time as they are being filed with the insurance regulator. Specific approval is not required, but the department retains the right of subsequent disapproval. In most instances, the subsequent disapproval is on a prospective basis only. In some states, refunds can be required.
 - Use-and-file rating laws are those where the rates can be introduced into the marketplace and, at a specified later date, must be filed with the regulator.
- No file, or open competition, rating laws do not require the rates to be filed with or approved by the state insurance department. However, the company must maintain records of experience and other information used in developing the rates and make these available to the commissioner upon request. Rates can be modified without notification to the insurance department.
- Flex rating is a system where prior approval of rates is required only if the rate change would be greater than (and sometimes less than) a certain percentage (e.g., 7%).

¹ With one exception: Illinois has no rating law.

² For NAIC or company purposes, one can find a list of each state's rating law by line of business along with citations of the applicable state statutes and/or regulations in the NAIC *Compendium of State Laws on Insurance Topics*.

➤ Competitive Market

With competitive rating laws, there is usually a requirement for the market to be “competitive,” or else the system reverts to prior approval for the line of business that is not competitive.

The NAIC *Competition Database Report* can be used as a starting point for examining the competitiveness of state insurance markets. Several factors to determine the competitiveness of a market would likely need to be considered, including market concentration, market entries and exits, market growth, insurance policy availability, and insurance company profitability.

➤ State Priority: Commercial vs. Personal Lines

In reviewing filings at the state, states often place more emphasis on personal lines filings versus commercial lines filings. The concept here is that personal lines consumers are less sophisticated and knowledgeable about insurance than commercial lines customers. There are also more societal considerations taken into account in personal lines insurance than commercial.

Rate Standards

Rate standards are included in the state rating laws and are the foundation for the acceptance, denial, or adjustment to rate filings.

Typical rate standards included in the state rating laws require that “rates shall not be excessive, inadequate or unfairly discriminatory.”³ These terms are sometimes defined exactly in state law or regulation, but when they are not defined, they are generally interpreted as follows:

- “Excessive” means the rates are too high, or that the rates would exceed the amount that is needed for a company to achieve an acceptable level of profit. However, some state laws say that when a market is competitive, no rates are deemed excessive.
- “Inadequate” means the rates are too low, or that the rates are such that a company could not sustain these rates for a long period of time without threatening solvency. Sometimes this assessment is made depending on competition, with an eye toward one company trying to gain market share over others.
- “Unfairly discriminatory” is a concept often based on “cost based pricing,” with the key word being “unfairly.” For example, charging different prices to a man vs. a woman is discriminatory; however, it is only unfairly discriminatory if it cannot be reasonably explained by differences in expected costs. With that said, there are sometimes restrictions on what criteria are allowed by law. A few states have enacted constraints on rating criteria such as the use of gender or marital status in private passenger automobile rating.

From the Casualty Actuarial Society’s *Statement of Principles Regarding Property and Casualty Insurance Ratemaking* adopted in 1988:

A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

Rate Justification and Supporting Data

Rates for property and casualty insurance are established by the filer before the costs of the product are known. This contrasts with pricing for manufactured products where a company would know the cost of the goods (i.e., how much their materials

³ *Property and Casualty Model Rating Law (Prior Approval Version)* (#1780) and *Property and Casualty Model Rating Law (File And Use Version)* (#1775).

cost, how much labor costs to build the product, etc.) before the product is sold. In insurance, however, a policy typically covers an accident or occurrence that will happen in the future, yet the costs of those accidents or occurrences will not be known until after they happen and claims are settled, which could be many years in the future. So, the pricing of insurance requires estimation of the future costs, making the determination of rate levels very difficult. Simply because actual results for a period are better than estimated in setting rates does not mean the rate selected was excessive or not actuarially sound; similarly, just because actual results are worse than estimated does not mean the rate selected was inadequate or not actuarially sound.

While the regulator is to approve rates and not methodologies, evaluation of the selections made by companies in their ratemaking calculations will help you to determine whether the rates meet statutory requirements.

The determination of the overall rate level may be based on prior loss experience and expected expenses, projected into the future. The basic concepts involved in that analysis are as follows:

➤ Historical Data

A company will likely start with historical years of data and will adjust that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. While most annual statement data is grouped by calendar year transactions, data for ratemaking is typically grouped by accident year, policy year, or report year:

- Accident year data is the accumulation of loss data on all accidents with the date of occurrence falling within a given calendar year, regardless of when the claims are reported or paid.
- Policy year data is the accumulation of loss data for accidents that are covered by the policy written (or incepting) for a specified year, regardless of when the claims are reported or paid.
- Report year data is the accumulation of all claim amounts for accidents where notice is given to the filer of a claim in that year, regardless of when the accident occurred (so long as the accident occurred during a time period covered by a policy) and no matter when the claim is paid.

The remaining discussion will center on accident year data, but other data could be more appropriate depending on the policy and line of business. And in some cases, the data used might not be years, but quarters, half-years, rolling four quarters, etc.

Definitions of Data Elements

Common data used by the filer would be:

➤ Earned premiums

Earned premium is the portion of a premium paid by an insured that has been allocated to the insurance company's loss experience, expenses, and profit year to date⁴. As an example, if an annual policy is written on Jan. 1 and premium is earned pro rata, all the premium is earned by the end of the year. If that same policy had been written on April 1 instead (after three months of the year have elapsed), then 9/12 (or nine months out of 12 months) of the premium is earned by the end of the year.

Earned premiums are typically used for rate analyses because they tend to be a better match to the loss data, however for some levels of detail (e.g., for minor coverages on the policy) where a company does not maintain earned premiums in their statistical system, written premiums are used. Written premiums are the total premiums generated from all policies written by an insurance company within a given period of time⁵.

⁴ *Dictionary of Insurance Terms*, Harvey W. Rubin, Fifth Edition, 2008.

⁵ *Dictionary of Insurance Terms*, Harvey W. Rubin, Fifth Edition, 2008.

The earned premiums could be calendar year or accident year. If they are calendar year data and there are significant audit or retrospective premiums, companies will tend to adjust their calendar year premiums for anticipated changes from audits or retrospective adjustments.

➤ Incurred Losses

Losses are the damages that must be paid for insured events. Losses can be grouped in many ways:

- Paid losses are the actual amount of total losses paid by an insurance company during a specified time interval.
- Incurred losses are those losses that have occurred within a stipulated time period, whether paid or not. The incurred losses would include paid losses plus an estimate of amounts remaining to be paid.
 - “Case” incurred losses are the incurred amounts established by the claims departments after review of claims.
 - “Total” or “ultimate” incurred losses include losses that have not yet been reported to the insurance company as of the case-incurred evaluation date.

➤ Incurred Loss Adjustment Expenses

Loss adjustment expenses (LAE) are the costs involved in an insurance company’s adjustment of losses under a policy. Some examples of expenses incurred in these activities are investigating and settling claims, legal expense, estimating the amounts of losses, disbursing loss payments, maintaining records, and claim office maintenance.

Since 1998, loss adjustment expenses are split in the Annual Statement into two categories: Defense and Cost Containment (DCC) and Adjusting and Other (A&O) expenses. See SSAP No. 55—*Unpaid Claims, Losses and Adjustment Expenses* for detailed definitions, but the general intention is that the DCC expenses are those that are correlated with loss amounts such as legal expense and the A&O are those expenses that are correlated with claim counts or are general loss adjusting expenses such as claim office rent.

For ratemaking purposes, the DCC expenses are evaluated alone or combined with loss amounts. The A&O are evaluated alone or combined with other expenses (and are sometimes included as a percentage of the projected combined loss and DCC).

The DCC expenses are often grouped by accident year. The A&O are not necessarily grouped by accident year but are needed in enough detail to determine a projected amount.

Some companies will be able to match some of their A&O expenses to specific claims and, thus, will then split their loss adjustment expenses into allocated (ALAE) and unallocated (ULAE) loss adjustment expenses. This adjustment can result in more accurate ratemaking.

➤ Other Expenses Incurred

Other expenses include items such as commissions, general expenses, other acquisition expenses, taxes, licenses, and fees.

Other expenses are grouped by calendar or accident year and are often stated as percentages of premium.

Variable expenses vary directly with premium, while fixed expenses do not. For example, state premium taxes are variable expenses because as insurance premiums increase, premium taxes increase. Rent for the insurer’s building is a fixed expense because as insurance premiums increase, the rent does not change. Some fixed expenses will actually increase as more policies are written, but if these expenses cannot be defined as a percentage of premium, they are generally considered to be fixed expenses.

The distinction between fixed and variable expenses is used when determining the impact of any proposed rate change. If premium will be increasing, then additional money will be needed to pay the higher variable expenses.

Some filings include the net cost of reinsurance either in with “other expenses” or as a separate adjustment. Regulators should check the state’s position on this issue, especially because some states have statutes or regulations that require “direct” data (before reinsurance) only. The rationale for including this net cost (after accounting for expected ceded losses and commissions) is to recognize the importance of reinsurance in that reinsurance can provide a benefit to the policyholders, especially from overall solvency of the insurance company and ability to pay policyholder claims. Rationale against including reinsurance cost are that reinsurance prices can be established to recoup past negative reinsurance loss history, and thus, should not be included in prospective rates and/or the individual risk transfer for which rates are being made is the transfer of risk from the policyholder to the insurer, not from the insurer to its reinsurer.

➤ Claim Counts

Claim counts are the number of claims. The number of claims can vary by company depending on their classification system. Companies calculate different claim counts depending on how they consider multiple claimants from one accident and how they consider multiple coverages from one accident. For example, in auto insurance for a claim with both bodily injury liability and property damage liability potential losses, one company might count this as one claim and another company might count it as two. The important consideration in ratemaking is that the company uses the claim counts consistently in the rate calculation, based on their definition.

Claim counts are not always needed; it depends on the methodology used in the rate filing.

➤ Exposures

Some ratemaking methods use exposures, or the underlying coverage unit. For example, in auto or home insurance, one auto or one home is typically one exposure unit. The exposure units can get more complex based on line of business, and include items such as payroll, receipts, sales, etc., but the important consideration in ratemaking is that the company is consistent and uses the exposure amounts appropriately.

Number of Years of Historical Data

There is a trade-off between stability and responsiveness when deciding how many and which years of data to use. Using recent data would be more responsive to reflect current claim conditions, however the most recent accident year data has more immature data (meaning that not all losses are reported and not much might be known about the reported losses, so there would be a lot of estimates in the incurred losses). The immature data could add potential errors in the estimation of the ultimate incurred losses. Using lots of years of data would likely be more stable as one year of data doesn’t significantly change the projection, but the older data might not reflect the current claim environment. Judgment is needed to determine how many years of data to use, with consideration of whether the amount of data is sufficient to be statistically reliable (or credible) and consideration of what the filing is trying to accomplish. A few states have requirements as to how many years of data must be used for a specific line of business.

Segregation of Data

Lines of business or products likely require separation of data for analysis purposes. Consideration must be given to similarity of the data (homogeneity) and whether there are sufficient data to be reliable (credibility). Segregation of data will be significantly different from the lines of business groupings in the Annual Statement.

Data Adjustments

Because the insurance contracts will be written to cover future accident periods, the past data needs to be adjusted to reflect the anticipated future premiums and costs. These adjustments will provide a profit/loss picture if no rate change occurs. Calculations can then be made to determine the overall rate need (or indication).

Premium Adjustments

If the method of analysis of the overall rate need requires premiums, one must adjust historical premiums to levels anticipated in the future (assuming the current rates were to remain in place). Since the ratemaking analysis is testing the current rating structure, the first adjustment to historical premiums is to reflect the premium that would have been collected had the current rates been in place in the past. The next adjustment is to project inflation-sensitive premiums (e.g., workers' compensation premiums that are a function of payroll, automobile physical damage premiums that are a function of vehicle costs) using trend analyses.

➤ Current Rates (On-Level or Current Level Premiums)

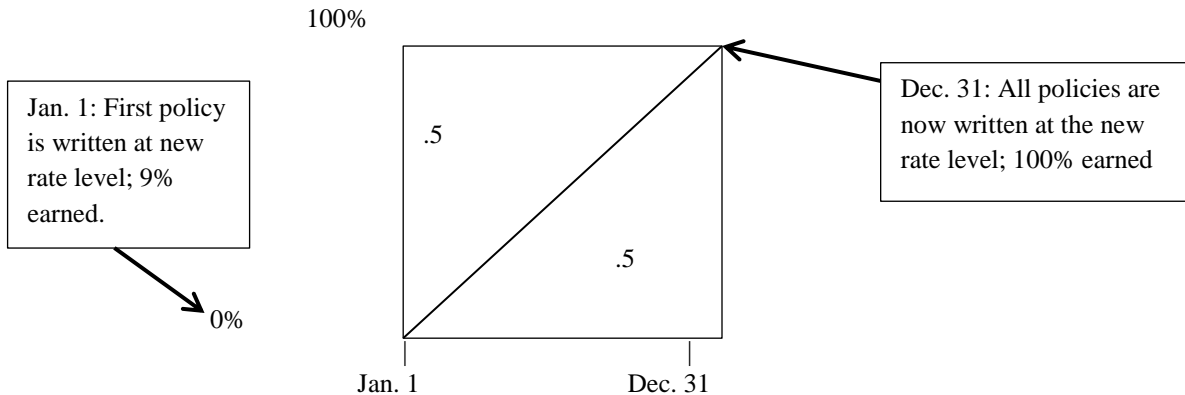
To adjust historical premiums to current level, one could re-rate all prior policies using the current rate. This would be an "extension of exposures" technique. If this is not possible, using the computer system or is too expensive to do manually, an alternate approach called the "parallelogram method" is often used.

The parallelogram method is based on geometric principles. A square represents the written premium for a calendar year. The bottom line of the square (the x-axis) represents the policy effective date. A vertical line represents the exposures effective on a particular date. A diagonal line represents the effective period for policies effective on the date the diagonal line touches the x-axis of the square.

In the parallelogram method, a diagonal line represents a change that affects policies as they renew (such as rate changes). The area of the square to the left of the diagonal line represents the amount of written premium for the year that is based on rates effective before the rate change. The area of the square to the right of the diagonal line represents the amount of written premium for the year that is based on rates effective after the rate change.

When a rate change is effective Jan. 1 and the policies are written as annual policies, there is a diagonal line that shows that half of the square represents earned premium at the old rate level. The area on each side of the diagonal line is one half, or 0.5.

Percent Earned



To adjust the entire year's premium to current rate level, multiply the year's premium by an on-level or current rate level factor. This on-level factor is calculated as

$$\text{Factor} = \frac{\text{New Rate Level}}{\text{Average Rate Level in effect}}$$

$$= \frac{(1 + \text{Rate Change})}{\text{Weighted Average of old rate level (or 1.00 in this case) and } (1 + \text{Rate Change})}$$

Assume the rate change was 7% effective Jan. 1. With an effective date of Jan. 1, the areas of the triangles are .5 at the old level and .5 at the new level. The on-level factor would be calculated as:

$$\text{Factor} = \frac{(1 + .07)}{1.00 \times .5 + (1 + .07) \times .5}$$

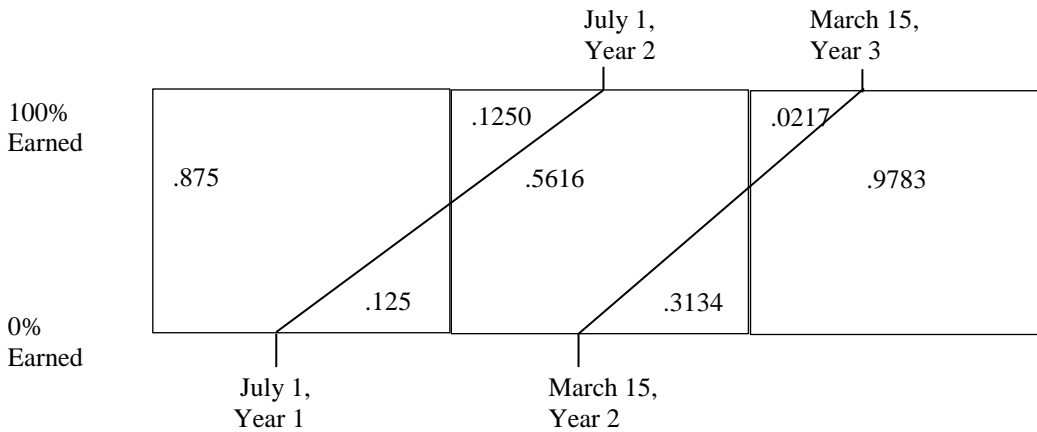
$$= \underline{1.07}$$

$$= \frac{1.035}{1.0338}$$

The calculation of the geometric area can get complicated when there are multiple rate changes that have impacted the same calendar year. Assume that in Year One there is a 6% rate change effective July 1. In Year Two there is a 4% rate change effective March 15.

Rate Change Effective Date	Percent Change
July 1, Year 1	6%
March 15, Year 2	4%

The areas are calculated first using geometry, but do not worry about how that gets done. Here are those numbers:



The factors are then the current price level or $(1 + .06) \times (1 + .04)$, divided by the earned price level as derived by multiplying the areas calculated in the figure above by the rate change that was effective during the matching time period:

$$\begin{aligned} \text{Year 1: Factor} &= \frac{(1 + .06) \times (1 + .04)}{1.00 \times .875 + (1 + .06) \times .125} \\ &= \frac{1.1024}{1.0075} \\ &= 1.0942 \end{aligned}$$

$$\begin{aligned} \text{Year 2: Factor} &= \frac{(1.06) \times (1.04)}{1.00 \times .1250 + 1.06 \times .5616 + 1.06 \times 1.04 \times .3134} \\ &= \frac{1.1024}{1.0658} \\ &= 1.0343 \end{aligned}$$

$$\begin{aligned} \text{Year 3: Factor} &= \frac{(1.06) \times (1.04)}{1.06 \times .0217 + 1.06 \times 1.04 \times .9783} \\ &= 1.0008 \end{aligned}$$

An important assumption in the Parallelogram Method is that policies are evenly distributed throughout the year (e.g., one policy is written every day of the year). For business such as commercial insurance, that is often heavily written with policy effective dates of Jan. 1 or July 1, this method would require adjustment.

➤ Audit or Retrospective Premiums

If there are significant audit or retrospective premiums for a company, the premiums need to be adjusted to reflect the typical development pattern. This is similar to how losses are developed (as described later in the Loss Development section).

➤ Premium Trends

When premiums depend on inflation-sensitive components, the future premiums will change with inflation. For example, payroll is often inflation sensitive and workers' compensation premiums are calculated as a base rate multiplied by payroll. So, as payroll increases, the premiums for workers' compensation will increase in the same proportion. A ratemaking process that uses premiums would require anticipation of changes in the premium exposure base. The adjustment to premiums is made through a trend factor. If payroll increases by 2% a year, then the premiums that are a percentage of payroll would increase by 2% a year to reflect trend. See the subsequent information about loss trends for additional information about trends.

Not all premium trends result from dollar-based exposure bases. Another example of premium trend arises in personal auto insurance rating with model year and symbol drift. For model years, companies might have automatic adjustments to the rates for the next model year (e.g., the next year's models will be priced 5% higher than this year's.) Symbol drift, or the change/increase in the insurance company's average auto symbol, should be reflected as a premium trend if it has not already been reflected as a rate change.

Losses and LAE (perhaps just DCC) Adjustments

➤ Loss Trends

The historical data reflects the level of claim costs at the time. Yet, over time, inflation and other factors can affect the number of accidents or the amount of claims. Since the ratemaking process includes an estimation of the future costs, the historical costs need to be adjusted for trend. Trends are often analyzed separately for claim counts and amounts, using frequency and severity:

Claim incidence is often evaluated using frequency, or the number of claims divided by the number of exposures. For auto insurance, the frequency could be the number of claims divided by the number of insured vehicles.

Claim amounts are often evaluated using severity, or average loss per claim. The severity could be the total amount of loss divided by the number of claims. (Here, "loss" could include DCC.)

The evaluation of trend generally involves fitting a curve (or line) to a set of internal data values, generally using either exponential or linear regression. Exponential is sometimes used when the percentage change is constant over time. Linear is sometimes used when the dollar change is constant over time (with the percentage change decreasing over time). Plotting the data on a graph is sometimes useful to evaluate the trend selection.

Linear: $Y = aX + b$
Exponential: $Y = b(ax)$

Where Y is the average claim amount or frequency
X is the time in years
a and b are constants determined by the regression

Trend can also be selected based on external data, such as from a component of the Consumer Price Index (CPI) or another insurance or general economic indicator. An important consideration in the selection of the trend is that the historical trend can be an indicator of a projected trend, but it is not the only consideration in selecting the trend. The selection of the trend should be reasonable and justifiable but should not have to match to a formula calculation.

Loss trends are occasionally evaluated with frequency and severity combined, in what is called the pure premium. Formulaically, frequency times severity equals pure premium. It is typically more advantageous to evaluate frequency and severity separately because significant events (such as law changes) that affect trend, affect frequency and severity differently and are not only easier to evaluate separately, but provide more information upon which to make informed decisions.

Trend factors are calculated for each historical period.

$$\begin{aligned} \text{Trend Factor (for a linear trend)} &= (1 + \text{selected trend \%})^{\text{Time Factor}} \\ \text{Trend Factor (for an exponential trend)} &= (e)^{\text{Selected Trend \%} \times \text{Time Factor}} \end{aligned}$$

The time factor is the number of years from the midpoint of the data year to the average loss date. The average loss date is the midpoint of the losses for the policies that have the new rates.

Example:

Historical data period: accident year 2010
Annual policies
Policy effective date of rate change: 6/1/2012
Annual rate changes are anticipated.
Selected trend: 3%

Assuming an average date of loss during a given year is the middle of the year and that policies renew evenly over the year,

The midpoint of the data year is 7/1/2010.
The midpoint of the projection is 6/1/2013.
The time factor is:

6 months of 2010
12 months of 2011
12 months of 2012
5 months of 2013
= 35 months
Time Factor = 35 / 12 months = 2.9167

The linear trend factor is $(1 + .03)^{2.9167} = 1.0900$

When calculating loss trends, it is important to select appropriate data and make appropriate adjustments. Some examples are as follows:

- Data should be adjusted for seasonal impacts. For example, if winter weather significantly impacts losses, then it is important to use 12-month rolling data rather than include some winter months without offsetting with the warmer months.
- It is also important to adjust the data for outliers, when appropriate. An example of an outlier is when a data period includes catastrophe amounts that increase the claim counts and average severities so that if the data is graphed, the data point is significantly higher than the other data points. An outlier distorts calculation of the true trend estimate.
- Changes to laws can impact both frequency and severity trends. For example, introduction of no-fault laws impact BI liability by generally decreasing claim counts and increasing average severities.

The selection of the large trend has significant impact on the resulting rate indication. A small difference in the percentage can result in large changes projected over numerous years.

➤ Loss Development

The change in losses over time (for a given accident year) is referred to as development. Paid losses generally increase over time (or develop) until the ultimate value of claims is reached and all claims are paid. Similarly, case incurred losses, losses for claims not yet reported, claim counts, and other amounts develop over time.

Loss development can be illustrated in loss development triangles, similar to the Schedule P loss development triangles in the property/casualty annual statement. Each accident year is a separate row and each column shows the development at increasing ages of development. The following is an excerpt of a cumulative paid loss development triangle from Schedule P:

Accident Year	Cumulative Paid Losses at Year End			
	2011	2012	2013	2014
2011	100	200	250	250
2012	XXX	150	300	375
2013	XXX	XXX	200	400
2014	XXX	XXX	XXX	250

Reading across the columns on the 2011 accident year row, this table illustrates that for those accidents that happened in 2011, the losses paid by the company cumulated to:

- \$100 as of the accounting date 12/31/2011
- \$200 as of 12/31/2012
- \$250 as of 12/31/2013
- \$250 as of 12/31/2014

On the next row for the 2012 accident year, you will notice that “XXX” appears in the first column. This is because no payments were made for accidents that occurred in 2012 prior to 2012 (because they had not yet happened). The table then illustrates that for those accidents that happened in 2012, the losses paid by the company cumulated to:

- \$150 as of the accounting date 12/31/2012
- \$300 as of 12/31/2013
- \$375 as of 12/31/2014

So, the development shows how the payments changed as time passed.

These triangles can be arranged differently than the Schedule P format. Instead of showing years for the columns, the number of months of development (called “age”) could be used. The column headings are then changed and the data is shifted to the left.

Accident Year	Cumulative Paid Losses at Age			
	12	24	36	48
2011	100	200	250	250
2012	150	300	375	
2013	200	400		
2014	250			

Reading across the columns on the 2011 accident year row, this table illustrates that for those accidents that happened in 2011, the losses paid by the company cumulated to:

- \$100 as of age 12 months (equivalent to the accounting date 12/31/2011)
- \$200 as of age 24 months (equivalent to the accounting date 12/31/2012)
- etc.

For books of business that are new or are rapidly changing, you will often find the triangles created by month or by quarter (with valuations every three months) instead of by year (with valuations every 12 months).

Loss development triangles are often used to calculate an estimate of the ultimate incurred losses. The method is called the loss development method and centers on the relationships of reported or paid loss amounts from one age to the next. The concept is that these relationships (or similar relationships) will be repeated in the future. The following is an example of the loss development method. In no way is this to be interpreted as the only or the preferred way to derive ultimate losses, but the method is provided as an illustration.

LOSS DEVELOPMENT METHOD EXAMPLE

Accident Year	Cumulative Paid Losses at Age				Estimated Ultimate
	12	24	36	48	
2011	100	200	300	300	?
2012	125	250	375		?
2013	150	300			?
2014	175				?

Step 1: Calculate Age-to-Age Factors

Accident Year	Age-to-Age Development Factors		
	12-24	24-36	36 – ultimate
2011	$200 / 100 = 2.0$	$300 / 200 = 1.5$	$300 / 300 = 1.0$
2012	$250 / 125 = 2.0$	$375 / 250 = 1.5$	
2013	$300 / 150 = 2.0$		
2014	$200 / 100 = 2.0$		

Step 2: Average the Factors

Factors can be averaged in numerous ways. There are three-year, four-year, five-year, and all-year averages; there are weighted averages and averages after eliminating the highest and lowest factors. It is beyond the scope of this chapter to compare and contrast reasonability of different averaging methods.

Accident Year	Age-to-Age Development Factors		
	12-24	24-36	36 – ultimate
All Year Average	2.0	1.5	1.0

Step 3: Select the Factors

Different averages might be analyzed and judgment might enter into selection of the age-to-age development factors to use in the projection.

Accident Year	Age-to-Age Development Factors		
	12-24	24-36	36 – ultimate
Selected	2.0	1.5	1.0

Step 4: Calculate the Estimated Ultimate Losses

Accident Year	Cumulative Paid Losses at Age				Estimated Ultimate
	12	24	36	48	
2011	100	200	300	300	300
2012	125	250	375	$375 \times 1.0 = 375$	375
2013	150	300	$300 \times 1.5 = 450$	$450 \times 1.0 = 450$	450
2014	175	$175 \times 2 = 350$	$350 \times 1.5 = 525$	$525 \times 1.0 = 525$	525

This example used paid losses which can be a proper method to estimate the ultimate incurred losses. Another popular alternative is to use case incurred losses. The example also refers to losses, but DCC also can be included.

[Note: This “development” is different from the annual statement Schedule P, Part 2 “development.” In Schedule P, the development is the accounting change that occurred in the ultimate incurred loss over the past year or two. It is not a projection of anticipated future development calculated here.]

Numerous adjustments might be appropriate to account for law changes, changes in policy terms (coverage and benefit level changes), distributional shifts (mixes of business), and changes in business volume over time.

There is often confusion about the difference between loss development and trend. Loss development would measure expected future changes over time in the given accident year payments; whereas, trend would measure the differences in these developed losses from one accident year to the next. Trend and development measure different things and do not overlap in their purpose.

Catastrophe or Large Loss Provisions

The overall rate need should contemplate the catastrophe or large loss occurrences expected in an average year. The typical procedure is to take out the catastrophe or large losses from the historical data and to add in an expected average amount.

Original practice to calculate a catastrophe factor was to use the relationship of excess catastrophe amounts to the underlying non-catastrophe amounts, as determined from 20 or more years of catastrophe loss experience. This factor relationship would then be multiplied by the historical accident year non-catastrophe losses to adjust the losses to an average catastrophe loss amount. [Note the separation of amounts into excess catastrophe and non-catastrophe generally requires establishment of a limit that should be de-trended for inflation for each year.] It is generally accepted that a large volume of data is required, for some insurers at least 30 years of data, and data should be adjusted to reflect the current situation (e.g., changes in underwriting by location, policy coverage, etc.)

This original practice is still in use today, however for some perils, especially for hurricanes and earthquakes; companies are often using advanced technology and are modeling catastrophe losses to determine the catastrophe factor. These models are able to evaluate the ever-changing value of insured property, the number of properties an insurer writes in catastrophe prone areas, the vulnerability of insured structures, the amount of loss covered by the filer, and other changes in catastrophe exposure. These models are typically based on the potential loss under various simulations and are, thus, difficult for most regulators to evaluate. However, because the rates calculated from a catastrophe model may better reflect an insurer's loss potential from catastrophic events, these models are becoming more widely accepted. Guidance on catastrophe models can be found in Actuarial Standard of Practice No. 38, *Using Models Outside the Actuary's Area of Expertise (Property and Casualty)*.

Insurance regulators recognize the importance of catastrophe models, but sometimes report inability to conduct detailed reviews of the models. The NAIC is currently investigating ways for regulators to more effectively and accurately evaluate models.

A company could have a catastrophe provision that is modeled and intended to cover certain perils plus have another catastrophe provision for other types of catastrophe or large losses not included in the modeling.

Loss Adjustment Expenses

If loss adjustment expenses were not included in the underlying loss data, provisions for loss adjustment expense need to be added. Typically, the DCC expenses are included with the losses in the analysis and the A&O expenses are added at the end. A common method to add the A&O expenses is to look at the ratio of historical amounts of A&O expenses to incurred losses and DCC for several calendar years. For example, if the average historical ratio was 0.05, the A&O factor would be 1.05. The A&O factor would then be multiplied by the projected loss and DCC amounts to achieve the projected loss, DCC, and A&O amount.

Data Quality

The quality of data is obviously an important issue in all aspects of insurance ratemaking, but especially because of the expansion of the level of detail of data used in insurance ratemaking and the proliferation of new tools and analysis techniques. The Casualty Actuarial Society's Data Management Educational Materials Working Party defines “quality data” as data that is appropriate for its purpose; as such, it is a relative and not an absolute concept. Data for an annual rate study

might not be appropriate for a more-detailed class relativity analysis. And, data for advanced techniques such as predictive modeling, catastrophe modeling, or credit scoring might need to be held to higher standards.

With varying needs of action depending on the use of the data and the impact of the data on the rate levels, regulators need to be comfortable that the company adequately tested their data quality in order to rely on the answers that result from use of the data. It might be appropriate for a company to provide a general narrative on the quality checks and control of the data, including examination of validity, accuracy, reasonableness, and completeness.

In Actuarial Standard of Practice No. 23, due consideration is required of the following:

- Appropriateness for intended purpose ...
- Reasonableness and comprehensiveness ...
- Any known, material limitations ...
- The cost and feasibility of obtaining alternative data ...
- The benefit to be gained from an alternative data set ...
- Sampling methods ...

The NAIC *Statistical Handbook of Data Available to Insurance Regulators* contains some data quality standards.

Rate Justification: Overall Rate Level

➤ Profit Provision

The profit provision is the company's estimate of their underwriting profit needs that, in combination with investment income and other miscellaneous (non-investment) income, will result in achievement of company, policyholder, and shareholder expectations.

Underwriting profit is calculated as:

- Earned premiums
- Less incurred losses
- Less incurred expenses (loss adjustment expenses and underwriting expenses)
- Less policyholder dividends

“Property/casualty insurance rates should provide for all expected costs, including an appropriate cost of capital associated with the specific risk transfer. This cost of capital can be provided for by estimating that cost and translating it into an underwriting profit provision, after taking leverage and investment income into account” or developing an underwriting profit provision and testing that profit provision for consistency with the cost of capital.⁶

In the determination of the underwriting profit needed, the company should consider the economic risk/reward situation from the risk in their insurance policies and the overall rate of return needed. To avoid excessive underwriting profit provisions, the filer should account for the investment income that will be derived from assets that support the unearned premium and loss reserves, and should also account for any risk loads included in the pricing of rating factors (e.g., the risk loads typically included in the increased limit factors for liability coverages).

Prior to the 1980s, it was common for insurance companies to use underwriting profit provisions from 2% to 5%, because policies covered short-tailed lines of business (e.g., property coverage where claim payments are made within a few years) and investment income was low. From the 1980s on, the high-investment income allowed significantly negative profit provisions, especially for longer-tailed lines of business (e.g., medical malpractice where claim payments might not be made for seven or more years).

⁶ Actuarial Standard of Practice No. 30 “Treatment of Profit and Contingency Provisions and the Cost of Capital in Property/Casualty Insurance Ratemaking,” Actuarial Standards Board, July 1997.

In consideration of appropriate profit provisions, an analyst can utilize the NAIC Profitability Report to determine reasonability. The Profitability Report includes historical underwriting profit by line of business by state. Care should be taken to avoid allowance of greater profitability for lower efficiencies or for having too much or too little capitalization for the amount of business written. A company's decisions about the allocation of surplus should be reviewed for reasonableness because this will have a significant impact on the resulting profit provision.

In some states with excess profit laws that cap the amount of profit an insurance company can have, there is additional protection to make sure underwriting profit provisions are not excessive.

Contingency Provision

The contingency provision provides for “the expected differences, if any, between the estimated costs and the average actual costs that cannot be eliminated by changes in other components of the ratemaking process.”...”While the estimated costs are intended to equal the average actual costs over time, differences between the estimated and actual costs of the risk transfer are to be expected in any given year. If a difference persists, the difference should be reflected in the ratemaking calculations as a contingency provision. The contingency provision is not intended to measure the variability of results and, as such, is not expected to be earned as profit.”⁷

When insurers include a contingency provision in their rates for lines of business with potential for catastrophes or with other significant potential for adverse deviation in expected costs, the regulator should discuss whether that is better defined as additional profit loading or an additional catastrophe provision. For example, if the line of business is subject to greater uncertainty and can be expected to require more capital to support, then the amount should be included in the profit provision. (In this case, companies often combine the profit and contingency provisions as one number.) If the provision is intended to cover extreme or unexpected catastrophe potential not accounted for in the catastrophe modeling process, then the amount should be recognized in the catastrophe provision. In any case, the filer should be able to justify a provision as being reasonable. Whether the contingency provision is considered to be a part of losses, expenses, or the profit loading, it should be considered in the calculation of the overall return on premium or equity.

Credibility

“Credibility, simply put, is the weighting together of different estimates to come up with a combined estimate. For instance, an insured's own experience might suggest a different premium from that in the manual. These are two different estimates of the needed premium, which can be combined using credibility concepts to yield an adjusted premium.”⁸ For a rate filing, credibility is commonly used to quantitatively describe “the level of believability” of data and is used when an insurer's historical data is insufficient to provide reliable ratemaking calculations. A credibility factor of 70% means there would be 70% weight assigned to the company's own indication, and the complement of credibility of 30% (= 100% - 70%) weight assigned to an alternative indication, or allocated to multiple alternative indications.

The determination of the credibility weight varies from pure selection (based on judgment) to detailed calculations using expected values and variances or minimization of the sum of squared errors. A common standard of credibility based on frequency and ignoring severity (assuming severity is constant) is a full credibility standard of 1082 claims.⁹ Partial credibility is then the square root of the number of claims divided by 1082. With 250 claims underlying the claim data, there would be $(250 / 1082)^{1/2}$, or 50% credibility. While this credibility standard might be used, it is not always appropriate. It is not appropriate for most lines of business since severity typically varies and the Poisson frequency distribution typically does not apply. There are numerous accepted methods of calculation of credibility factors.

Evaluation of credibility factors is difficult for regulators because selection is often a matter of judgment and credibility selections vary depending on what is being evaluated (e.g., credibility can be claim counts for some items and premium volume for others) or for what purpose credibility is being used (e.g., rate level vs. trend). The filer should be able to explain the reasonability of their credibility selection.

⁷ Actuarial Standard of Practice No. 30 “Treatment of Profit and Contingency Provisions and the Cost of Capital in Property/Casualty Insurance Ratemaking,” Actuarial Standards Board, July 1997.

⁸ *Foundations of Casualty Actuarial Science*

⁹ Assumptions: There is a constant size of loss and varying number of claims. The assumed claim frequency distribution is Poisson. The calculation assumes the actual total losses will be within 5% of the expected losses with probability of 90%. The model allows for no variation in the average size of loss.

Once a credibility factor is selected, it is also important to evaluate the reasonableness of the selection of the alternative indication. Common examples for a statewide indication are a regional indication, countrywide indication, or inflation.

Calculation of Overall Rate Level Need: Methods

Two commonly used methods to determine the overall rate level need are the loss ratio method and the pure premium method.

➤ Pure Premium Method

The pure premium method starts with the loss costs needed to pay claims and adds in expenses. Splitting the expenses by the fixed and variable components, the rate formula would be

$$\text{Indicated Rate} = \frac{\$ \text{Projected pure premium} + \$ \text{Projected fixed expenses}}{1 - \text{Variable expense \%} - \text{Profit and contingencies \%}}$$

This method makes intuitive sense but still requires significant analysis to determine the individual components. In addition, exposure units are sometimes not available or meaningful, so the method would not be useable. However, with new lines of business or products, this method is the only alternative and would be based on significant judgment.

➤ Loss Ratio Method

A loss ratio is losses divided by premium. Losses and premium can be defined in numerous ways, but for analysis of the overall rate level need, it is likely that the loss ratio is the projected ultimate loss and loss adjustment expense divided by projected premiums. An indicated rate is the old rate times the ratio of the projected loss ratio to the target loss ratio (e.g., projected loss ratio divided by the target loss ratio.)

Projected Loss and LAE Ratio =

$$\frac{\text{Incurred Loss and DCC adjusted for trend, loss development, CAT/large losses, A\&O, law changes, etc.}}{\text{Projected on-level premium}}$$

Target Loss and LAE Ratio = $\frac{1 - \text{Variable expense \%} - \text{Profit and contingencies \%}}{1 + \text{Ratio of fixed expenses to losses}}$

Indicated Rate Change = $\frac{\text{Projected Loss and LAE Ratio}}{\text{Target Loss and LAE Ratio}} - 1$

Indicated Rate = Old Rate x (1 + Indicated Rate Change)

➤ Loss Ratio Method vs. Pure Premium Method

- The loss ratio method produces an indicated rate percentage change. The pure premium method develops indicated rates directly. Thus, the loss ratio method requires historical data and old rates.
- For new coverages or new lines of business, typically the pure premium method is used, or another method based significantly on judgment or competitor market rates.
- Both methods require projection of ultimate losses.
- Only the loss ratio method requires the projection of premium. The pure premium method uses earned exposure units.
- Both methods will produce identical rates when identical data and consistent assumptions are used.

Rate Justification: Rating Factors

➤ Rating Factors

Many rating systems utilize a “base-times-factor” methodology. The premium to charge is calculated from a base rate with additional price being added or credited (typically by multiplying by rating factors) depending on the policy coverage options selected and the risk characteristics of the policyholder. Policy coverage options in auto insurance would be choices such as increased limits and deductibles. Risk characteristics commonly considered in the rating variables for auto insurance are age, gender, marital status, driving record, citation record, vehicle rating group (by make/model), annual mileage, vehicle use, garaging location (also known as territory), and others. [Note: Some states do not allow some of these rating variables.]

The use of classifications and similar rating variables allows for the price of insurance to be more equitable amongst policyholders, because policyholders pay a price commensurate with the risk they bring to the insurance company. Regulators do need to evaluate classifications for unfair discrimination. A rule of thumb is that prices are not unfairly discriminatory when consumers are charged different amounts that are actuarially justified (or justified based on risk/cost).

In addition rate classifications help to maintain availability in the market for all risks. If one rate would be charged to every policyholder, then some groups of policyholders with identifiable characteristics would create large profits to insurance companies, and others would result in large losses. As these groups are identified, the insurance companies would start to write the more profitable business and would not write the others, resulting in availability problems for those high-risk groups.

➤ Acceptability of Rating Factors

Some rating factors, such as education or occupation, might be controversial or perceived to be discriminatory against protected classes and might not be acceptable in a state. For unprotected classes, the more that the rating factors relate to the exposure covered in the insurance policy, the more acceptable they tend to be. You should be aware of your state’s laws and regulations regarding which rating factors are allowed.

➤ Calculation of Rating Factors

Rating factors are generally developed for each rating variable (although additive dollar amounts are also options). Rating factors less than 1.00 are credits or discounts from the base rate. Rating factors greater than 1.00 are surcharges from the base rate. Rating factors of 1.00 are typically the base rate (although other classifications could also have rating factors of 1.00).

Each rating variable is divided into groups that have rating factors associated with them. For example, a company that slots insured vehicles into rating groups based on damageability and cost to repair vehicles would develop rating factors for each group. The following is an example of rating factors by group:

Vehicle Rating Group	Rating Factor
1	.90
2	.95
3	1.00
4	1.05
5	1.10

If the base rate is \$200 for the Vehicle Rating Group 3, the price this company would charge to insure a vehicle included in Vehicle Rating Group 1 would be \$180 (= \$200 x .90).

Development of the rating factors is similar to how the overall indication is developed. The loss ratio method can again be used to create or modify rating factors. The indicated rating factor for Vehicle Rating Group 1 would be the current rating factor of .90 multiplied by the ratio of the loss ratio for Group 1 divided by the loss ratio of Group 3. If the loss ratios were

63% for Group 1 and 70% for Group 3, then the indicated rating factor for Group 1 would be .81 (= .90 x 63% / 70%). There might be additional steps for credibility or to account for fixed expenses that do not vary by rating group (also called “flattening” for expenses).

Because there are numerous rating variables in the classification system, it is accurate to adjust all of the relativities simultaneously or do a sequential analysis with loss ratios being adjusted along the way for rate credits/debits already evaluated. The sequential analysis removes potential double counting of the same underlying loss effects.

Once the indicated rating factors are calculated, the overall rating impact from changes to the rating factors should be calculated. The change in the average rating factor is the overall rating impact, although one must take care in the calculation of the average rating factor. A rating factor should never be averaged with the premium that includes the impact of the rating factor; however, the current level premium should be divided by the current rating factor and then used to weight the factors. An alternative to using premium prior to application of the rating factor is to use exposures. Once the overall rating impact from changes to the rating factors is calculated, the base rates would change enough so that in total, the overall selected rate change is met.

An example of this analysis is provided:

Overall Rate Need (= Selected Rate Change): 7%

Data:

Vehicle Rating Group	Current Rating Factor	Loss Ratio	On-level Premium
1	.90	63%	\$1000
2	.95	71%	\$1200
3	1.00	70%	\$1200
4	1.05	72%	\$1000
5	1.10	77%	\$500

Calculation:

Vehicle Rating Group	Current Rating Factor	Loss Ratio	Loss Ratio Relativities	Indicated Rating Factor
1	.90	63%	.63 / .70 = .90	.90 x .90 = .81
2	.95	71%	.71 / .70 = 1.01	.95 x 1.01 = .96
3	1.00	70%	.70 / .70 = 1.00	1.00 x 1.00 = 1.00
4	1.05	72%	.72 / .70 = 1.03	1.05 x 1.03 = 1.08
5	1.10	77%	.77 / .70 = 1.10	1.10 x 1.10 = 1.21

Vehicle Rating Group	On-level Premium	Current Rating Factor	On-level Premium Prior to Rating Factor (at Base Rate)
1	\$1000	.90	\$1000 / .90 = 1111.11
2	\$1200	.95	\$1200 / .95 = 1263.16
3	\$1200	1.00	\$1200 / 1.00 = 1200.00
4	\$1000	1.05	\$1000 / 1.05 = 952.38
5	\$500	1.10	\$500 / 1.1 = 454.55
Total			4981.20

The average current rating factor is calculated as

$$\frac{.90 \times 1111.11 + .95 \times 1263.16 + 1.00 \times 1200.00 + 1.05 \times 952.38 + 1.10 \times 454.55}{4981.20} = .9837$$

The average indicated rating factor is calculated as

$$\frac{.81 \times 1111.11 + .96 \times 1263.16 + 1.00 \times 1200.00 + 1.08 \times 952.38 + 1.21 \times 454.55}{4981.20} = .9819$$

Overall rating impact from changes to Rating Factors:

$$= .9819 / .9837 - 1 = -0.2\%$$

Price Change needed to Base Rates to achieve overall 7% rate change:

$$= [1 + \text{overall price change}] / [1 + \text{Rating Factor Impact}] - 1$$

$$= [1 + 7\%] / [1 + (-0.2\%)] - 1$$

$$= 7.2\%$$

Calculation of Deductible Rating Factors

A deductible is the amount the policyholder is to pay in the event of a claim, as established in the policy. The insurance company is responsible for the covered loss amount above the deductible.

Deductible factors are a function of the losses remaining to be paid compared to total loss that would be paid without the deductible, with an adjustment for the fact that some expenses (such as commission expense or office rent) are not eliminated with the deductible.

The first step is to determine the loss elimination ratio, or the amount of losses eliminated by the deductible divided by the total amount of losses. An example of this calculation is provided:

Loss Size	# of Claims	Total Loss Amount	Losses After \$100 Deductible
\$100	10	1,000	0
\$250	10	2,500	1,500 (2,500 - 10 x 100)
\$500	5	2,500	2,000 (2,500 - 5 x 100)
\$1,000	4	4,000	3,600 (4,000 - 4 x 100)
Total (Sum)		10,000	7,100
Loss Eliminated: 10,000 - 7,100 = 2,900			
Loss Elimination Ratio (LER): 2,900/10,000 = .29			

The Loss Elimination Ratio (LER) is then adjusted for fixed expenses to calculate the deductible factor:

$$\text{Deductible Factor} = \frac{\text{Expected Loss Ratio} \times (1 - \text{LER}) + \text{Fixed Expense Ratio}}{1 - \text{Variable Expense Ratio}}$$

If the Expected Loss Ratio is 60%, the Variable Expense Ratio is 30%, and the Fixed Expense Ratio is 10%, then the Deductible Factor would be:

$$\text{Deductible Factor} = \frac{.60 \times (1 - .29) + .10}{1 - .30}$$

$$= \frac{.60 \times (1 - .29) + .10}{1 - .30}$$

$$= .75 \text{ (rounded)}$$

The LER suggests a 29% reduction, however, with flattening for expenses, the rate credit is only 25% (1.00 - .75 deductible factor).

Calculation of Increased Limit Factors

Increased limits are typically defined as the limits of liability above the minimum required limits (e.g., the financial responsibility limits in auto insurance) established by the state. Loss ratio and pure premium methods do not work well for increased limit pricing, largely because of sparse data at the higher limits and of policy limit censorship (e.g., if a loss is \$500,000 but the limit of liability is \$100,000, then only the \$100,000 gets coded into the data system).

Mathematical distributions are often used to derive increased limit factors. Available data is fitted to a mathematical distribution, and then that distribution is used to extrapolate anticipated expected losses at higher levels of limits.

When using loss data, consideration needs to be given to any differences in loss development or loss trends by limit. Loss development factors tend to be higher for higher limits of liability because the losses at the higher limits tend to be the ones that take a longer time to settle. Trend factors also tend to be higher for higher limits of liability because the growth of loss amounts for lower limits are capped more often by the limit of liability.

Increased limit factors often contain risk loads that increase as the limits of liability increase. Based on economic principles, it is appropriate to obtain higher rates of return when accepting higher risk. As noted in the section titled “Profit and Contingency Provisions,” it is also appropriate to consider this when selecting the profit and contingency provision to apply to basic limit rates.

Credibility for Rating Factors

Just as credibility, or the level of believability of data, was considered in the overall indicated rate change, credibility is considered in the rating factor indications. While common examples of the alternative indication used when applying credibility to the overall rate change are a regional indication, countrywide indication, or inflation, credibility for rating factor indications is often weighted with the overall indication.

Interaction between Rating Variables (Multivariate Analysis)

If the pricing of rating variables is evaluated separately for each rating variable, there is potential to miss the interaction between rating variables. Care should be taken to have a multivariate analysis when practical. In some instances a multivariate analysis is not possible.

Approval of Classification Systems

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to classification plans can be significant and have large impacts on the consumers’ rates, regulators should focus on these changes.

Some items of proposed classification can sometimes be deemed to be against public policy, such as the use of education or occupation. You should be aware of your state’s laws and regulations regarding which rating factors are allowed.

Rating Tiers

Some states allow an insurer to have multiple rate levels, or rating tiers, within a single company. These rating tiers are another way of classifying risks for rating purposes. Typically, there are requirements for rating tiers: the underwriting rules for each tier should be mutually exclusive, clear, and objective; there should be a distinction between the expected losses or expenses for each tier; and the placement process should be auditable. Tiers within a company are mainly seen in personal lines products.

One particular concern with rating tiers would be the analyses of whether a plan produces unfair discrimination. Questions arise around the time-sensitive aspects of the underwriting criteria and any related re-evaluation of the tiers upon renewal. For example, consider two tiers where the insured is placed in the “high” tier because of a lapse of insurance in the prior 12 months. The question is: What happens upon renewal after there has no longer been a lapse of insurance for 12 months? Does the insured get slotted in the “low” tier as he would if he was new business? Some statutes limit the amount of time that

violations, loss history, or insurance scores can be used, and some statutes might only allow credit history to be used for re-rating at the policyholder's request. Regulators should consider the acceptability of differences in rates between existing and new policyholders when they have the same current risk profile.

Insurers also can create different rating levels by having separate companies within a group. While regulators should examine rating tiers within an insurer to a high degree of regulatory scrutiny, there tends to be less scrutiny with differences in rates that exist between affiliated companies. Workers' compensation insurers are more likely to obtain rating tiers using separate companies.

Rate Justification: New Products

When new products are introduced, there are often new unanswered questions for a regulator, especially because new products are the most difficult to price. There may be additional judgment and use of competitor rates involved with new products. Regulators should discuss new issues with management and consider using NAIC message boards to discuss issues.

➤ Individual Risk Rating

The rating system established with base rates and rating factors, sometimes called "manual rates," typically groups policyholders within classifications based on each policyholder's individual characteristics. However, there could be some policyholders, especially in the commercial lines of business, where it is appropriate to modify the manual rate based on the policyholder's own loss experience. The most common methods of rating based on individual actual loss experience are called experience rating, schedule rating, and retrospective rating. These plans are typically required to be filed with the state.

➤ Experience Rating

Experience rating uses the actual loss experience of the policyholder to calculate a rating discount or surcharge. A typical process is that actual individual losses are capped at a maximum single loss, the actual capped losses are compared to similarly limited expected losses, and credibility is considered to develop the experience rating modification factor. (There are other detailed adjustments to data in the calculations.) The states typically place limitations on the amount that experience rating can impact the overall rate.

Typically, there is a requirement of the policy being a minimum size to qualify for experience rating and a requirement that all policies meeting that size requirement be experience rated.

➤ Schedule Rating

Schedule rating is a method of pricing property and liability insurance. It uses charges and credits to modify a class rate based on the special characteristics of a risk. Insurers have been able to develop a schedule of rates because experience has shown a direct relationship between certain physical characteristics and the possibility of a loss. For example, implementation of an effective safety program should likely result in lower insurance rates but will not be fully reflected in loss experience for a few years. Companies who change their delivery drivers from experienced drivers to youthful drivers should likely pay more. Some examples of schedule rating categories might include:

- Premises: Condition, Care
- Equipment: Type, Condition, Care
- Employees: Selection, Training, Supervision, Experience

Each state establishes limitations on schedule rating. Typically, there is a limitation on the overall percentage impact on the policyholder's rates from schedule rating.

Typically, there is a requirement of the policy being a minimum size to qualify for schedule rating, which is often less than the level required for experience rating.

➤ **Combination of Experience and Schedule Rating Factors**

States typically require companies to state whether the experience rating factor and schedule rating factor are additive (where discounts/charges are added together) or multiplicative (where factors are multiplied together). If the experience rating factor is .90, or includes a 10% discount, and the schedule rating factor is 1.03, or includes a 3% charge, the additive factor would be .93 ($= 1 - 10\% + 3\%$) and the multiplicative factor would be .927 ($= .90 \times 1.03$).

➤ **Retrospective Rating**

Retrospective rating is where a policyholder pays an initial deposit premium (likely based on manual rates) at the time the policy is issued, but the premium is adjusted over time as claims emerge and more information is known about the true costs that have arisen from the insurance policy. Retrospective rating plans differ from typical insurance pricing. Typical pricing is prospective and does not allow for recoupment of past losses.

The analysis for retrospective rating is similar to experience rating in that actual losses are used, individual claim amounts can be capped, and resulting amounts are compared to expected amounts at the same level of capping and same point in expected development. The retrospective adjustment is usually limited at minimum and maximum premium levels. There is also a limitation in how many years of adjustments are made.

➤ **Dividend Rating Plans**

Dividend rating plans, used most commonly in workers' compensation, are sometimes allowed. The company can charge more up-front to provide more cushion when losses are worse than expected, but when loss experience is better than expected, the company can disperse extra profits out to policyholders. This plan is often used as an acceptable marketing tool.

Predictive Modeling

The ability of computers to process massive amounts of data has led to the expansion of the use of predictive modeling in insurance ratemaking. Predictive models have enabled insurers to build underwriting models with significant segmentation power and are increasingly being applied in such areas as claims modeling and used in helping insurers to price risks more effectively.

Key new rating variables that are being incorporated into insurers' predictive models include homeowners' rates by peril, homeowners rating by building characteristics, vehicle history, usage-based auto insurance, and credit characteristics.

Data quality within and communication about models are of key importance with predictive modeling.

Advisory Organizations

➤ **Advisory Organization Filings**

Advisory organizations develop loss costs, policy forms, risk classifications, and other miscellaneous rating rules that may be used by insurer members of the organizations.

Allowable advisory organization activities are likely defined in your state rating law. The NAIC model rating laws define the advisory organizations' permitted and prohibited activities with the intent to prohibit anticompetitive behavior and discourage concerted rate action by insurers. Generally, advisory organizations are not allowed to publish fully developed rates, including all expense and profit loadings, for the insurance companies to use. They can, however, provide advisory prospective loss costs, which would be the recommended insurance charge prior to consideration of expenses (typically, other than loss adjustment expenses) and profit.

When an advisory organization makes a loss cost or rating rule filing, the state’s resources applied to the filing are generally high given that the components of the filing will be used by many insurance companies and have a large impact on the market.

➤ Insurance Company’s Use of Advisory Organization’s Loss Costs

Adoption of the advisory organization’s loss costs requires development of a loss cost multiplier to add in any missing expenses and profit. The NAIC developed model filing forms for loss cost multipliers (Appendices A, B, and C). A calculation of the loss cost multiplier when a company fully adopts the advisory organization’s loss costs and has no expense constants is illustrated:

	Selected Provisions	
A. Total Production Expense	15	%
B. General Expense	10	%
C. Taxes, Licenses and Fees	3	%
D. Underwriting profit and Contingencies (adjusted for investment income)	2	%
E. Other	0	%
F. Total	30	
G. Expected Loss Ratio: $ELR = 1 - F$ (in decimal form)	.70	
Loss Cost Multiplier = $1 / G$	1.429	

The expense selection within the loss cost multiplier is often justified with a multiple-year analysis of previous expense levels, as well as a determination of the appropriateness of projecting those past historical numbers to the future policy period.

When a company files to adopt the loss costs of an advisory organization, they can adopt the loss costs without modification, or they can deviate from those loss costs in some respect. Some examples of deviation are adding, consolidating, or eliminating classes or other rating factors, changing the rating steps or formula, or using a percentage deviation from the advisory organization’s overall rate level. With a deviation measured as a certain percentage, then the calculation of the loss cost multiplier is adjusted. First, the loss cost modification factor is calculated as $1.00 +/-$ the deviation. For example, if the deviation is -10%, then the loss cost modification factor is .90 ($1.00 - .10$). If the deviation is +15%, then the loss cost modification factor is 1.15 ($1.00 + .15$). The loss-cost multiplier formula is then adjusted as the loss cost modification factor divided by the expected loss ratio (vs. the formula of 1 divided by the expected loss ratio).

	Selected Provisions	
A. Total Production Expense	15	%
B. General Expense	10	%
C. Taxes, Licenses and Fees	3	%
D. Underwriting profit and Contingencies (adjusted for investment income)	2	%
E. Other	0	%
F. Total	30	
G. Expected Loss Ratio: $ELR = 1 - F$ (in decimal form)	.70	
H. Deviation	-.08	
K. Loss Cost Modification Factor = $1 + H$.92	
Loss Cost Multiplier = K / G	1.314	

The deviation from advisory loss costs should be explained.

- Loss Cost Multiplier Forms

There are rate filing forms used to file loss cost multipliers to be applied to advisory organization loss cost filings. The NAIC has some model filing forms developed by the NAIC Operational Efficiencies (EX) Working Group. You should be aware of your state's filing form requirements.

- Insurance Company's Use of Advisory Organization's Rating Rules

In addition to filing prospective loss costs for companies to use to create rates, advisory organizations also impact rates through the rating rules. These rating rules sometimes contain rating factors (e.g., classification factors, increased limit factors, experience rating plans, etc.) that could significantly impact the final rates of the policyholder. Because of the rate impact and also because of the need to analyze for unfair discrimination, the rating rules are important to consider, in addition to the overall rate level changes.

In addition to analyzing the advisory organizations' rating rules, there can be numerous rules where the insurance company needs to create their own rating manual rules. For example, minimum premiums are not established by the advisory organization, and, thus, the company should create rate manual pages that list the minimum premiums that will be charged. For deductibles, the advisory organization might issue the expected elimination ratios and then the company would consider the expense impact to create the deductible factors (because expenses would not be eliminated in the same proportion as loss amounts).

Workers' Compensation Special Rules

In the NAIC model rating laws, there are special rules for the workers' compensation line of business. A uniform classification system and uniform experience rating plan are required, although some subclasses and other variations might be allowed, so long as the data can be reported under the uniform statistical system. For example, if there was one classification for all types of restaurants, a company might be able to justify a split of the restaurant class into restaurants that serve liquor and those that do not.

Premium Selection Decisions

- Indicated Rate Change vs. Selected Rate Change

After applying credibility, the indicated rate change should reflect the company's best estimate of their premium needs given their current or expected book of business. However, insurance companies also have other business considerations including competition, marketing, legal concerns, impact of the rate change on retention, etc. A company might wish to deviate from their indicated rate change and should justify those decisions, within the constraints of the law.

- Capping and Transition Rules

With advances in technology, it is possible for companies to introduce capping of rates on individual policies with an aim toward gradually increasing policyholders' rates, rather than making large modifications all at one time. Similarly, premiums are often proposed to be modified when an insurer acquires another company's book of business or decides to move from or to an advisory organization's plan. These types of proposed capping are sometimes called "renewal premium capping," "rate capping," "a rate stability program," or "transition rules."

Transition rules for individual policyholders can get quite complex and you need to be aware of your state's positions on premium capping rules. Any premium capping and transition rules require weighing the pros and cons of the potential for unfair discrimination (with some customers not paying the rate commensurate with the risks they have) vs. rate stability for existing policyholders.

If premium capping or transition rules are allowed, additional decisions will need to be made:

- ⇒ Which rates should get capped?
- ⇒ Do rate decreases get capped? If so, what is the impact if the policyholder asks to be quoted as new business?
- ⇒ Do all rate increases get capped or only above a certain percentage?
- ⇒ How much time will lapse or how many renewal cycles will occur before the new rates are in place or different rating plans are merged?
- ⇒ Should the insured be told what the final premium will be once no more capping is applied?
- ⇒ How would exposure change be addressed? If the policyholder buys a new car or changes their liability limits, what is the impact on their rate capping?
- ⇒ How many rate-capping rules can be implemented at any given time?

When premium capping or transition rules have been incorporated, future indicated rate changes and rating factor analyses need to properly reflect the fully approved rate changes. If the overall approved rate change was +10%, yet capping resulted in only 8% being implemented in the first year, the remaining amount to recognize the full 10% should be reflected in the premium on-level adjustment. Otherwise, the indicated rate would be redundant.

Some states encourage more frequent filing of rate changes that can help to avoid the need of premium capping and transition rules. Some states might prefer capping of individual rating variables, rather than capping for individual policyholders.

Installment Plans

Some states consider installment plans to be premiums and, thus, subject to the same regulatory review as premiums. The states might require justification of the plan's costs, electronic funds transfer (EFT) fees, bad debt write-offs included in the installment fees, and use of any competitor information. The states might develop benchmarks of typical charges for installment plans to assess the reasonability of filed fees.

Policy Fees

Companies sometimes charge policy fees that are considered by states to be premiums and, thus, subject to the same regulatory review as premiums. Policy fees are generally charged to cover fixed expenses that are not related to the loss exposure.

You should be familiar with your state requirements as to whether policy fees are allowed to be "fully earned" once the policy is written. Some states may require return of some portion of these fees in their pro-rata or short rate laws.

Potential Questions to Ask Oneself as a Regulator

Every filing will be different and will result in different regulatory analyses. But the following are some questions the regulator might ask oneself in a rate filing review:

1. Regarding data:
 - a. Is the data submitted with the filing enough information for a regulatory review?
 - b. Is the number of years of experience appropriate?
 - c. Did the company sufficiently analyze and control their quality of data?
2. Regarding the support and justification of rates:
 - a. Did they propose rate changes without justification?
 - b. Are proposals based on judgment or competitive analysis? If so, are the results reasonable and acceptable? Are there inappropriate marketing practices?
 - c. Are the assumptions (loss development, trend, expense load, profit provision, credibility etc.) used to develop the rate indication appropriate? Are they supported with data and are deviations from data results sufficiently explained?
 - d. Is the weighting of data by year (or credibility) properly justified or does it appear random?
 - Is there more weight being placed on data in one year solely because it produces a higher indicated rate change?

- If there are two indications being weighted together and one is for a rate increase and one is a rate decrease, is the weighting justified?
- e. Is there satisfactory explanation about why a proposed rate change deviates from the indicated rate change?
- 3. Regarding differences in assumptions from previous filings:
 - a. Have methodologies changed significantly?
 - b. Are assumptions for the weighting of years or credibility significantly different? Or does there appear to be some manipulation to the rate indication?
- 4. Is there unfair discrimination?
 - a. Do classifications comply with state requirements?
 - b. Are proposed rates established so that different classes will produce the same underwriting results?
- 5. What do you need to communicate?
 - a. Can you explain why you are taking a specific action on the filing?
 - b. What do you need to tell the Consumer Services Department?
 - Can you explain the impact of the rate change on current business? How big is the company and how much of the market is impacted?
 - What are the biggest changes in the filing (and the ones on which consumer calls might be expected)?
 - What is the maximum rate change impact on any one policyholder?

Questions to Ask a Company

If you remain unsatisfied that the company has satisfactorily justified the rate change, then consider asking additional questions of the company. Questions should be asked of the company when they have not satisfied statutory or regulatory requirements in the state or when any current justification is inadequate and could have an impact on the rate change approval or the amount of the approval.

If there are additional items of concern, the company can be notified so they will make appropriate modifications in future filings.

Additional Ratemaking Information

The Casualty Actuarial Society (CAS) has an extensive examination syllabus that contains a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS website contains links to many of the papers included in the syllabus. Recommended reading is the *Foundations of Casualty Actuarial Science*, which contains chapters on ratemaking, risk classification, and individual risk rating.

Other Reading

Some additional background reading is recommended:

Foundations of Casualty Actuarial Science, Fourth Edition (2001):

- Chapter 1: Introduction
- Chapter 3: Ratemaking
- Chapter 6: Risk Classification
- Chapter 9: Investment Issues in Property-Liability Insurance
- Chapter 10: Only the section on Regulating an Insurance Company, pp. 777–787

Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty ratemaking.

Casualty Actuarial Society (www.casact.org): “Basic Ratemaking.”

American Institute for Chartered Property Casualty Underwriters: “Insurance Operations, Regulation, and Statutory Accounting,” Chapter Eight.

Association of Insurance Compliance Professionals: “Ratemaking—What the State Filer Needs to Know.”

Review of filings and approval of insurance company rates.

Summary

Rate regulation for property/casualty lines of business requires significant knowledge of state rating laws, rating standards, actuarial science, and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and flex rating.
- Rate standards typically included in the state rating laws require that “Rates shall not be inadequate, excessive, or unfairly discriminatory.”
- A company will likely determine their indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, Catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.
- Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.
- Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.
- Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.
- Casualty Actuarial Society’s *Statement of Principles Regarding Property and Casualty Insurance Ratemaking* provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.
- NAIC model laws also include special provisions for workers’ compensation business, penalties for not complying with laws, and competitive market analysis to determine whether rates should be subject to prior approval provisions.

While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rule may require the examiner to adopt different standards or guidelines than the ones described.

Chapter Three Glossary

Adjusting and Other Expenses: Those expenses other than DCC. A&O includes, but is not limited to, fees and expenses of adjusters and settling agents, loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year, attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder, and fees and salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster. (SSAP No. 55)

Advisory Organizations: As defined in the *Property and Casualty Model Rating Law (Prior Approval Version)* (#1780): “‘Advisory organization’ means any entity, including its affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities ...”

ALAE: Loss adjustment expenses that are assignable or allocable to specific claims. (*Foundations of CAS*)

Base Rate: Benchmark premium rates for each risk classification.
(www.lni.wa.gov/ClaimsIns/Insurance/RatesRisk/How/RiskClass/default.asp)

Consumer Price Index: An index of the cost of all goods and services to a typical consumer.
(<http://wordnet.princeton.edu/perl/webwn>)

Defense and Cost Containment: Includes defense litigation, and medical cost containment expenses, whether internal or external. DCC expenses include, but are not limited to: surveillance expenses; fixed amounts for medical cost containment

expenses; litigation management expenses; loss adjustment expenses for participation in voluntary and involuntary market pools if reported by accident year; fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses; attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and the cost of engaging experts. (SSAP No. 55)

Detrending: The statistical or mathematical operation of removing trend from the series. Detrending is often applied to remove a feature thought to distort or obscure the relationships of interest. (www.ltrr.arizona.edu/~dmeko/notes_7.pdf)

Experience Rating: Statistical procedure used to calculate a premium rate based on the loss experience of an insured group. (*Dictionary of Insurance Terms*)

Exposure rate: Basis to which rates are applied to determine premium. (www.irmi.com/online/insurance-glossary/terms/e/exposure-base.aspx)

Exposures: The basic rating unit underlying an insurance premium (*Foundations of CAS*)

Loss Development: Difference in the amount of losses between the beginning and end of a time period. (*Dictionary of Insurance Terms*)

Loss Ratio Method: Modification of premium rates by a stipulated percentage for closely related classes of property or liability insurance policies. The objective of such modification is to more directly align the combined actual loss ratio of the classes of policies under consideration with the expected loss ratio of these classes. The resultant alignment should show no significant standard deviation or variation of the actual loss ratio from the expected loss ratio

Manual Rate: Published cost per unit of insurance, usually the standard rate charged for a standard risk. (*Dictionary of Insurance Terms*)

Pure Premium: Calculation of the pure cost of property or liability insurance protection without loadings for the insurance company's expenses, premium taxes, contingencies, and profit margins. (*Dictionary of Insurance Terms*)

Pure Premium Rating Method: Approach that reflects losses expected. It is a calculation of the pure cost of property or liability insurance protection without loadings for the insurance company's expenses, premium taxes, contingencies, and profit margins. The pure premium is calculated according to the relationship:

$$\text{Pure Premium} = \frac{\text{Total Amount of Losses (and LAE) Incurred per year}}{\text{Number of Units of Exposure}}$$

Retrospective Rating: Method of establishing rates in which the current year's premium is calculated to reflect the actual current year's loss experience. An initial premium is charged and then adjusted at the end of the policy year to reflect the actual loss experience of the business. (*Dictionary of Insurance Terms*)

ULAE: Loss adjustment expenses that are assignable or allocable to specific claims. (*Foundations of CAS*)

CHAPTER FOUR

The Basics of Life and Annuity Regulation

Introduction

Many states do not regulate life insurance premium rates and annuity purchase rates, except for credit life insurance. A number of states do require the filing of life insurance rates and for any changes to the rates. The rationale for not regulating life insurance and annuity rates is that competition and market forces would adequately regulate rates. The review of a life insurance or annuity filing would generally be a review of various contract provisions and of compliance with the corresponding nonforfeiture law. A life insurance filing might need to include premium rates, in order to confirm compliance with the *Standard Nonforfeiture Law for Life Insurance* (#808). Some states also require compliance with the provisions in the *Valuation of Life Insurance Policies Model Regulation* (#830).

Laws and Regulations

Each state legislature has enacted state insurance laws relating to the regulation of life insurance, based on the following NAIC model laws and regulations:

Model #805: *Standard Nonforfeiture Law for Individual Deferred Annuities*

Model #806: *Annuity Nonforfeiture Model Regulation*

Model #808: *Standard Nonforfeiture Law for Life Insurance*

Model #820: *Standard Valuation Law*

Model #830: *Valuation of Life Insurance Policies Model Regulation*

The insurance commissioner adopts regulations needed to implement insurance rating laws. You will need to become familiar with your state laws and related regulations.¹⁰

State Regulation of Life Insurance and Annuities

There are three types of life insurance policies and annuity contracts based on how investment earnings on the supporting assets are credited to the contract.

- Variable life insurance and variable annuity contracts provide for benefits that vary to reflect the investment experience of the asset supporting the contracts. Variable contracts are regulated by the U.S. Securities and Exchange Commission (SEC), in addition to state insurance departments.
- Equity-indexed universal life insurance and equity-indexed annuities are products in which the interest credited to the policies is based on an outside index, usually a general index of equity returns. The supporting assets are typically debt instruments and equity options, not equities. These products are currently considered fixed-income products and are regulated by the state insurance departments.
- All other life insurance and annuity products, including those that participate in divisible surplus and those with other nonguaranteed elements, are regulated by state insurance departments. Participating policies provide for the distribution of surplus, according to experience, including investment experience on the supporting assets.

With the exception of participating policies, contracts other than variable contracts do not reflect investment experience.

¹⁰ For NAIC or company purposes, one can find a list of each state's rating law by line of business along with citations of the applicable state statutes and/or regulations in the NAIC *Compendium of State Laws on Insurance Topics*.

Interstate Insurance Product Regulation Commission (IIPRC)

The IIPRC is an important modernization initiative that is transforming the way asset-based insurance products are filed, reviewed, and approved—allowing consumers to have faster access to competitive insurance products in an ever-changing global marketplace. The IIPRC promotes uniformity through the application of uniform standards embedded with strong consumer protections.

The IIPRC serves as an instrumentality of its member states by leveraging regulatory resources and expertise to establish uniform standards. These uniform standards are the foundation for the IIPRC's central point of electronic filing.

Life and annuity products are included in the IIPRC. Companies have the choice of filing rates and forms through the IIPRC or directly with the state(s). If a company chooses to file directly with a state, the state regulator applies the existing product standard laws and procedures of the respective state. If a company files with the IIPRC, then the IIPRC standards and review process are applied.

Cash Surrender Values and Paid-up Nonforfeiture Benefits

Under the standard nonforfeiture law for life insurance, many life insurance policies require paid-up nonforfeiture benefits and cash surrender values. Some term life insurance policy forms are specifically exempt from the nonforfeiture law. Under the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805), many annuity contracts require paid-up annuity benefits and cash-surrender benefits. Deferred annuities and universal life insurance policies typically provide for surrender penalties. Compliance with the nonforfeiture laws limits surrender penalties. Form filings include an actuarial memorandum, which provides a product overview and demonstrates compliance with the appropriate nonforfeiture law or demonstrates the exemption from the nonforfeiture law.

Credit Life and Disability Insurance

Rates are reviewed prior to issue on decreasing term and/or disability insurance designed to pay the balance due on an outstanding loan. Generally, the rates are based on loan balance amounts of 10 years or less. Premiums may be static or may increase and/or decrease with the loan and the benefit amount.

Rates and tables filed are the most current prima facie rates and coverages that utilize applications with medical questions would include the underwritten rates schedules. Single-premium rates are filed at prima facie rates according to the required formula and any variations from that formula must provide a chart comparing the rates produced that certify that the rates are equivalent for all loan durations.

For net coverages, a table of net premium rates for a representative set of terms and interest rates and a statement of basis may be included. The amount insured is the indebtedness outstanding less the unearned interest and finance charges.

For closed-end net coverage, the monthly outstanding balance rates may be used or single premium rates may be calculated according to a formula that demonstrates it is actuarially consistent with the rates filed.

Rates filed for disability (including critical-period coverage) should not exceed the 1974 *Basic Tables of Credit A&H Claims Costs* times a state-specific factor (also published by the NAIC). For 60 months or longer, premiums generally would not exceed the NAIC 1970 extended tables. Revolving outstanding balance accounts should be filed for approval. The open-ended disability rates include the benefit payoff within 48 months, including accruing interest and charges. If the filing is longer than 48 months, the filing would include a rate adjustment that demonstrates a reduction consistent with the extended benefit period.

Revolving-account coverages would be filed using the prima facie rates for outstanding insured indebtedness. Rate plans that develop fixed-level rates for the duration of the coverage should include a narrative and the level rate formula that is equivalent to the total premium at prima facie rates divided by the number of months covered.

Combinations of coverage for level and decreasing coverage rates should include a combined formula. Reserving and refund formulas may be included in the filing for credit insurance. An experience report is sent to the NAIC each year.

CHAPTER FIVE

The Basics of Health Rate Regulation

Introduction

This chapter provides an overview of rate regulation for health insurance, including information about typical state rating laws and rate standards, ratemaking data, methods, and common regulatory issues.

Some calculations are provided throughout the chapter to aid understanding of subjects, but not all regulatory reviewers are required to understand the mathematical or actuarial aspects of these calculations.

Note that the terms “plan,” “policy,” “contract,” and “product” refer to the same concept.

Rating Laws and Guidance Manuals

Each state legislature has enacted state insurance rating laws, some of which are based on the following NAIC model rating laws and guidelines:

Model #118: *Small Employer Health Insurance Availability Model Act*

Model #119: *Model Regulation to Implement the Small Employer Health Insurance Availability Model Act*

Model #134: *Guidelines for Filing of Rates for Individual Health Insurance*

Model #641: *Long-Term Care Insurance Model Regulation*

Model #651: *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*

The insurance commissioner adopts regulations needed to implement insurance rating laws. You will need to become familiar with both your state rating laws and related regulations.¹¹

In addition, the NAIC has published guidance manuals for specific lines of business:

Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation

Guidance Manual for the Evaluation of Ratings Manuals and Filings Concerning Small Employer and Individual Health Insurance

Medicare Supplement Insurance Model Regulation Compliance Manual

Types of Health Insurance

There are several product lines of insurance that are classified as health insurance. This classification includes:

- Disability income insurance provides periodic payments if the insured is disabled under the terms of the contract.
- Long-term care insurance is designed to provide specialized insurance coverage for skilled nursing care and custodial care in a nursing home, assisted living facility, or home health care services required when the insured is unable to perform the specified activities of daily living or is cognitively impaired. Long-term care insurance typically covers specialized services that are not usually covered by comprehensive or major medical health insurance.

¹¹ For NAIC or company purposes, one can find a list of each state’s rating law by line of business along with citations of the applicable state statutes and/or regulations in the NAIC *Compendium of State Laws on Insurance Topics*.

- Comprehensive or major medical health insurance pays for all or part of medical expenses incurred by an insured.

The regulation of the comprehensive insurance market is split into three parts.

- Government-sponsored health benefit plans are government programs that provide health insurance benefits. These programs may be funded entirely by government funds or by a combination of government funds and premiums paid by the covered individuals enrolled in the program. The risk of financial loss is borne by the government. These programs might provide comprehensive major medical health insurance benefits (such as Medicaid and Medicare), limited primary health insurance benefits (such as county health clinics), or limited specialized health insurance benefits. These health benefit plans are regulated by federal regulatory agencies, such as the U.S. Centers for Medicare & Medicaid Services (CMS), or other state agencies.
- Employer-sponsored self-funded health benefit plans are plans sponsored by an employer to provide health insurance benefits to the employer's employees. These plans may be funded entirely by the employer or by a combination of employer funds and amounts withheld from covered employees' wages. The risk of financial loss is borne by the employer. However, most self-funded plans purchase commercial "stop loss" coverage for added protection. These self-funded plans usually provide comprehensive major medical health insurance benefits, and may provide benefits only to the employee or to the employee and the employee's dependents. These health benefit plans are regulated for the most part under the Federal Employee Retirement Income Security Act (ERISA) statute through the Department of Labor (DOL), the Centers for Medicare and Medicaid Services (CMS), and the Internal Revenue Service (IRS).
- Commercial insurance health benefit plans are plans marketed by insurance companies (which are licensed to sell insurance by each state in which they market) to provide health insurance benefits to insured persons. These types of plans are funded by the premiums collected from insured employers or individuals. The risk of financial loss is borne by the insurance company.

Commercial major medical insurance benefit plans can be issued as fee-for-service plans or managed care, either for profit or not for profit, health service plans (Blue Cross and Blue Shield is a nonprofit health service plan). Some plans require the use of a specific provider network. Usually, these plan designs are also referred to as managed care or health maintenance organizations. Usually, an insured person pays a copayment or coinsurance for covered medical services.

Commercial limited health insurance plans are not considered major medical insurance plans. Limited health plans usually cover lump sum benefits based on the type of service the member receives or the diagnosis.

The health insurance benefits provided vary from comprehensive major medical health insurance to specified limited health insurance benefits, such as dental, vision, or specified disease. Commercial health insurance is governed by state and federal law and is regulated by state insurance departments.

Medicare is a government-sponsored health benefit plan for people age 65 or older and for people of any age with certain disabilities. Medicare has the following parts listed below. These Medicare benefits (Parts A, B, C, and D) are regulated by the U.S. Centers for Medicare & Medicaid Services (CMS).

- Part A (Hospital Insurance) helps cover inpatient care in hospitals and skilled nursing facilities.
- Part B (Medical Insurance) helps cover doctors' services, as well as outpatient care and home health care.
- Part C (Medicare Advantage Plans) is a health option run by private insurance companies.
- Part D (Medicare Prescription Drug Coverage) is a prescription drug option run by private insurance companies.

Medicare supplement and Medicare Advantage policies are specialized health insurance products designed to complement the federal Medicare program.

Medicare supplement policies are designed to pay balances left over after traditional Medicare has paid. These policies are sold as a "supplement" to the basic Medicare Part A and Part B programs and provide additional coverage beyond the basic Medicare benefits.

Medicare Advantage (also known as Medicare Part C) policies are specialized health insurance products authorized by CMS to replace the traditional federal Medicare program. These policies are sometimes called a health maintenance organization (HMO) because some require the insured person(s) to obtain services from a specific provider network.

Medicare Advantage policies are sold as full replacement products. In other words, instead of providing specialized coverage for the “gaps” in Medicare like a supplementary product (with Medicare still bearing most of the insurance risk), Medicare Advantage products replace Medicare completely and the health insurance company bears the full risk of financial loss (with Medicare bearing no financial risk, other than paying the member’s portion of the premium to the health insurer).

Medicare supplement policies are regulated by state insurance departments.

Rate Standards and Justification

Rate standards are included in the state laws and are the foundation for the acceptance, denial, or adjustment to rate filings. Typical rate standards included in the state laws require that “The benefits are reasonable in relation to the premium charged.” This is usually accomplished by reference to an expected loss ratio, which is the ratio of the expected incurred claims to the expected earned premiums. The loss ratio standards are either specified in law or set by the regulatory authorities. For example, the minimum loss ratio for Medicare supplement insurance is set in the federal Social Security Act at 65% for individual business and 75% for group business.

The expected loss ratio is calculated by projecting earned premiums and incurred claims and determining the overall loss ratio. The period of the projection may vary by type of business. For major medical business the projection period might be one or two years. For long-term care or disability income insurance, the projection period might be 30 years or more.

Some of the assumptions that go into a projection are:

- **Morbidity:** Morbidity is a statistical projection of future illness, sickness, and diseases based on experience of other plans with similar benefits occurring by age in a given group of people.
- **Selection factors:** These factors for the first few years reflect the effect of underwriting on claim costs. For example, selection factors might be 0.90 in the first year, 0.945 in the second year and 0.98 in the third year, followed by 1.00 thereafter.
- **Trend factors:** This is the assumed annual inflationary trend in the morbidity costs consisting of increased frequency of claims and the increased cost of a medical procedure. Trend factors are based on assumed future growth of medical claims (the medical trends rate) developed based on generally accepted actuarial principles.
- **Persistency:** Persistency means the percentage of insurance remaining in force, or the percentage of policies that have not lapsed. This is the assumed rate at which policyholders will continue to pay premiums each year. Persistency varies by type of health policy.
- **Interest rate:** This is the interest rate used to discount the projected earned premiums and the projected incurred claims. It is an after-tax rate based on the current and anticipated investment earnings.

Many of the assumptions—such as the trend rate, interest rate, and persistency—will vary over time and among issuers. Therefore, it is not possible to present reasonable ranges on the assumptions. Each state will have its own process for compiling critical assumptions for purposes of developing its own database that can then be used to compare new filings.

Rates for many health insurance products can be adjusted as experience develops. Rate increases are usually limited to one a year. The process for a rate increase is similar to the initial rate justification, except there is past experience to consider. The experience from the time the plan was first issued is accumulated to the current time. Earned premiums and incurred claims are also projected from the current time. A rate increase must meet the lifetime loss ratio target (reflecting experience results and projected results) and a future loss ratio target.

If the amount of business in force in a particular state is too small to be considered as credible data, that state may require the rate increase to be based on the business nationwide. To adjust for different premium rates in each state, the historical experience and the projection of future experience may be recalculated to reflect the premium rates in the filing state.

The following is an example of a rate increase on a block of major medical business. The projection period is one year, because the new rate schedule is expected to be in effect for one year. In this example, the request may be made for a rate increase in the 10% – 12% range because that would bring the anticipated loss ratio down from 81.2% to the 72% range. A 12% increase would raise the projected earned premiums to \$75,600,000, which would produce a loss ratio of \$54,800/\$75,600 or 72.5%.

Major Medical Rate Increase

Earned Premiums	Incurred Claims	Expected Claims	Loss Ratio	Expected Loss Ratio
Past Experience				
55,803,100	40,398,000	41,146,000	72.4%	73.7%
Projected Experience for One Year				
67,500,000	54,800,000	49,730,000	82.2%	73.7%

The following is an example of an initial Medicare supplement filing. The projection period is the assumed lifetime of the business. The loss ratio over the entire period meets the 65% standard set in the Social Security Act.

Medicare Supplement Initial Filing

Calendar Year	Discounted Earned Premiums	Discounted Incurred Claims	Loss Ratio
1	95,867	57,765	0.603
2	157,068	102,910	0.655
3	129,863	85,086	0.655
4	107,370	70,348	0.655
5	88,772	58,164	0.655
6	73,397	48,089	0.655
7	60,684	39,760	0.655
8	50,173	32,874	0.655
9	41,482	27,180	0.655
10	34,298	22,472	0.655
11	28,357	18,579	0.655
12	23,446	15,361	0.655
13	19,384	12,701	0.655
14	16,027	10,501	0.655
15	13,252	8,682	0.655
16	10,956	7,178	0.655
17	9,058	5,935	0.655
18	7,489	4,907	0.655
19	6,193	4,057	0.655
20	5,120	3,354	0.655
21	4,233	2,773	0.655
22	3,500	2,293	0.655
23	2,894	1,896	0.655
24	2,392	1,567	0.655
25	1,978	1,296	0.655
26	1,636	1,072	0.655
27	1,352	886	0.655
28	1,118	732	0.655
29	924	606	0.656
30	764	501	0.656
31	632	414	0.655
32	522	342	0.655
33	432	283	0.655
34	357	234	0.655
35	295	194	0.658
Total	1,001,285	650,992	0.650

Disability Income Insurance

Many states require prior approval of rates before allowing the disability income contracts to be marketed. Filings must include an actuarial memorandum that describes the assumptions used for any new features and the impact on rates that will be charged. Rates are usually included with the forms or separately for any changes to the previously approved rates.

Some states have developed minimum loss ratio requirements that must be met before approval. These depend on whether the disability income contract is noncancelable, optionally renewable, or guaranteed renewable. Because the noncancelable contract is the most liberal for the consumer (and the insurer is assuming more risk), such contracts generally allow for a lower loss ratio than for the optional renewable and guaranteed renewable products.

Depending on the features provided, the reviewer might have additional requirements in order to determine if the contract meets the minimum loss ratio objective. The *Uniform Individual Accident and Sickness Policy Provisions Law* (#180) provides additional guidance for individual disability contract rate review.

Medicare Supplement Insurance

Medicare supplement policies are designed to pay some or all of the deductibles and co-payments of Medicare Part A and Part B. Requirements for this business are specified in the federal Social Security Act and overseen by the U.S. Centers for Medicare & Medicaid Services (CMS). There are 10 plans defined in the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

Several of those requirements are:

- Plans must be guaranteed renewable. This means that premium rates may be increased, but a policy may not be cancelled unilaterally.
- There is an open enrollment for individuals 65 years and older during the first six months of initial enrollment in Medicare Part B and for individuals with who attain age 65 and have been receiving or ever received Medicare Part B due to disability or end-stage renal disease (ESRD) prior to age 65.
- The model regulation provides that an issuer must annually file its rates, rating schedules, and experience by policy duration for approval by the states according to each state's filing and approval requirements. This filing is required whether or not an issuer is seeking a rate revision.
- Each insurer is required to file annually a refund calculation form for each type of standard benefit plan that it has issued. If the experience on a plan exceeds the benchmark ratio, a refund or credit might be required on that plan.

More details are available in the *Medicare Supplement Insurance Model Regulation Compliance Manual*.

Small Group Insurance

Small group business covered by *The Small Employer Health Insurance Availability Model Act* (#118), has additional requirements on the gross premiums by age. The federal Health Insurance Portability and Accountability Act (HIPAA) defines a small employer as one that employs two to 50 employees. Most states' small group definitions align with HIPAA. The age brackets may not be smaller than five-year increments and have to begin with age 30 and end with age 65. In addition, there are rate compression requirements that limit the relationship between the highest premium and the lowest premium by issue age. More details are available in the *Guidance Manual for the Evaluation of Ratings Manuals and Filings Concerning Small Employer and Individual Health Insurance*.

Long-Term Care Insurance

The target loss ratio for long-term care insurance was 60% for many years to determine if the premiums were reasonable in relation to benefits. Long-term care insurance differs from comprehensive health insurance because the claim costs are moderate at the lower ages, but increase rapidly at ages above age 75. Because of the long period over which premiums are paid, the assumption of the rates of voluntary lapses is important.

Some of the plans developed in the 1970s and 1980s had significantly higher lapse rate assumptions than those that actually developed. As a result on some plan there were rate increase requests of 30% – 40% every few years. This became a burden on the policyholders, who were generally retired and/or on a fixed income.

In 2000, the *Long-Term Care Insurance Model Regulation* (#641) was amended to change the approach for regulating long-term care rates.

- The initial loss ratio requirement was eliminated and was replaced with a requirement that an actuary certify, using reasonable conservative assumptions, that the premiums would remain level over the lifetime of the policy.
- The requirement to justify a rate increase changed from the 60% level to a 58% loss ratio on the lifetime initial premiums, plus 85% on all increased portions of the premiums. This reduces the value of a rate increase to a company.
- There is an additional requirement that the company must disclose past rate increases.
- There is an additional requirement that the company must annually provide regulators with the developing experience on the plan. If this experience demonstrates that the rate increase was not justified, a portion of the increase must be undone.
- There is an additional requirement that if a company shows a pattern of filing regular rate increases, the commissioner can require the company to cease issuing long-term care insurance.

An additional result of the large rate increases was a requirement to offer as an option a nonforfeiture benefit. All federally tax-qualified long-term care insurance policies are required to offer this option and several jurisdictions require it on non-qualified policies. The insured that elects a nonforfeiture option may be given benefit options with different premium costs, including reduced paid-up, shortened benefit periods, and extended term. More details are available in the *Guidance Manual for Rating Aspects of the Long-Term Care Insurance*.

Individual long-term care insurance products may be filed with the IIPRC. The standards for the IIPRC are required to provide the same or greater protections as set forth in the *Long-Term Care Insurance Model Regulation* (#641). In general, policy forms filed with the IIPRC should not be mixed with forms filed with the individual states. An initial rate filing must have uniform premiums for all states in the IIPRC. Premiums may vary by state in a rate increase filing if there is actuarial justification for the differences. The IIPRC has authority to approve initial rate filings and rate increases for individual long-term care insurance.

Some of the additional requirements of the IIPRC standards for long-term care insurance are:

- Companies that offer a product with rates that are scheduled to increase up to age 65 must also offer a product with issue age rates.
- There are specific requirements for premium schedules that are not a level premium.
- All initial rate and rate increase filings are subject to prior approval, regardless of individual state requirements.
- A rate increase filing may not introduce a rating characteristic that was not relied on in the initial rate filing.

CHAPTER SIX

The Federal Affordable Care Act and Plan Management

Introduction and Key Term Definitions

Both state regulators and Health Insurance Marketplaces are required to handle the function of oversight activities, known as Plan Management, under the federal Affordable Care Act (ACA) and other related regulations. Plan Management includes certifying (or re-certifying and de-certifying) qualified health plans (QHPs), as well as reviewing rate and plan benefit data and oversight duties. Terms to be familiar with as you read this chapter are:

- **ACA** - The federal Patient Protection and Affordable Care Act, a health care reform law enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010.
- **ACA-Compliant Plan** - A non-grandfathered plan issued on or after January 1, 2014, that complies with all of the ACA market reforms.
- **Advanced Premium Tax Credits (APTC)** - A tax credit that can reduce the amount paid for health insurance.
- **Actuarial Value (AV)** - The percentage paid by a health plan of the total allowed costs of benefits. Plans inside or outside the marketplace must fit within one of the “metal” tiers: bronze, silver, gold or platinum, and which are defined by AV.
- **AV Calculator** - The federal Centers for Medicare & Medicaid Services (CMS) tool that calculates the actuarial value, and metal levels, of all nongrandfathered plans in the individual or small group market.
- **Binder** - A collection of templates and plan data in SERFF, sent by one company to one state. Information in the binders is reviewed by state regulators to see if it meets plan management requirements for the upcoming plan year. Sometimes these are also referred to as “Plan Binders.”
- **Catastrophic Health Plan** – A type of high-deductible health plan for people under 30 or those who qualify for a hardship exemption.
- **CCIIO** - The Center for Consumer Information and Insurance Oversight.
- **CMS** - The federal Centers for Medicare and Medicaid Services.
- **Cost-Sharing Reduction (CSR)** – The subsidies that reduce the deductibles, coinsurance/copays and other out-of-pocket charges. CSR is available only with the purchase of a silver category plan.
- **Effective Rate Review** - A state program that CMS has determined meets the requirements set forth in §154.301(a) and (b) for the relevant market segment in the state. This means CMS has agreed to take the state’s determination of whether a rate increase that is subject to reporting (those that are 10% or more) is unreasonable. (From 45 CFR §154.102)
- **Essential Health Benefits (EHBs)** - The set of health care service categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. These must be included in all ACA-compliant plans sold or renewed in the individual or small group markets. Large group plans may not apply annual or lifetime limits to EHBs if they offer them. EHBs are based on a benchmark plan identified by the state or the federal government.
- **Federally Facilitated Marketplace (FFM)** - The federal marketplace for the selling and buying of health insurance. Includes a Small Business Health Options Marketplace for small employers to purchase health insurance called the FF-SHOP.
- **Grandfathered Plan** - A plan or policy that was in place (in existence) on March 23, 2010, and has not been changed in ways that substantially cut benefits or increase costs for plan holders. “In place” or also referred to as “in force” means a policy of health insurance coverage that is active, and the premium payments have been made as of a point in time.
- **Health Insurance Marketplace (Marketplace or Exchange)** - A website where individuals and small businesses can learn about health insurance, choose a plan and enroll in coverage. Marketplaces can be run by a state (SBM) or run by the federal government (FFM or SBM-FP).
- **HHS** - Refers to the U.S. Department of Health and Human Services.
- **Issuer** - An insurance company, insurance service or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance

(within the meaning of section 514(b)(2) of ERISA). Sometimes referred to as insurer, carrier or company in the state regulatory environment. (From 45 CFR §144.103)

- **Navigators** - Individuals or organizations that are trained and able to help consumers, small businesses and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.
- **Non-Discrimination** - An issuer must not discriminate on the basis of race, color, national origin, disability, age or sex under any health program or activity, any part of which is receiving federal financial assistance, as included in Section 1557 of the ACA.¹²
- **Plan** - With respect to an issuer and a product, refers to the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network and service area. (From 45 CFR §144.103)
- **Plan Management** - Activities associated with the QHP process, including certification, monitoring/oversight, re-certification and de-certification.
- **Product** - A discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type within a service area.(From 45 CFR §144.103)
- **Qualified Health Plan (QHP)** - A plan that is certified by the Health Insurance Marketplace and provides EHBs, and follows accepted limits on cost sharing and complies with other requirements, such as, accreditation and quality standards.
- **Qualified Dental Plan/Standalone Dental Plan (QDP/SADP)** - A standalone dental plan that is certified by the Health Insurance Marketplace.
- **State-Based Marketplace (SBM)** - A state-based marketplace where the state has implemented a Marketplace for the selling and buying of health insurance. May include a Small Business Health Options Marketplace or SHOP for small employers to purchase health insurance.
- **State-Based Marketplace-Federal Platform (SBM-FP)** – A state-based marketplace that is governed by the state, but uses the federal marketplace platform.
- **Summary of Benefits and Coverage (SBC)** – A federally required document concisely detailing, in plain language, simple and consistent information about health plan benefits and coverage.
- **System for Electronic Rate and Form Filings (SERFF)** - A Web-based application that facilitates form, rate and plan management submissions from insurance companies to state regulatory entities.
- **Transitional Plan** - A non-grandfathered plan of health insurance coverage that complied with the early market reforms under the ACA and was in place as of October 1, 2013. Also known as “grandmothered plan.”
- **Web Public Access (WPA)** - A link to SERFF which allows users to view information publically available for form, rate and/or plan management submissions. This is also referred to as SERFF Filing Access.

In SERFF, plan management functionality was added to accommodate the filing of QHP and QDP submissions. If a state determines that it wants to establish a Marketplace that Marketplace is known as a State-Based Marketplace, and it carries out its own plan management functions. If a state chooses not to establish its own Marketplace, then HHS establishes a Federally Facilitated Marketplace in that state. As primary enforcers of the federal Public Health Service Act (PHSA), states are responsible for enforcing the market-wide reforms found in the ACA. The market wide reforms that fall under Plan Management include but are not limited to EHB, AV, cost-sharing limitations and the rules relating to rating. The ACA requires that all Marketplaces ensure that QHPs are certified. In states that are effective rate review states, premium rates are examined and in prior approval states rates are approved before an issuer is allowed to put any increase into effect. States work with HHS throughout this process. Plan management requirements of the states and the federal government will change over time, making it probable that some sections of this chapter will need future revision.

History

The ACA was signed into law by President Barack Obama in March 2010 after nearly a year of hearings, debate and votes. Its major provisions went into effect January 1, 2014. The ACA affirms the principle that every U.S. citizen should have health care available to them.

¹² <http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>

Soon after its passage, the ACA became the subject of several lawsuits challenging its constitutionality, ultimately resulting in hearings before the U.S. Supreme Court. Those opposing the ACA expressed the belief that its requirement that individuals carry insurance or pay a penalty was an overreach of federal authority. States also challenged the provisions of the ACA calling for the expansion of Medicaid.

In June 2012, the Supreme Court issued a decision regarding the *National Federation of Independent Business et al v. Sebelius, Secretary of Health and Human Services, et al* (NFIB v. Sebelius 132 S.Ct. 2566 (2012)). The decision upheld most provisions of the ACA, including the individual mandate. The Supreme Court's decision removed substantial legal uncertainties surrounding health care reform and paved the way for implementation of many, but not all, of the key provisions of the ACA. In June 2014, the Supreme Court issued a decision regarding *Burwell, Secretary of Health and Human Services, et al. v. Hobby Lobby Stores, Inc., et al* (Burwell v. Hobby Lobby 134 S.Ct. 2751 (2014)). This decision provided an avenue for religious organizations with deeply held religious beliefs to be exempted from providing contraception coverage.

The individual mandate states that individuals who fail to purchase health insurance (with a few exceptions) must make a shared responsibility payment. The payment is referred to as a penalty imposed on those who forgo insurance. This penalty was interpreted to actually function as a tax.

The June 2012 decision also contained a surprising twist. The court ruled that the ACA's Medicaid expansion was optional for the states. The court stated that HHS could not force states to comply with the Medicaid expansion by threatening to withhold existing Medicaid funding. States have the option of expanding Medicaid eligibility as provided under the ACA or declining to do so and continuing to operate their Medicaid programs with existing federal funding.

The ACA called for each state to establish a Marketplace for the purchase of health insurance by individuals and small businesses by January 1, 2014. If a state failed to take steps to establish a Marketplace, HHS would operate a Marketplace in that state. States had to decide which business model made sense for their state. There are several FFMs, a few SBMs, and state-based marketplaces using the federal platform (SBM-FP)

A Marketplace provides tools for a shopper to compare options, select a health insurance plan, receive verification of coverage and make payments. As required by the ACA, each Marketplace is expected to include:

- Provide assistance to purchasers.
- Facilitate enrollment in QHPs.
- Facilitate eligibility for the advanced premium tax credit.
- Facilitate eligibility for the cost-sharing reduction plans.
- Provide individuals with access to other health benefit programs such as Medicaid.
- Certify health plans meeting federal, and sometimes state, benefit standards.

Each of the levels must offer the same set of minimum EHBs. The basic difference among these plans is the cost-sharing mix picked up by plans and individual insureds. Plans participating in the Marketplace are identified as:

- Catastrophic - a deductible equal to the total annual cost sharing limit and first-dollar coverage of at least three primary care visits. Maximum age of 30 years old to qualify.
- Bronze - actuarial value of 60%, equates to the consumer being responsible for on average 40% of covered benefits.
- Silver - actuarial value of 70%, equates to the consumer being responsible for on average 30% of covered benefits.
- Gold - actuarial value of 80%, equates to the consumer being responsible for on average 20% of covered benefits.
- Platinum - actuarial value of 90%, equates to the consumer being responsible for on average 10% of covered benefits.

To help facilitate review and approval of these products, NAIC/SERFF developed Plan Management Binders. Each binder includes multiple templates and identifies plans, metal level, service areas, networks, prescription drugs, rates, forms and examples for in-versus out-of-network. CMS also has provided tools to assist in the review and approval of plans. The tools focus on key areas of regulation including but not limited to prescription drug coverage, cost sharing and non-discrimination.

Categories of Regulatory Health Insurance Coverage Plans

All plans of health insurance coverage provided in the individual, small group and large group markets are categorized into one of three regulatory categories. A plan's category defines the extent to which the ACA reforms apply, as well as which of

the reforms apply. A plan can be a grandfathered plan, a nongrandfathered transitional plan or a nongrandfathered ACA-compliant plan.

The federal transitional policy is a policy announced by CMS/CCIIO which, when allowed by the state and opted by the issuer, provides a policyholder the option of keeping its nongrandfathered non-ACA-compliant health insurance coverage in force for some period of time rather than being required to transition to a nongrandfathered ACA compliant plan in 2014. The federal transitional policy option is outlined in three bulletins; 1) one issued on November 14, 2013¹³; and 2) a second one extending transitional relief to more plans which was issued on March 5, 2014¹⁴; and 3) a third one allowing the extension of transitional coverage through December 31, 2017, which was issued on February 29, 2016. Transitional relief and/or the extension of transitional relief applies only in states where the insurance regulator opted to permit the relief and only in the markets specified. Further, an issuer has the option to provide transitional relief on a market-by-market basis in the markets permitted by the state. Lastly, the policyholder has the option to maintain the transitional relief plan. All three (the state, the issuer and the policyholder) must opt-in for transitional relief to be provided/available. If a state does not permit the relief, or if an issuer does not opt to provide it in a state where it is permitted, or if a policyholder did not opt for it when offered, then the coverage issued the policyholder is a nongrandfathered ACA-compliant plan, which complies with all of the of the ACA market reforms.

The chart below describes the three categories, some of the applicable ACA reforms and other information about each category of plans.

	Grandfathered Plans	Non-Grandfathered Transitional Plans	Non-Grandfathered ACA-Compliant Plans
Definition	Plans in force as of March 23, 2010	Plans that are nongrandfathered and were in force on October 1, 2013	Plans that are non-grandfathered and issued as of January 1, 2014 or later
Markets Affected¹⁵	Individual, Small Group (1-50 employees) and Large Group (51+ employees)	Individual, Small Group (1-50 employees) and in some cases Large Group (51+)	Individual, Small Group (1-50 employees) and Large Group (51+ employees)
Time Limit	None, but cease when changes are made to the plan specifications that are beyond those permitted in the regulation	For plans in force on October 1, 2013, and cannot be extended past December 31, 2017.	None, but plans may be replaced by other plans of this same type within limits of federal regulations
Notes	Refer to federal regulation (45 CFR §147.140) for which provisions of the ACA apply as the reforms can differ according to the plan's market	Transitional relief was an option provided to the state insurance regulator, then the insurer and then the policyholder. Refer to federal regulations for which provisions of the ACA apply as the reforms can differ according to the plan's market.	Refer to federal regulation for which provisions of the ACA apply as the reforms can differ according to the plan's market and whether the plan is offered on the Marketplace.

¹³ <https://www.cms.gov/ccio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf>

¹⁴ <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/transition-to-compliant-policies-03-06-2015.pdf>

¹⁵ States may have different definitions of small employer and/or large employer which use a different number of employees in the count.

Resources

The table below lists some helpful online Plan Management information and system resources. Please note that the URLs provided were current as of January 1, 2016, but could change. Some of the URLs provided may require additional sign-on access.

Resource Name	Source Organization	Description	URL
SERFF Health Insurance Exchange Plan Management (HIX)	NAIC/SERFF	Access to free recorded Plan Management training for industry and state users. See the “On Demand Tutorials” section. Documentation is also provided regarding state plan management systems and process timelines, QHP templates and technical specifications for state-based Marketplace systems.	http://www.serff.com/hix.htm
SERFF System Online Help	NAIC/SERFF	Log on to SERFF and click the “Help” link to find instructions and information regarding SERFF System Plan Management functionality. See the Appendix sections for State and for Industry that are included in the “User Manual” for instructions on SERFF Plan Management functionality. Also see additional information from the links for “PPACA” and “Plan Management.”	https://login.serff.com/index.html
CCIIO– Qualified Health Plans	CMS.gov/CCIIO	Primary QHP certification resource for detailed QHP application requirements and materials. Application instructions, data templates, supporting documents and justification forms, and data review tools are accessible on this site.	https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html
CCIIO- Regulations and Guidance	CMS.gov/CCIIO	Comprehensive topical listing of federal healthcare reform regulations and guidance. Includes chronological list of “Updates.”	https://www.cms.gov/cciio/resources/regulations-and-guidance/
Health Insurance Oversight System (HIOS) and Plan Management and Market-Wide Functions Portal	CMS.gov/CMS Enterprise Secure Portal	HIOS is CMS portal for access by issuers and state regulators (as applicable), to the HIOS system application modules and to Plan Management and Market wide functions. (Accessible through CMS Enterprise Portal: registration required.)	https://portal.cms.gov/wps/portal/uauthportal/home/
REGTAP	CMS	Register for CMS training webinar calls regarding the QHP Certification process and other ACA regulatory processes. Site also provides a portal to submit and track inquiries and includes searchable FAQ and Library resources. (Registration required.)	https://www.regtap.info/index.php

Resource Name	Source Organization	Description	URL
RxNorm	US National Library of Medicine/Unified Medical Language System (UMLS)	Accessible downloads of national Rx data, including normalized names, classifications and unique identifiers (including the RXCUI identifiers used in the QHP Rx Formulary Template), for medicines and drugs. (Free resource – registration/license agreement required.)	https://uts.nlm.nih.gov/home.html

The following modules are currently available in HIOS:

Acronym	Module Name	Module Purpose
HIOS-Portal	Health Insurance Oversight System (Portal)	The HIOS-Portal module houses all the HIOS Consumer oversight modules and encompasses other functionality, such as Manage Account and Manage an Organization (Company creation, Issuer creation and Editing company information; certain user roles only). Approvals will be done through the HIOS Portal.
HIOS-PF	Plan Finder Product Data Collector	The HIOS-PF module collects state, issuer, and product information regarding the private health insurance industry. For state users, HIOS-PF collects data regarding the insurance companies within that state and the products sold to individual and small group markets to compare to the data filings of those issuers. Issuer Submission users can download a pre-populated template, update product information, and then upload the file on the “Upload Finalized Data Template” tab.
HIOS-CAP	Consumer Assistance Program	The HIOS-CAP module is used by states and its case workers to provide beneficiaries and consumers insurance-related guidance and assistance. It provides state users with the capability to collect, manage and submit information about the various cases handled by the case workers. The HIOS-CAP module allows data to be reported into the HIOS system.
HIOS-RRJ	Rate Review Justification	The HIOS-RRJ module allows issuers to report their premium rate increases with justifications. It also supports CCIIO and the State Department’s ability to review these health insurance premium rates in order to protect consumers from unreasonable premium increases and track all rate changes and bring visibility to unreasonable rate increases submitted by issuers.
HIOS-RRG	Rate Review Grants	The HIOS-RRG module was created by HHS to support the Department of Insurance (DOI) of states in their effort to track health insurance rate changes within their states. Participating states are provided grants towards this effort, and these states provide HHS with reports on how they use the grant funding, metrics regarding rate change data submitted to them by the health insurance companies and the states’ review of these rate changes.
HIOS-HPOES	Health Plan and Other Entity Enumeration System	The HIOS-HPOES module assigns unique Health Plan Identifier (HPID) and Other Entity Identifier (OEID) numbers. The system facilitates the submission and approval of HPID and OEID applications.

Acronym	Module Name	Module Purpose
HIOS-MLR	Medical Loss Ratio	The HIOS-MLR module facilitates the upload of the MLR-annual form and supplemental materials after the user successfully confirms to the issuer association for their company. The system also allows specific users to attest to the uploaded data within a defined submission period.
RBIS	Rates and Benefits Information System	The RBIS module provides health insurance issuer users with the capability to submit and manage detailed product benefit and eligibility information about their product and plan offerings. Users are required to submit, validate and attest to their product data, which is then made public on the consumer-facing website, <i>www.Healthcare.gov</i> .
DCM-FFM	Document Collection Module – Form Filing Sub Module	The DCM-FFM module allows users to create submissions based on issuer, market and product information. Issuers then append supporting documentation to these submissions. HHS uses these documents to assess state regulatory compliance.
DCM-MCM	Document Collection Module – Market Conduct Sub Module	The DCM-MCM module allows HHS users to create requests to issuers for documentation in support of a Market Conduct Examination (MCE). Issuers respond to the requests by providing required documentation and attesting to the accuracy of the information provided.
DCM-MEC	Document Collection Module – Minimum Essential Coverage	The DCM-MEC module allows submitter users to create submissions on behalf of their organizations. These submissions consist of certifying official contact information and any documentation pertaining to their MEC plan(s). HHS will perform reviews based on the documentation to determine if the MEC plans meet the regulatory requirements.
DCM-SDC	Document Collection Module – State Document Collection	The DCM-SDC module is a sub-module within HIOS that provides states with the ability to submit the Effective Rate Review Survey via online submission for review by CCIIO and designated Third Party contractors. Reviewers examine submissions based on established rate review policies to determine compliance with the Rate Review process.
NFGHP	Non-Federal Governmental Plan	The NFGHP module allows both self-funded and fully insured plans to register their organization within HIOS, but only self-funded plans may complete a HIPAA opt-out election.

Acronym	Module Name	Module Purpose
ERE	External Review Election	If HHS determined that a state's external review process does not meet either the NAIC-Parallel or NAIC-Similar standards, plans and issuers in the state must participate in a federally administered external review process by electing to either use HHS-administered external review process or by contracting with private accredited independent review organizations (IROs). The selection of a federally-administered external review process is called an External Review Election (ERE). This module will facilitate the data collection and review process of external review elections data for all issuers belonging to states and territories that have been determined to have noncompliant external review laws.
AST	ASSISTER	The AST module allows Assister Organizations to create, edit, attest and certify assister records. Once assister records have been certified, the assisters will receive a certificate that will allow them to assist in their respective areas.
HIOS-MQM	Marketplace Quality Module	The HIOS-MQM module supports the Center for Clinical Standards and Quality (CCSQ) in its Health Insurance Marketplace Quality Initiatives (MQIs) to generate quality ratings for qualified health plans (QHPs). The HIOS-MQM module supports the following activities: <ul style="list-style-type: none"> • Receipt, verification and storage of clinical measure data and enrollee survey response data which are used to generating the quality ratings • Preview of the quality.
	QHP Issuer Module	The QHP Issuer Module allows users to submit information pertaining to administrative data, program attestations, state licensure, good standing, accreditation, network adequacy, and Essential Community Providers (ECPs).
	QHP Benefits and Service Area Module	The QHP Benefits and Service Area module allows users to submit health plans and benefits data to be evaluated for QHP certification. This module will collect data pertaining to network, service area, prescription drugs and plan and benefits.
	QHP Rating Module	The QHP Rating module allows users to submit rate data information for plans and benefits of the issuers that wish to offer plans for a given Exchange.
	Unified Rate Review Module	The Unified Rate Review module allows users to submit market wide rate review template and other required information within an issuer's single risk pool.
	State Evaluation Module	The State Evaluation module allows submission of market wide rate review template and other required information within an issuer's single risk pool.
	Financial Management Module	The Financial Management module provides access to vendor management functionality in the Marketplace. It provides access for both CMS and issuers.
	Edge Server Management	The Edge Server Management module allows organizations with the attributes of EDGE Server TPA to access the module under the financial management function.

Marketplace Types and Responsibilities

Marketplace Structure:

Each state is required by the ACA to have a health care insurance Marketplace. A Marketplace, under the ACA, is where consumers (which may include small businesses) may shop for and enroll in health care coverage. Plans available on the Marketplace must be QHPs or QDPs, meaning that the plans comply with the benefit and actuarial value requirements of the ACA.

There are four types of Health Insurance Marketplaces. Each state Marketplace is one of these types. They are presented here in order of the amount of responsibility the federal government has for administering them. As federal policy evolves, state-by-state results may vary from the four types of Health Insurance Marketplaces described below. At one end of the spectrum is the FFM, administered entirely by the federal government. At the other end is the SBM, which is the responsibility of the state alone. In between are the State Partnership Marketplace (SPM) and SBM on the federal platform, in which responsibility is shared between the federal government and the states.

➤ **Federally-Facilitated Marketplace (FFM)**

FFM refers to a state's method of fulfilling its requirement to have a Marketplace, and also to the federal Marketplace platform itself, HealthCare.gov.

States have the option to enter into a "federal platform agreement" to use this federal Marketplace platform as the marketplace for their QHPs and QDPs, rather than creating their own Marketplaces. In such states, consumers shop for and enroll in coverage through HealthCare.gov.

This platform includes a Marketplace for individual QHPs. It also includes a Marketplace for small business plans, called the federally facilitated Small Business Health Options Marketplace (FF-SHOP).

The FFM has its own infrastructure that facilitates consumer shopping for health care plans and processes eligibility and enrollment. This federal platform is administered by CCIIO.

State and Federal Responsibilities in the FFM:

The ACA contemplates that states be the primary regulators of issuers, including enforcement of market reforms. States can, however, notify CMS that they either lack statutory authority to enforce or are not otherwise enforcing one or more provisions of the ACA. CMS may also make a determination that particular states are not substantially enforcing the requirements. In these situations, CMS must enforce those provisions in those states.

Most states are enforcing the ACA market reforms themselves. These states are sometimes referred to as primary enforcement states. In the other states, CMS is responsible for enforcing the ACA either through a collaborative arrangement with the state or by direct enforcement.

Where CMS and a state have entered a collaborative arrangement, the state may lack authority to enforce the ACA, but still seeks to enforce the ACA market reforms through voluntary compliance from its issuers. Only when unsuccessful does the state refer a potential violation to CMS for possible enforcement action.

In direct enforcement states, the states either do not have authority to, chooses not to or fails to enforce one or more ACA market reforms, but do not have a collaborative arrangement with CMS. CMS must directly enforce the ACA requirements in that state. That means that issuers submit their policy forms directly to CMS, which conducts the reviews of these forms for compliance with the ACA market reform provisions and works with issuers to resolve concerns. CMS may also perform other enforcement activities such as market conduct examinations and handling of consumer complaints having to do with the ACA requirements.

FFM states must abide by CMS requirements, which cover areas such as:

- Process and deadlines for applications to market QHPs using the FFM

- In states that use the FFM, QHP and QDP plan documents are filed with CMS via HIOS. However, some states with an FFM may require submission of the same material as part of the state's review of market-wide reforms such as AV, EHB and cost-sharing limitations.
- Certification of plans (although the FFM seeks input from the state that the plans that the issuer has submitted to be certified have been accepted/approved by the state)
- Standards for training consumer assistants and processes for consumer assistance
- Standards for contracting with Producers (Agents and Brokers) (who wish to sell via the FFM)
- Standards of training and conduct for Producers (who wish to sell via the FFM)
- Privacy and security of personally identifiable information
- Procedures for eligibility determination, enrollment re-enrollment (renewal); and termination of coverage
- Processes for exemptions from the ACA shared responsibility payment
- The functions of the FFM and FF-SHOP
- Payment and collections handling
- Administrative appeals for issuers.

Additionally, some Marketplace standards relating to open and special enrollment for QHPs also apply market wide, and states would be expected to enforce those standards on non-QHPs.

➤ **State Partnership Marketplace (SPM)**

An SPM is a hybrid model wherein the state is responsible for some aspects of the Marketplace, while HHS administers others. An SPM allows states to retain control of key decisions and to tailor their Marketplaces to the particular needs of the states. It may also serve as a temporary option to allow for additional time and experience as a state develops its own SBM.

In states with an SPM, consumers shop for and enroll in coverage through the federal Marketplace website, *www.HealthCare.gov*.

State and Federal Responsibilities in SPMs:

States with SPMs must fulfill the CCIIO requirements applicable to them, as well as their responsibilities as agreed in their individual partnership agreements with CMS.

There are two main models for SPMs. In a “State Plan Management Partnership Marketplace”, states create agreements with CCIIO regarding the responsibilities of each for plan review functions. SPM states recommend plans to CCIIO for certification as QHPs and QDPs (as well as for recertification and decertification), and retain responsibility for day-to-day administration and oversight of QHP and QDP issuers. In a “State Consumer Partnership Marketplace”, CCIIO performs plan management functions, while the states retain responsibility for consumer assistance and outreach. CCIIO is responsible for funding and award of grants to Navigators, while the states are responsible for day-to-day oversight of the Navigators. States with this type of SPM are responsible to develop and administer their own consumer assistance programs (and may choose also to be responsible for outreach and education) regarding the Marketplace and the plans available to state residents. However, these programs must use the federal training standards and training program required of Navigators. They have the option to add state-specific training.

States may also choose to retain responsibility for a combination of plan management and consumer outreach activities regarding QHPs and QDPs, ceding responsibility for others to CCIIO.

In states with a State Consumer Partnership Marketplace (where CCIIO performs the plan management functions), QHPs and QDPs are filed with CMS using the HIOS system. In states with a State Plan Management Partnership Marketplace (where the state performs the plan management functions), QHPs and QDPs are filed with the state using SERFF.

➤ **State-based Marketplace on the Federal Platform (SBM-FP)**

The SBM-FP is a new Marketplace structure formalized in the Notice of Benefit and Payment Parameters Rule for 2017.¹⁶ This is the model currently used by several states that previously has been called a Supported State-Based Health Insurance

¹⁶ <https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>

Marketplace (SSBM). Under this model, states are still considered to have an SBM, because these states are responsible for administering all of their own Marketplace functions. The one thing these states do not do is create their own Marketplace platforms. Instead, these states use the federal HealthCare.gov website as the Marketplace where their consumers shop for and enroll in coverage. In this way, states retain all their own regulatory control over insurance plans and the state insurance market, but avoid spending the resources necessary to create and maintain their own Marketplace websites.

State and Federal Responsibilities in an SBM-FP:

A SBM-FP or SSBM looks much like an SPM in which the state has retained both plan management and consumer assistance functions. Like an SPM, an SBM-FP or SSBM requires a “Federal Platform Agreement” with the state, setting forth the responsibilities of each party.

According to the Notice of Benefit and Payment Parameters for plan year 2017, the terms of Federal Platform Agreements between CMS and SBM-FPs specify certain expectations. SBM-FPs retain primary responsibility for overseeing QHPs and issuers according to requirements that are not less strict than those for QHPs and issuers on the FFM. These requirements include requirements and standards for:

- Publishing the formulary drug list on the issuer’s website
- Network adequacy
- Essential community providers
- Meaningful difference
- Changes of ownership of issuers
- Adherence of issuers and downstream entities to CMS requirements
- Records maintenance
- Compliance reviews
- Casework
- Consumer assistance.

In addition, SBM-FPs are required to comply with all of the same eligibility and enrollment rules as FFM states.

➤ **State-Based Marketplace (SBM)**

An SBM is a Marketplace in which all Marketplace functions are performed by the state. In such states, consumers shop for and enroll in coverage through websites established and maintained by the states.

SBMs are subject to some, but not all, of the requirements to which the FFM and the FF-SHOP are subject. SBMs may create their own processes and requirements for plans to be sold on these Marketplaces. This includes setting deadlines for some activities that are different from the FFM and FF-SHOP deadlines, though must comply with the federal open enrollment period. An SBM can also establish its own risk adjustment program. Each SBM will have its own unique requirements.

A few states have what is called a Bifurcated Marketplace. These states use the federal Marketplace platform, HealthCare.gov, for sale of individual QHPs, and operate their own Small Business Health Options (SHOP) Marketplace. The model under which these states use the federal Marketplace platform varies.

A reading of these descriptions of the Marketplace structures demonstrates that while they loosely fit into the general categories above, each Marketplace is unique in terms of the precise responsibilities performed by the state and those taken on by CCIIO. Nor is the list of states using each model stable. Since the Marketplaces began their first open enrollment for QHPs in 2013, several states have changed their models. Some changes were due to technological issues with SBMs that required states to abandon their own Marketplace platforms in favor of the federal platforms. As discussed, SPMs can be a temporary stop on the road to an independent SBM. As the health care landscape continues to evolve, additional changes can be expected.

Multi-State Plans (MSPs)

MSPs are not a type of Marketplace. They are a type of health plan created by the ACA. MSPs are administered by the federal Office of Personnel Management (OPM), which is the office that administers the federal Employee Health Benefits program for federal employees. The purpose of the MSP program is to work toward establishing a set of health care plans

that will ultimately be offered nation-wide. OPM's goal is that MSP issuers will ultimately offer at least two MSP options (one silver level and one gold level plan) on every state's Marketplace.

OPM does not have authority to require issuers to offer multistate plans.

State and federal responsibilities regarding MSPs:

OPM engages in some traditional state regulation functions with respect to MSPs. Interested issuers engage in an application process with OPM, wherein the issuers submit proposals for MSPs in the states where the issuers choose to offer them. (Again, the goal is that the issuer will phase in additional states over time, toward the goal of offering MSPs nationwide.) The OPM application process is analogous to the "filing" of plans with the states for review and approval. OPM reviews the MSPs in conjunction with the states where they will be offered, and certifies the MSPs to be offered on those states' Marketplaces.

OPM and the issuer then negotiate a contract for the issuer to offer the MSP in those states. OPM transfers the plan data to the state Marketplaces, which are required to accept the certified MSPs. In performing these functions, OPM works together with the relevant states' DOI and their Marketplaces.

MSPs must comply with the laws of the states where they are offered, unless those laws conflict with OPM's implementation of the MSP program or the ACA. There are three notable exceptions. The first is that issuers of MSPs must offer at least one silver and one gold MSP option that exclude abortion coverage, consistent with the HHS appropriations definition in every service area within every state where they offer MSPs¹⁷. In addition, issuers may offer other options that either offer or exclude abortion coverage consistent with applicable federal and state law. The second is that, rather than being required to comply with the states' requirements for external review of adverse determinations, MSPs are subject to OPM's own external review program for such appeals. (MSP complaints, which are reports of dissatisfaction with coverage and/or services provided and not specifically related to denial of a claim, are still handled by the relevant state.) Finally, MSP benefits may, but are not required to, be substantially equal to the benchmark plan of the states where they will be sold. Instead, MSP benefits may be substantially equal to one of three federal Employee Health Benefits Program benchmark plans.

Marketplace Requirements:

The federal requirements for establishment and administration of Marketplaces, including technical requirements specific to states and issuers in Marketplaces that use the FFM, are largely found in Title 45 CFR Parts 144, 146, 147, 153, 154, 155, 156 and 158. The FFM also has an application process that includes a number of processes and submission requirements.

One of the challenges for some states in implementing the ACA has been the need to sort through the federal requirements to determine which apply to those states' particular Marketplace models. This has been especially challenging during the first years of the ACA, as federal and state regulators have needed to make many adjustments to their Marketplace laws and requirements based upon experience with this new health care insurance landscape. One example of these adjustments to Marketplace laws and requirements is the annual issuance of new requirements by federal regulators for QHPs and QDPs for the following plan year. These are changes to the ACA regulations (codified, as stated above, in Title 45 CFR).

Each year since the Marketplaces became operative; CCIIO has released two documents that set forth requirements for Marketplaces for the coming plan year and may also include market wide requirements, such as rating, special enrollment opportunities and clarification of EHB provisions. The first is the Benefit and Payment Parameters Rule (Rule). This Rule, which has been issued in draft form in late November or early December each year, has been finalized around February of the following year.

The second document is the Letter to Issuers. The draft Letter to Issuers has been issued in late December each year and finalized the following February.

⇒ The Notice of Benefit and Payment Parameters

¹⁷ Please note that when there are additional state restrictions on coverage of abortion services, the MSPs reflect those additional state restrictions. For example, a state may have taken action to prohibit Marketplace plans from providing abortion coverage pursuant to Section 1303 of the ACA.

The first document is the Notice of Benefit and Payment Parameters (Notice). This Notice communicates a set of new or amended federal regulations regarding several ACA programs. As federal regulations, these rules are binding on all Marketplaces, regardless of structure, unless a specific rule, by its terms, applies only to certain types of Marketplaces.

Each year, the Notice has included a long preamble to the rules, providing narrative explanation of the changes being made and their intent. This guidance assists states in understanding CMS' interpretation of these rules and the ACA as a whole.

Every Rule, as this set of regulations is frequently called, includes certain parameters for the following year. Every Rule sets the dates for the annual enrollment period for the following year. It also sets the parameters for the ACA premium stabilization programs (risk adjustment, reinsurance and risk corridors – 3Rs) for the following year. The Rule includes updates to HHS Risk Adjustment model (for the Risk Adjustment program), including the risk adjustment factors. The FFM user fee for the following plan year is set in the Rule. The Rule also annually sets the maximum annual limitations on cost sharing for standard and Reduced Cost Sharing health plans, as well as for Standalone Dental Plans that offer the EHB for pediatric oral services.

In addition to the provisions that are included in every year's Rule, changes also have been included each year in different areas of ACA regulation. For example, CMS has used the Rule to make updates and changes to the technical processes by which the information and payments flow in the premium stabilization programs. This includes requirements for what data must be submitted to CMS, and how it is to be submitted. CMS has also used the Rule to set or change standards for rates, benefits and networks. Additionally, it has set requirements in the rule for people and entities that provide consumer assistance with QHPs and QDPs, such as Navigators. The Rule has set and updated requirements for rate review and disclosure. This includes, for effective rate review states, dates upon which all rate information for a particular plan year must be made publicly available.

⇒ The Annual "Letter to Issuers" from CMS

The second document that has been issued annually by CMS is called the Letter to Issuers. While directed to issuers in the FFM, the Letter to Issuers also includes some requirements common to all SPMs and SBM-FPs. While the requirements in the Letter to Issuers are not binding on SBMs, states use them to inform and form the basis for SBM requirements. The Letter to Issuers is similarly useful to SBMs and issuers as it includes guidance on CMS's interpretation of ACA provisions.

The Letter to Issuers is based upon the rules governing Qualified Health Plans (QHPs) and the Marketplaces, as well as on the Rule. The Letter to Issuers and the Rule are released close together in time and are complements to one another.

Some of the provisions that have been set forth in the Letter to Issuers are:

- Procedures and requirements for application to sell plans on the FFM
- The extent to which CMS would perform rate and form review for FFM states, and the extent to which it would rely upon the FFM states to perform this review
- Procedures and requirements for certification and recertification of QHPs to be sold on the FFM
- Dates and deadlines for QHP certification on the FFM, such as:
 - The deadline for issuers to submit applications to CMS for certification of their QHPs or stand-alone QDPs
 - The dates within which certain changes to applications may be made
 - The schedule for "correction notices" and "corrections" of issues found during review of the submitted plans
 - The deadline by which Certification Agreements between CMS and issuers must be signed.
- Clarification or changes to CMS expectations for activities such as provider contracting, claims handling, online provider directories and formularies, and language access
- Registration and training requirements for Producers (Agents and Brokers) in the FFM.

The Letter to Issuers notifies stakeholders which types of plans (currently only QHPs and standalone QDPs) may be sold on the FFM. In it, CMS sets certification standards for QHPs and QDPs for the following year.

CMS has used the Letter to Issuers to signal particular areas in which it will focus its review of rates, forms, and networks. It has included instructions for fulfilling particular requirements (such as the ECP standard, accreditation requirement and nondiscrimination).

CMS has also used the Letter to Issuers to explain how account management will be conducted and monitored and to set out program requirements.

Overall, a particular state can find the requirements for its Marketplace in Title 45 CFR, in the agreement (if any) between CMS and that state, in the technical requirements for plan certification set forth by the Marketplace platform the state uses, and in the annual CMS Notice of Benefit and Payment Parameters Rule and Letter to Issuers.

Review Standards

Market wide Reform Standards

The ACA and applicable regulations establish that health plans, and standalone dental plans (SADPs), must meet a number of standards in order to be certified as QHPs or QDPs. Several of these are market wide standards that apply to plans offered in the individual and small group markets both inside and outside of the Marketplaces established by the ACA. The remaining standards are specific to health plans seeking QHP certification from the Marketplaces.

Market wide reform standards:

- Actuarial Value (Metal Level), [45 CFR 156.135]
- Annual Limitation on Cost Sharing, [45 CFR 156.130]
- Catastrophic Plan Requirements, [45 CFR 156.155]
- Clinical Trials, [PHSA section 2709(a)]
- Coverage of Essential Health Benefits (EHB), [45 CFR 156.115]
- EHB Discriminatory Benefit Design, [45 CFR 156.125]
- Eligibility of Children until at least age 26, [45 CFR 147.120]
- Formulary – USP Category Class Count, [45 CFR 156.122]
- Guaranteed Availability and Renewability of coverage, [45 CFR 147.104 & 106]
- Internal Claims and Appeals and External Review Processes, [45 CFR 147.136]
- Mental Health Parity and Addiction Equity Act (MHPAEA), [45 CFR 147.160]
- No Lifetime or Annual Limits, [45 CFR 147.126]
- Nondiscrimination Formulary Clinical Appropriateness, [45 CFR 156.125]
- Nondiscrimination Formulary Outlier, [45 CFR 156.122]
- Patient Protections, [45 CFR 147.138]
- Preventive Health Services covered without Cost-Share, [45 CFR 147.130]
- Prohibition of Preexisting Condition Exclusions, [45 CFR 147.108]
- Prohibition on Waiting Periods that exceed 90 days (Group), [45 CFR 147.116]
- Self-only Annual Limitation on Cost Sharing, [Refer to preamble to HHS Notice of Benefit and Payment Parameters for 2016 and CCIIO FAQ Part XXVII¹⁸]
- Rating Reforms, [45 CFR Part 154]
- Rules Relating to Rescissions, [45 CFR 147.128]
- Summary of Benefits and Coverage (SBC) and Uniform Glossary, [45 CFR 147.200]
- Medical Loss Ratio, [45 CFR 158.102]
- Minimum Essential Coverage (MEC) [45 CFR 156.604]

Marketplace (QHP) specific standards: [45 CFR Part 155 subpart K]

- Market wide reform standards (as listed above)
- Accreditation, [45 CFR 155.1045, 156.275]
- Cost Sharing Reduction Plan Variation Requirements, [45 CFR 156.420]
- Essential Community Providers, [45 CFR 156.235]
- Meaningful Difference, [45 CFR 156.298]
- Network Adequacy, [45 CFR 156.230]
- Non-Discrimination Cost Sharing Outlier [45 CFR 156.125]
- Program Attestation [Refer to Letter To Issuers In The Federally Facilitated Marketplaces¹⁹]
- QHP Discriminatory Benefit Design, [45 CFR 156.200]

¹⁸ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf>

¹⁹ https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-Letter-to-Issuers-12-23-2015_508.pdf

- Service Area, [45 CFR 155.1055]
- SHOP Tying [45 CFR 156.200]
- *Standardized Options*, [45 CFR 155.20, Preamble discussion (pages 12289-12293) from the final HHS Notice of Benefit and Payment Parameters for 2017 (FR Vol. 81, No. 45, published March 8, 2016)]
- Patient Safety Standards, [45 CFR 156.1110]

FORMS, RATE, AND PLAN REVIEWS UNDER THE ACA

Under the ACA, states insurance regulators are charged with primary enforcement of the provisions of the federal law. This enforcement manifests in various traditional state regulatory processes as well as in newly created processes addressing new and unique regulatory concerns under the ACA. Traditional processes utilized by state insurance regulators to confirm issuer compliance with the ACA include policy form and rate review. New processes include: 1) the review of plan-level compliance; 2) the review of QHP certification standards reviews; 3) the use of computer-based tools to facilitate these reviews; and 4) the coordination with federal agencies on implementation, enforcement and interpretation of federal laws, regulations, sub-regulatory guidance, and requirements. This sub-section will explore the connection between insurance policy form, rate and plan level reviews, as well as the tools utilized by state insurance regulators to check compliance. It also will touch upon the necessary state/federal coordination efforts that the ACA requires.

➤ Policy Form Review

While the ACA makes sweeping changes to the substantive requirements with which the form review process is designed to verify compliance, the process itself remains the same in many respects. For most provisions of the ACA, form reviewers verify that the policy documents either contain required elements or do not contain provisions that violate prohibitions or restrictions in the law. State insurance regulators are already familiar with this type of review, even if the substantive requirements are new.

Other reforms in the ACA, however, require important changes to the way that issuers file policy forms and the states review them. Most significantly, while forms were filed and evaluated at the product level in the past, several provisions of the ACA require analysis at the plan level. Plan level review will be discussed in more detail in a section below.

Insurance form filings typically include:

- Contracts (also referred to as “evidence of coverage” or “policy”).
- Certificates (also referred to as “member handbook” or “benefit booklet”).
- Schedule of benefits (also referred to as “explanation of benefits” or “schedule of benefits”).

In some states, the form filing may also be required to include the federal SBC, and the state may review such documents for compliance with applicable laws. In other cases the Marketplace may review these documents. Some states consider the SBC to be a marketing piece and those states would review pursuant to that review process.

Processes for submission of insurance forms vary from state to state. Some states may permit the use of variable language in submitted forms to allow insurers ease of administration and to allow regulators to review common policy provisions in an efficient manner. Other states may not permit the intermingling of different products within a single insurance form, and require submission of separate forms for each product. While some provisions lend themselves more readily to a merged form review, provisions dealing with the cost-sharing and actuarial value of plans must be reviewed on a plan-by-plan basis. For this reason, issuers will most likely need to submit the necessary information for review of these provisions on a plan-by-plan basis, indicating which product filings these plans are based on. The SERFF Plan Management system and the federal Plan Management templates (both discussed in the Plan Review section below) help facilitate the review of plan level requirements. States where form and plan review are both performed connect the two processes and typically consider that the two processes are dependent upon each other – deficiencies in one sometimes lead to deficiencies in the other or at least a need to address a deficiency in both. In addition to plan level compliance, state insurance regulators who review insurance policy forms for compliance must incorporate review of forms to be used with QHPs (plans certified to be issued on an Marketplace) which are sometimes subject to unique statutory or regulatory provisions that do not apply to non-QHP plans

(nor the insurance forms associated with them). These requirements are mainly related to procedures for enrollment and disenrollment through the Marketplace, although the states may also impose their own QHP certification requirements. These standards may be located in federal regulation, federal sub-regulatory guidance, or state insurance or Marketplace-related statutes and regulations.

State insurance regulators, whether the state has an FFM or SBM, also will review policy forms for compliance with federal ACA market wide reforms, such as EHBs and cost-sharing limitations. Some states may have adopted these standards into state law, but other states may utilize federal statutes and regulations and the authority granted states as the primary enforcers of the federal provisions as authority to require compliance with ACA market reform standards.

➤ **Rate Review**

The ACA includes several provisions that affect health insurance rating and rate review. These provisions include requirements for the review and disclosure of rate submissions above certain defined thresholds, rating and underwriting requirements and limitations, programs to mitigate adverse selection and pricing risk, and additional requirements placed on plans offered through Marketplaces. State insurance regulators' processes related to rate review must now allow for potential differences between:

- Grandfathered, transitional, and ACA-compliant plan,
- Plans inside and outside of the Marketplace
- Plans by market if the states have varying levels of review authority and effective rate review designations
- Rate increases, where applicable, at or above defined thresholds (currently 10%) versus those under the defined thresholds.

The ACA also creates roles related to rate review for the federal government and Marketplace entities. Marketplace governance and functional responsibilities vary across the states and may include various combinations of state insurance regulators, Marketplace entities and the federal government. The federal government specifically plays a role in rate review in cases where a state does not have an effective rate review program.

Most of the states with rate review laws require that the issuer provide a qualified actuary's opinion that the rates are reasonable and comply with state and/or federal laws. This allows the states to rely on the Code of Professional Conduct and the Actuarial Standards of Practice that actuaries must follow. In addition, the states often look at the whole financial picture of an issuer, such as review of Risk Based Capital (RBC) levels and the issuer's profits, when reviewing rate filings.

Federal regulation recognizes and builds upon the traditional role the states have played in regulating insurance rates and complements existing state-based rate review processes. Federal law provides that all proposed rate increases in the individual and small group markets that are at or above 10% are subject to review, and issuers are required to provide a public justification prior to implementation of the increase to both the state and CCIIO.²⁰ In the 2016 Notice of Benefit and Payment Parameters, the requirement to submit and post a rate justification was expanded to all rate submissions. States with effective rate review programs review rates to determine whether they are in accordance with state law and if the increase is unreasonable. In the states that do not have the legal authority or resources to review rates, CCIIO reviews proposed rates to determine whether they are reasonable, based on actuarial and other analyses that are currently used by many states to assess rate increases.

While the federal regulations do recognize the traditional role that state insurance regulators have played in rate review, the regulations have also established mostly uniform standards regarding: 1) what is required to be submitted; 2) when it is submitted; 3) the time a state has to review the rates and take action; and 4) what, when and how a state (which has an effective rate review program) must uniformly disclose information about ALL rate filings in the ACA-compliant individual and small group markets. These standards, which have evolved over time, are generally established in federal regulation (45 CFR Part 154) and through federal bulletins and sub-regulatory guidance (including the annual "Letter to Issuers in the FFM"). States with FFMs are then required to follow the federal timelines for review and public disclosure of rate filings in

²⁰ Section 2794 (42 U.S.C. 300gg-94) of the federal Public Health Service Act

order to retain an effective rate review designation. Similarly, states with an effective rate review program and SBMs, must coordinate their reviews with the requirements of their SBMs, while also following applicable federal standards for the timing and reporting of the final determinations on rate submissions subject to reporting (10% or more annually).

Federal provisions relating to reporting and publication of rate filings differ depending on the market and the regulatory category of the plan. Additionally, CCIIO has two different modules in HIOS to collect the information about rate filings subject to reporting which vary based on those same criteria.

The federal regulations relating to reporting of rate increases of 10% or more apply to all nongrandfathered health insurance coverage in the individual and small group markets. Therefore, states with an effective rate review program must accommodate federal provisions in their review of transitional (nongrandfathered) plans rates. But outside of the federal requirement to report increases of 10% or more, states are free to adopt their own review process, data requirements, and implementation provisions for transitional and grandfathered business.

Federal rate review requirements set minimum standards for all states and states can require more information from issuers and maintain existing processes that exceed federal standards.

- **Federal Rating Requirements for ACA-compliant plans**

The ACA limits rating variations for nongrandfathered ACA-compliant plans in the individual and small group markets to the following:

- Geographic rating area: The states are charged with defining standard geographic rating areas, subject to approval by the secretary.
- Age: Age factors will be limited to a ratio of 3:1 for adults; permissible age bands are defined in federal regulation through a standard federal default age curve. States may establish their own age curve as long as the 3:1 ratio is maintained.
- Family structure: Federal regulation establishes that in most cases an individual must be charged an age-appropriate rate for his or her coverage, with no recognition in rates given for a family unit. Therefore, a family's premium is the sum of the individual age-specific rate for each person in the family, with each adult (whether the policyholder, spouse or dependent child) 21 or older charged an appropriate rate for his or her age. For children younger than 21, the federal law establishes a single age factor and provides that in a family unit, each child younger than age 21-up to three total children-will pay an individual rate. If a family has more than three children younger than age 21, federal law provides that no additional premiums can be required.
- Tobacco use: Rating for tobacco use is limited to a ratio of 1.5:1 and must be applied to the individual's premium. States have the option to apply different tobacco rating factors as long as they don't exceed 1.5:1.

- **Rating of ACA-compliant plans inside and outside the Marketplace**

Issuers offering QHPs in the Marketplace must offer the "same premium rate" for plans offered inside and outside of the Marketplace whether they are sold directly or through an agent. Since all rates for QHPs and non-QHPs must be established with the single-risk pool methodology, state insurance regulators review rates for both inside and outside the Marketplaces. States may establish different or additional requirements than the federal requirements relating to rates, such as submission of federal rate templates (discussed in the Plan Review section below) which disclose all rate, age and geographic area combinations for each plan and are utilized by the Marketplaces to populate their "shopping" portals.

- **Rate Filing Justification**

As required under 45 CFR §154.301 states with effective rate review programs must post to their websites Part I, Part II and Part III of the federal Rate Filing Justifications and provide a means for public comments to be submitted on proposed rate increases. States can meet these requirements by providing links to the federal website www.Healthcare.gov, rather than posting the Rate Filing Justifications on their websites. Whether a state publishes on its own website or provides a link to the federal websites, federal regulation establishes that the Rate Filing Justifications must be publicly disclosed on a uniform

basis when originally received (for filings subject to reporting) and when final for all rate filings (no matter the change in the rate). States using www.healthcare.gov for this disclosure avoid the issue of managing the uniform disclosure of rates, which can be hampered by state public disclosure laws and by a state's own global efforts for transparency of regulatory submissions (such as through direct public access to filings through a state filing system or WPA).

For transitional plans, which use a different module in HIOS for reporting rate increases subject to reporting, states with effective rate review programs must still make information available to the public as required under the federal regulations relating to reporting of rate increases, but they are not bound by standards relating to timing and uniform disclosure that apply to ACA-compliant plans.

➤ **Plan Review**

As noted in the section about Form Review, in addition to form level compliance, the ACA establishes standards of compliance at the plan level which may not be readily confirmed by a state through form review only. Further, if a state insurance regulator is partnering with its Marketplace (whether that is an SBM or the FFM) to perform plan management activities, then that insurance regulator will be confirming compliance with various plan level criteria, including QHP certification standards established by the FFM and/or the SBM. Additionally, some states that are not in partnerships with their Marketplaces may still wish to confirm plan level compliance with certain market wide ACA standards (such as AV, EHB and cost-sharing limitations) as part of their regulatory oversight of the health insurance markets in the state.

In response to the need for a different approach to compliance, a new module in SERFF was developed. The Plan Management module was designed specifically to assist Plan Management states with collecting, reviewing and performing the plan management activities under their partnership agreements. In states performing plan management reviews for their Marketplace, the binders facilitate submission of the QHP application and related federal or state data templates by issuers wishing to participate on the Marketplace. In such a state, the state insurance regulator confirms that an issuer's plans are compliant at the plan level, including the QHP certification standards, and conveys the list of plans that meet such criteria to the Marketplace for certification. The states use federal and/or state review tools on the federal or state data templates to facilitate and assist in the analysis of plan level compliance, and to assist in making determinations for their recommendations.

In the case of issuers wishing to participate on the Marketplace in a state that is NOT a plan management partner, the issuer submits the federal data templates and other QHP application materials in HIOS or the system required by the SBM. In some states, the state insurance regulator may request those same templates be submitted in a SERFF plan binder in order for the state to complete its regulatory duties. Some states may also require issuers who participate only off the Marketplace to submit some of the federal data templates in a binder.

Federal data templates and the federal tools to facilitate review of them can be accessed on CMS website at <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>. SBM applications and related state-specific data templates should be accessed at those state's Marketplace websites.

State insurance regulators determine whether plan level compliance is part of their regulatory processes related to ACA plans and, if so, to what degree they use SERFF Plan Management functionality, federal or state data templates, and federal or state template analysis tools as part of those reviews. For a particular state, this determination may change over time.

Data templates include templates that provide information on plans and benefits, covered prescription drugs, networks, service areas, actual premiums for each plan/age/geographic area combination, and business rules for administration of the plan benefits and rating. In addition to assisting with plan level compliance reviews, the templates are also used by the Marketplace to populate the online plan compare tool.

Tools that are available to assist with reviews of the templates include tools to review the prescription drug formulary, cost-sharing limitations, meaningful difference in plan designs and discrimination in benefits. The tools are typically in Excel spreadsheet format and include instructions on their use within the spreadsheets themselves. State insurance regulators however, must further develop standards and interpretation to fit their regulatory needs and policies.

CHAPTER SEVEN

Policy Form Filings

Public Policy and Policy Form Review

What are regulators trying to accomplish with the process that calls for the filing and review of policy forms, endorsements, riders, and other insurance contract language? Policy form review ensures protection for the public and the filer. In spite of the importance of insurance contracts in people's lives, the public does not generally take the time to read and understand the coverages, policy limits and coverage limitations, and duties of the insured and insurer spelled out in great detail in insurance policies and other related contractual documents. These documents affect the benefits that a person is entitled to receive and the obligations that the individual has to protect and obtain those benefits. Also, insurers might inadvertently draft contractual language that delivers benefits that are unintended or fails to comply with provisions contained in state law and/or regulation.

Insurers also benefit from the services offered by the contract review analyst. A contract review analyst is probably much more familiar with the requirements contained in state laws and regulations for the products that they are assigned to review than any insurer employee. The analyst also sees product filings from multiple insurers and is able to benefit from an understanding of a particular market in ways that an insurer's employees cannot duplicate. This allows the contract review analyst to review a policy form, rider, or endorsement with a vast knowledge base that can be helpful to insurers. For example, if an insurer has inadvertently failed to comply with a law or regulation, the contract review analyst can point out the shortcomings of the filing and ask the filer to make appropriate changes. Insurance companies oftentimes want to use the same product in multiple states and, therefore, a specific requirement in a particular state might not be adequately addressed and the contract review analyst will be able to help the filer accordingly.

Policy form review ensures that high standards of quality are maintained. These include delivery of generally expected benefits to the policyholder, avoidance of contractual abuse by the filer, inclusion of mandatory provisions that are specified in law or regulation, exclusion of provisions that are prohibited by law or regulation, and assurance that the insurance contract has an acceptable appearance for its intended audience.

Regulators must give forms careful scrutiny to ensure that they contain the essential elements required by statute and/or regulation. In some states, the review of policy forms includes the review of advertising material for specified lines of business.

When used in this chapter, the term "policy form" includes policies, certificates, applications, riders, declarations or information page, amendments and endorsements, etc., as well as notices, disclosures, outlines of coverage, and other forms required for use with any type of policy contract, including advertising material. It further includes an actuarial memorandum that might be included with a form filing by life insurers. "Advertising material" includes any advertising or promotional literature that includes an invitation to inquire, invitation to contract, and institutional items.

Standards for Policy Forms Review

What are the standards for review of policy forms and other contractual language? First, the contract review analyst should determine if a particular product offering meets the state's definition of an insurance product and if that insurer is licensed in their state to sell that line of insurance. To figure this out, the contract review analyst needs to quickly scan the form and decide if an acceptable risk transfer takes place and review the policy form for conformance with the state's definition of insurance. This first step also allows the contract review analyst to determine which product standards to apply to the remaining review of the contract.

The contract review analyst should review the policy forms and other contract language for compliance with laws and/or regulations related to the particular product that is being offered. There might also be some readability requirements (Flesch test or other readability or understandability measurement, selection of font type face and type size) contained in state law.

It is common for state legislatures to mandate the inclusion of certain language within a particular policy form, as well as certain notices or contract provisions. These take many forms, including statutory notices, limitations on cancellation or nonrenewal, bankruptcy or insolvency clauses, incontestability clauses, valued policy conditions, reinstatement provisions, grace periods, coordination of benefits, time limit on payment of loss, time limit on tender of unearned premium, and many others. The contract review analyst should review the policy forms and other contract language for compliance with laws,

regulations, and case law related to these statutory or regulatory mandates. The use of checklists to assist with this task is recommended.

State legislatures often enact laws that contain prohibitions related to policy forms and other contractual language. Each state's prohibited provisions vary, but they often include unacceptable cancellation or non-renewal conditions; no provision for cancellation; false, deceptive or misleading advertising; and misuse of deductibles and co-payments. The contract review analyst should review the policy forms and other contract language for compliance with laws, regulations and case law related to these statutory or regulatory prohibitions. The use of checklists to assist with this task is recommended.

The contract review analyst also should be concerned that, if required, the filer has a corresponding rate filing or actuarial memorandum filed for the policy form being filed. The contract review analyst independently (or with assistance) might need to determine if the policy form is consistent with its pricing or actuarial memorandum. For example, a form change to restrict previously supplied coverage with no corresponding rate filing might be an indication for the analyst to question the filer further. While the intent of this section is not to suggest that the contract review analyst should perform a complete rate review, it is important that the filer have on file corresponding rules, rates and rate systems, or actuarial memoranda. The contract review analyst might need to coordinate activities with the rate filing examiner for implementation effective date consistency for rate and form filings.

At the end of the review, the contract review analyst should be able to address the following questions, as applicable. (All of the following questions might not apply to every policy form or every filing under consideration.):

- ⇒ Is the policy form an insurance contract? If so, what type?
- ⇒ Is the policy form for a legal purpose?
- ⇒ Does the policy form contain an acceptable risk transfer?
- ⇒ Does the insuring agreement contain a clear and concise statement of what the filer is offering to the policyholder?
- ⇒ Does the policy form contain a statement regarding the consideration that the policyholder is providing to the filer?
- ⇒ Does the policy form contain clear definitions regarding who is accepting the risk transfer, who is covered under the contract, and for terms that might need to be explained to the policyholder?
- ⇒ Are the filer's coverage agreements and limits of liability clearly spelled out?
- ⇒ Are the duties of the filer and the policyholder or claimant clearly spelled out?
- ⇒ Are any coverage limitations or exclusions clearly spelled out?
- ⇒ Does the policy form contain any provisions that unreasonably or deceptively affect the risk purported to be transferred to the filer?
- ⇒ Are all of the mandated provisions or conditions included in the policy form?
- ⇒ Are there any statutory or regulatory prohibited conditions or clauses contained in the policy form?
- ⇒ Have readability requirements (including font type and size) been met?
- ⇒ Are the policy form and any other contractual language consistent with its pricing or actuarial memorandum?
- ⇒ Is any related advertising material consistent with the policy form and any other contractual language?

Speed to Market Imperatives

It is the job of the contract review analyst to see that compliant insurance products reach consumers in the marketplace as soon as possible. Meeting this goal serves the needs of both the insurance industry and the public. Filers need to have speed to market to meet the competitive pressures of the marketplace. Insurers compete with each other and, for some products, with other financial services providers such as financial institutions and securities broker/dealers, and in some cases, unregulated entities. Thus, the speed with which insurance products are able to be delivered to the public is important to insurers. The public also benefits from speed to market as they are able to purchase products that meet their risk management and/or price needs in a timely fashion. There is no need for the contract review analyst to sacrifice a compliant filing review for the sake of speed. The public, in addition to wanting speedy access to insurance products, wants the insurance products to meet their risk management needs and fully comply with the applicable provisions of state law and regulation. Speed and compliance are not mutually exclusive concepts.

Insurers also need to recognize that speed to market is a two-way street. It is easy for a contract review analyst to process a filing that is fully compliant. No communication with the filer is needed, other than to send a notice that the filing is approved or acceptable for use. Non-compliant filings require a great deal of time for the contract review analyst to read and document the shortcomings in the filing. Attention to detail by the filer before submitting a filing helps shorten the review time and get products to market sooner. This also improves an insurer's competitive position as its filings will be completed sooner than its competitor's non-compliant filings.

The key to speed to market efficiency is transparency of regulatory filing requirements. This can be accomplished by use of the Filing Review Standards Checklists available for most lines of businesses and products. Some other Speed to Market Tools currently in use include the Products Requirements Locator (PRL), Uniform Filing Transmittal Documents and the Product Coding Matrix. Note, however, that the Uniform Filing Transmittal Documents are not necessary when a filing is submitted through SERFF. The checklists and PRL provide a common format for display of the statutory and regulatory filing requirements in a manner that is useful to industry filers. The checklists and PRL have another benefit, in that the contract review analyst can use them to organize the filing review. The checklists and PRL are effective when they are drafted in clear language that tells the filer what the regulator expects to find in a compliant filing. When a filer has included information from the Product Coding Matrix it helps the analyst determine the insurance product and risk transfer. Filings submitted through the IIPRC need to meet the filing submission requirements contained in the applicable Uniform Product Standard for the product being filed.

Speed to Market in a Prior-Approval Environment

Speed to market can be obtained in a prior-approval environment. The steps listed in this section are equally applicable to a file and use law with a waiting period. In some states the prior approval law has a safeguard built in for insurers so that the regulator cannot indefinitely delay granting approval to a product filing. This safeguard called a "deemer" generally provides that a filing is "deemed approved" once a specified number of days has elapsed from receipt of the filing. The contract review analyst needs to know the applicable deemer period including any additional waiting periods and how to go about extending the review period. It is imperative that the contract review analyst know the specific statutory and regulatory requirements and direction by management of their state for the applicable line of business under review in the handling of deemers as the overall goal is to have the contract review analyst and filer work together to meet statutory or regulatory policy form language requirements and the filer's requested effective date.

The following best practices allow the public to receive the benefits of a quality filing review and the filers to receive a prompt and complete review of their product filings. The goal is a compliant filing that meets the needs of the public, the regulator and the filer.

- **Step 1: Filing Preparation**

The filer develops a product filing and submits the policy form and any related endorsements, riders, declarations or information page and any other contract documents in accordance with the statutory and state regulatory requirements. The filer should include any required advertising material or should inform the regulator when this information was filed. The filer should also include the necessary transmittal documents and additional information to provide the regulator with the information needed to process the filing. To assure that the insurance product is properly recognized, the filer should use the Product Coding Matrix to select the filing type.

- **Step 2: Filing Submission**

The filer submits the filing to the insurance regulator. This can be done either in paper or electronically using SERFF or other electronic means as permitted by the state. SERFF is capable of tracking both electronic and paper filings and is recommended for uniformity and consistency of process among states.

- **Step 3: Filing Receipt and Assignment**

The regulator receives the filing and records it in the applicable tracking system. At time of receipt, the filing is assigned to a contract review analyst and the date of receipt is recorded.

- Step 4: Determining a Priority Level

The filing priority will be directed by management of the particular insurance department.

- Step 5: Reviewing a Filing

The contract review analyst reviews the filing consistent with the assigned priority level and in accordance with the regulatory standards provided to the filers in the *Speed to Market Tools* or within SERFF. All deficiencies should be included in the first communication if possible. Partial filing reviews only slow the process for insurers, the public and the regulator.

- Step 6: Communication of Filing Disposition

The contract review analyst communicates the results of a filing review to the filer. The filing can be approved if the reviewer determines that the filing is compliant with all of the statutory and state regulatory standards and does not otherwise violate established public policy. Depending on the state and if any necessary requirements are met, the filing can also be “deemed approved” if the time specified in the law has run without communication to the filer.

If the contract review analyst determines that a filing is deficient, the contract review analyst should send a written (or electronic) communication (frequently called an “objection letter”) to the filer that clearly specifies all filing deficiencies, including reference to the specific statutes and regulations the filing violates. Some states include a statement in the objection letter that until the deficiencies are remedied the filing is disapproved and may not be implemented. The letter may also specify the filer’s legal remedy to challenge the disapproval; most often, this would be that the filer could request a hearing. Some states specify the timeframe within which the deficiencies are expected to be remedied. Such remedies may take the form of an amendment to the filing or the submission of additional supporting information. If the analyst has not heard from the filer by the specified date, the filing is presumed to be disapproved or the contract review analyst may disapprove the filing or the contract review analyst may ask the filer to withdraw the filing.

The contract review analyst should note that if the state law has a deemer provision, the objection letter must be transmitted to the filer prior to the date that the deemer tolls. If the filing is deemed approved because the deemer has tolled without regulatory objection to the filing, see Step 8—Withdrawal of Approval of a Noncompliant Filing after the Effective Date.

The analyst should recognize that some questions or requests for additional supporting information may require extensive work on the part of the filer. In some cases, the filer will need to request an extension of the time allotted. It is in the interest of speed to market that both the regulator and the filer work together to achieve compliant filings as quickly as possible.

Just as filers are expected to respond promptly to objection letters, filing review analysts should respond promptly, subject to priorities established by management, to the amendments or other responses that result from those letters. The analyst should review the response to the objection letter and determine whether the filing is now in compliance and can be approved, or whether the response raises additional compliance issues. If the latter, a second objection letter should be sent to the filer, and the process continues.

All filings that reach the statutory deadline for a deemer should be processed as “deemed approved” and marked accordingly so that the contract review analyst might return to them at a future date and perform a review if time permits. See Step 8.

- Step 7: Recording the Filing Disposition

The contract review analyst should enter information about the filing disposition, including the effective date, in the applicable tracking system.

- Step 8: Withdrawal of Approval of a Noncompliant Filing after the Effective Date

Most state prior approval laws recognize that there will be times where a filing is found to be out of compliance after it is effective. This could occur when a filing is deemed approved because the regulator did not have sufficient staff available to process the filing within the statutory time frame. It could also occur if a contract review analyst missed something during the filing review or if a law has changed that would require a revision to a policy form or other contract language. The contract

review analyst is encouraged to communicate with the filer about the noncompliant aspects of the filing and obtain the necessary corrections or withdrawals. Alternatively, the statutory remedy specified in most state prior approval laws is to send a notice of hearing to the filer.

Speed to Market in Non-Prior-Approval Environments

Speed to market is inherent in non-prior approval environments. The steps listed in this section are applicable to a file and use law without a waiting period, a use and file law or laws specifying informational filings. In these laws there is no deemer provision, as the filer is not required to wait for the regulator to opine on the appropriateness of a filing. This does not mean that the filer can choose to sell noncompliant products. All product filing laws provide methods for consumer protection. What differs is the timing of the regulatory action.

The following best practices allow the public to receive the benefits of a quality filing review and the filer to receive a prompt and complete review of their product filings. Just like in prior approval environments, everyone needs to remember that a compliant filing is the goal that meets the needs of the public, the regulator and the filer.

- **Step 1: Filing Preparation**

The filer develops a product filing and submits the policy form and any related endorsements, riders, declarations or information page and any other contract documents in accordance with the statutory and state regulatory requirements. The filer should include any required advertising material or should inform the regulator when this information was filed. The filer should also include the necessary transmittal documents and additional information to provide the regulator with the information needed to process the filing. To assure that the insurance product is properly recognized, the filer should use the Product Coding Matrix to select the filing type.

- **Step 2: Filing Submission**

The filer submits the filing to the insurance regulator. This can be done either in paper or electronically using SERFF or other electronic means as permitted by the state. SERFF is capable of tracking both electronic and paper filings and is recommended for uniformity and consistency of process among states.

- **Step 3: Filing Receipt, Assignment, and Communication with the Filer**

The regulator receives the filing and records it in the applicable tracking system. At time of receipt, the filing is assigned to a contract review analyst and the date of receipt is recorded. Depending on the review directed by management of the particular insurance department the analyst will proceed in one of two ways. In states where a filing is acknowledged without review, the analyst will acknowledge the receipt of the filing and may inform the filer that it might be reviewed at a future date. In states where a review is performed to be certain the filing is compliant before the filing is acknowledged, the analyst will follow steps 4 and 5 below and when it is determined that the filing is compliant, the analyst will acknowledge the filing has been “filed” and inform the filer.

- **Step 4: Determining a Priority Level**

The filing priority will be directed by management of the particular insurance department.

- **Step 5: Reviewing a Filing**

The contract review analyst reviews the filing consistent with the assigned priority level and in accordance with the regulatory standards provided to the filers in the *Speed to Market Tools* or within SERFF. All deficiencies should be included in the first communication if possible. Partial filing reviews only slow the process for insurers, the public and the regulator.

- **Step 6: Recording the Filing Disposition**

The contract review analyst enters information about the filing disposition, including the effective date, in the applicable tracking system. If the filing is compliant the process ends here. If not, proceed to Step 7.

- Step 7: Withdrawal of Approval of a Noncompliant Filing After the Effective Date

State policy form filing laws recognize that there will be times where a filing is out of compliance. Since file and use, use and file and informational filing laws allow insurers to implement filings before regulators review them, they all contain methods for the contract review analyst to withdraw approval of a noncompliant filing. The contract review analyst is encouraged to communicate with the filer about the noncompliant aspects of the filing and obtain the necessary corrections or withdrawals. Alternatively, the statutory remedy specified in most state laws is to send a notice of hearing to the filer.

The Result

When these steps are followed, regulators can expect that the public and insurers will be protected and that insurance consumers will benefit from the availability of compliant insurance products that serve their risk management needs.

Process Flow

Each state should insert its own process flow chart here.

CHAPTER EIGHT

Speed to Market Tools

An Overview of Speed to Market

In the mid-1990s, regulators and industry representatives embarked on discussions related to compliance challenges faced by industry within the rate and form filing arena. There was clear agreement among the parties that the existing paper-intensive rate and form filing process lacked modernization and efficiency. By March 2000, the NAIC put forth its *Statement of Intent—The Future of Insurance Regulation*, which was focused on modernizing many facets of the state-based insurance regulation schema, all designed to further improve insurance marketplace efficiencies and accommodate insurance consumers now and in the future.

There is general agreement that ensuring the insurance industry operates on a financially sound basis in order to honor policy commitments to families and businesses is critical. And without a doubt, the insurance industry and the financial market continue to change. These changes are driven by the economy and technology as well as new and innovative ideas. In light of these changes, the NAIC membership has continued to focus on creating greater efficiency and effectiveness within state-based regulation.

State insurance commissioners have long recognized the need to improve the timeliness and quality of the reviews given to insurer filings of insurance products and their corresponding advertising and rating systems. Specifically, in the NAIC's modernization plans, the following statement describes the members' position: "Interstate collaboration and filing operational efficiency reforms ... state insurance commissioners will continue to improve the timeliness and quality of the reviews given to insurers' filings of insurance products and their corresponding advertising and rating systems."

When insurance regulators embarked on a plan to address this aspect of the industry, it was referred to as the 'Speed to Market Initiative' and refers to a company's ability to offer a new product in the marketplace in an expedient fashion. In the insurance industry, Speed to Market can be greatly impacted by insurance regulation. This impact has fostered a greater awareness of the importance for Speed to Market to companies and consumers and the role state insurance regulation plays in helping to achieve this timely delivery.

Speed to Market is of benefit to both companies and consumers. A faster delivery of a new product for sale allows the companies more flexibility in reacting to changes in the market resulting in products that meet the current needs of consumers. In an electronic, real-time, global economy, the need for companies to produce and deliver new products to the marketplace quickly continues to expand. Quick delivery of insurance products to market increases the number of products available when consumers make difficult insurance decisions in this competitive market. Since faster Speed to Market benefits the consumers, it also becomes a focus for state insurance regulators.

In their efforts to promote Speed to Market, state insurance regulators focused attention on four primary areas : 1) integration of multi-state regulatory procedures with individual state regulatory requirements; 2) encouraging states to adopt regulatory environments that place greater reliance on competition for commercial lines insurance products; 3) full implementation of SERFF, including integration with operational efficiencies developed for the achievement of Speed to Market goals; and 4) development and implementation of a central point of filing, for Life and Health products, to develop uniform national product standards. Through the efforts of state insurance commissioners, and with the support of state legislatures, the goal is to provide an efficient and responsive regulatory environment for both insurers and insurance consumers.

The NAIC established the Speed to Market (EX) Task Force to lead this important initiative, specifically focusing on items 1-3 above. In order to carry out its work, the Task Force leverages a myriad of working groups and subgroups that change and evolve as needs are identified and objectives accomplished. Since 2000, the Task Force has been a leader in the development and implementation of operational efficiencies, further discussed below, and national standards for product filings. As a result, by year end 2009 51 states/jurisdictions were using SERFF and 50 states had completed implementation of the key operational efficiency initiatives. In addition, 22 state insurance departments had established mandates for using SERFF simply to improve the efficiency of their internal operation. These mandates were the result of SERFF's success and the fact that the vast majority of filings were already being submitted via SERFF. The Task Force, through its working groups continues to provide oversight in evaluating additional filing efficiencies for both regulators and the insurance industry.

In addition, the Task Force coordinates with and supports the IIPRC, which became operational in May 2006 and is focused on standards development and centralized multi-state filing and product review in the life and health arena.

Under the leadership of the Task Force, this *Product Filing Review Handbook* has been developed to assist state insurance regulators and industry with the filing process. The objective is to identify best practices that will streamline and improve the filing and review process. The Handbook is intended to be updated as needed, recognizing a continually evolving market.

The Task Force also works closely with the SERFF Board and the Board's Product Steering Committee to enhance and promote Speed to Market objectives through SERFF. The Board is comprised of regulator and industry members that are focused on improving the rate, rule and form filing process. The Board has established a Product Steering Committee (PSC) that includes both regulator and industry members. The PSC holds open meetings and receives input from any SERFF state or company user. The committee is generally comprised of individuals who are the actual users of the SERFF system. This allows the users direct input into the tool and their input has proven extremely valuable in SERFF's development over time.

The NAIC serves as a central repository for information, development and support of tools to achieve Speed to Market and uniformity across the states. The best way for the NAIC to keep on track with the needs of this dynamic industry is to receive input from the people who use the products and are involved in the regulatory process on a day-to-day basis. To this end, the Operational Efficiencies Working Group (OEWG) has established a vehicle for suggestion submission and reviews those suggestions. The NAIC strongly encourages the input of regulators, filers and interested parties, via participating in working groups and committees as interested parties or by submitting ideas, suggestions and requests in a manner consistent with the suggestion policy of their state. Anyone may request to be added to the interested parties list for participating working groups or committees. The Speed to Market Filing Suggestion Form is a direct, easy mechanism for the regulator, filer, or other interested party to recommend, through the NAIC, enhancements to the Speed to Market tools. Everyone active in rate, rule, and form filings is encouraged to send suggestions regarding Speed to Market tools via this form. The suggestion form is located at www.naic.org/documents/committees_ex_speed_oewg_suggestion_form.pdf.

Users may also request to be added to a Speed to Market group or committee by visiting the "Committee and Activities" page on the NAIC website. Click the group or committee of interest and make the request through the NAIC support staff contact listed. The current Speed to Market task force, committees and groups are:

- Speed to Market Task Force

The mission of the Speed to Market (EX) Task Force is to serve as the NAIC's focal point for modernization of the insurance product filing and review processes. The Task Force monitors the development and implementation of Speed to Market operational efficiencies and supports the development of national standards in conjunction with the IIPRC. The Speed to Market Task Force also supports IIPRC initiatives that require uniformity and policy changes within the states.

- Operational Efficiencies Working Group

The Operational Efficiencies Working Group oversees the implementation and ongoing maintenance/enhancement of Speed to Market operational efficiencies that have been adopted.

- National Standards Working Group

The National Standards Working Group coordinates with/works jointly with the IIPRC's Interstate Compact National Standards Working Group in accelerating the drafting of national standards for insurance products that are eligible for inclusion in the IIPRC.

- Product Filing Efficiency Subgroup

The Product Filing Efficiency Subgroup provides oversight in evaluating filing efficiency issues for both regulators and industry.

- Product Requirements Locators Subgroup

The Product Requirements Locators Subgroup of the Operational Efficiencies Working Group provides oversight for the merging of the Review Standards Checklists and the Product Requirements Locators for life, health and property/casualty insurance coverage into a single tool.

- Product Filing Review Handbook Subgroup

The Product Filing Review Handbook Subgroup is charged with the development and maintenance of a *Product Filing Review Handbook* to detail the operational efficiency tools and describe best practices for state reviewers with regard to the review of insurance product filings.

- SERFF Board

The SERFF Board considers changes to SERFF to enhance and promote Speed to Market objectives requested by the Speed to Market Task Force.

- SERFF Product Steering Committee

The Product Steering Committee (PSC) is a group of state and industry SERFF users that works with the NAIC to detail changes to SERFF based on a system user perspective.

The Speed to Market groups report progress at each NAIC national meeting via state specific compliance reports. These reports, termed Speed to Market Assessment Reports, are delivered to the NAIC members at each national meeting and provide updates on implementation and use of Speed to Market tools like Uniform Product Coding Matrix, Standard Filing Types, Electronic Funds Transfer and IIPRC. Filing turn-around times and the elimination of requirements or limitations that inhibit filing via SERFF are reported as well.

The Speed to Market Tools

The Speed to Market tools have been developed by insurance regulators with experience reviewing insurance product filings, to add an element of uniformity to the insurance filing process. While recognizing that national filing compliance review standards are not appropriate for many insurance products, uniformity of process across state boundaries has improved regulatory compliance. These Speed to Market tools allow for a more streamlined approach in the regulatory submission process, while maintaining the state specific statutory protections in place for the varying needs of consumers from region to region and state to state. By using the following tools correctly, the regulators' workloads are decreased and Speed to Market is greatly enhanced without sacrificing the benefits of state review.

Uniform Review Standards Checklists

The Review Standards Checklists provide a means for insurance companies to verify the filing requirements of a state before making a rate or policy form filing. The checklists contain information regarding specific state statutes, regulations, bulletins or case law that pertains to insurance product issues. Currently, most states have developed and posted Review Standards Checklists to their state websites.

The Review Standards Checklists, Best Practices and the Instruction for Completion of Checklists are provided on the NAIC website. The Best Practices were developed after discussions with regulators and interested parties and provide helpful insights, such as "states should develop training and outreach programs to facilitate the proper use of the checklists and work with insurers to develop review standard checklists training programs for appropriate personnel." The Instruction for Completion of Checklists is also helpful in that it provides general instructions and Instructions for Completion.

Each checklist consists of the following four columns: Review Requirements; Reference; Description of Review Standards Requirements; and Location of Standard in Filing. Under Review Requirements, the typical categories are broadly presented under General Requirements, Policy Forms, and Requirements for Rates.

When a filer uses a product checklist, they have been aided in determining if that filing is ready for sending to the regulatory authority. States report that insurers taking advantage of this regulatory modernization have found the likelihood for successfully submitting a filing increases dramatically, vastly improving Speed to Market for insurers. By referencing and/or providing a comprehensive checklist, the filer and reviewer are assured that the necessary portions of a filing have been completed and submitted. This shortens the time spent in review by cutting down on the communications and delays in requesting missing data and rechecking the filing for completion.

Product Requirements Locator

The Product Requirements Locator is designed to allow filers to obtain current filing requirements by state from one website location by querying from the entry of Product Name, Category Requirement, and Jurisdiction. The Product Requirements Locator is intended to offer easy reference to the NAIC Uniform Standard Review Checklists and to provide, through the NAIC website, a one-stop shopping mechanism for filers to be able to obtain current state filing requirements for insurance products. A filer could, for example, seek the state filing requirements for the line(s) of insurance they wish to file from the Product Requirements Locator and then complete the appropriate checklist for submission to the state filing reviewer. Although the Product Requirements Locator is available for all states to use, it has not yet been populated by all states for all lines of business.

Not only does the Product Requirements Locator reduce the time filers must spend in researching the individual states' filing requirements, but it also helps to assure none of the necessary requirements are missed. The use of the Product Requirements Locator can enhance Speed to Market by reducing the missing pieces of filing documentation submitted to the state. The cleaner a filing is upon initial submission, the faster the review process can be executed and the less time will be spent on unnecessary communications regarding missing documentation post-submission.

The Product Requirements Locator may be found on the NAIC website.

Uniform Transmittal Documents

The Property and Casualty Transmittal Document and the Life, Accident and Health, Annuity and Credit Transmittal Document each provide a uniform transmittal form to be completed by the industry filer whenever a filing is submitted. The transmittal documents are designed to obtain essential information in a uniform manner for evaluating rate, rule, and/or policy form filings. The transmittal documents are accompanied by a description of items listed within the document.

The Uniform Transmittal Documents are found on the NAIC website. Among the basic information required when submitting these documents is the following: Company Name and Tracking Number, Contact Information of Filer, Filing Information, and Filing Description. A Form Filing Schedule and a Rate/Rule Filing Schedule are available, as appropriate, to be included with the filing. Each of the Uniform Transmittal Documents also has instructions for completion available on the website.

All Uniform Transmittal Document fields have been built directly into SERFF and are part of every SERFF filing. Fields from the Uniform Transmittal Documents have been placed on the General Information tab, Form Schedule and Rate/Rule Schedules in SERFF.

The use of the Uniform Transmittal Documents provides a consistent format for collecting and displaying basic filing information. Speed to Market is increased not only when filers are able to input the information in a consistent format, but this consistent format also bolsters Speed to Market on the state side when reviewers do not need to search through a filing to find information housed in differing locations on each filing. The standardized format increases the completeness of general filing data and provides a standardized view that filers and reviewers alike can use to access general filing information quickly and electronically, directly from the SERFF filing.

Uniform Product Coding Matrices

The Uniform Property and Casualty Product Coding Matrix and the Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix provide uniform product naming conventions, consistent terminology, a numerical coding system, and descriptions for use in product filings. The Uniform Product Coding Matrices (PCM) were developed by the NAIC to provide a mechanism for states to adopt commonly used names, codes, and descriptions in a consistent format for each product line countrywide.

The PCM is typically updated on an annual basis—depending on the current needs of the market. As legislation and products change, the PCM must also change to reflect current needs in the industry. The PCM is updated at the beginning of every year to maximize its effectiveness in providing a uniform, comprehensive naming convention for insurance products.

This annual update is also the time that a thorough review of all Requirements, Submission Requirements and General Instructions in SERFF is requested. Keeping these filing instructions up to date is the best way to ensure SERFF and Uniform Product Coding Matrices are being utilized to their fullest Speed to Market potential. Outdated or incomplete SERFF information becomes an impediment to Speed to Market. This thorough annual review, in conjunction with the additional intermittent reviews listed in the SERFF section below, will take full advantage of the efficiencies inherent in using the available Speed to Market tools together. These updates can only be made by specific managers at the state and by SERFF staff. However, the updates affect all reviewers' workloads and should be made with input from the reviewers.

This is also the time to make suggestions for future PCM updates. All users may submit suggestions for PCM changes per the state suggestion submission guidelines. Suggestions for future PCM changes may be made via the Speed to Market Filing Suggestion Form.

The use of current, updated Uniform Product Coding Matrices helps greatly in improving the efficiency of multi-state filings by standardizing the naming conventions across the states and reducing confusion in the selection of specific product names on multi-state filings. The uniform set of product names also allows the NAIC members to report on aggregate statistics relevant to state regulation. These statistics can lead to further improvements in Speed to Market.

The Property and Casualty or Life, Accident and Health, Annuity and Credit Product Coding Matrix are available for viewing on the NAIC website.

IIPRC

The IIPRC establishes a mechanism for developing uniform national product standards for life insurance, annuities, disability income insurance, and long-term care insurance products. It also creates a single point to file products for regulatory review and approval via SERFF. In the event of approval, an insurer would then be able to sell its products in multiple states without separate filings in each state. The IIPRC's purpose is to form the basis for greater regulatory efficiencies while allowing state insurance regulators to continue providing a high degree of consumer protection for the insurance buying public.

The uniform standards-setting process at the IIPRC is conducted through comprehensive public notice and comment periods that afford full opportunity for input to industry, consumers and the general public. The IIPRC ensures that products can quickly enter the market while ensuring that those products are suitable for consumers and have appropriate protections in place. By year end 2009, 54 product standards had been adopted and many more were under development.

The IIPRC is good news for both consumers and insurers. Consumer protection is the hallmark of the state-based regulatory system. Insurers may continue to rely on the extensive expertise of the states in reviewing complex products. State insurance regulators believe the state-based IIPRC is the preferred solution to enhance Speed to Market efficiencies while continuing to provide insurance consumers with strong and established protections.

SERFF

SERFF is an internet application designed to provide an efficient process for rate, rule and form filing and review. Filings are created and submitted by industry filers for review by the appropriate state business area. Users' access to SERFF is via a secure site that requires a user logon id and password.

The NAIC members acknowledge and promote SERFF as the premier Speed to Market tool and encourage states and insurers to fully utilize SERFF for all product filings. SERFF facilitates communication, management, analysis and electronic storage of documents and supporting information. The system is designed to improve the efficiency of the rate, rule and form filing and approval process and reduces the time and cost involved in making regulatory filings. It also provides up-to-date filing requirements, while it streamlines and accelerates the rate and form filing process for states and companies. SERFF identifies state filing Submission Requirements as promulgated by the state, which ensures greater accuracy and completeness during the filing process. In addition, SERFF workflow features assist states in the review process; therefore filings are typically reviewed in less time and with fewer problems for companies to resolve. The result is greater Speed to Market for the filers and a more manageable review process for the states.

SERFF has demonstrated that it can improve the filing process such that filing turnaround times are significantly reduced, primarily due to increased organization, accessibility to accurate Submission Requirements, consistency in rate, rule and form review and speedy electronic delivery of the filing submission and correspondence and fees to the state. SERFF enables filings to be submitted completely and in compliance with state requirements—the first time. The consistent submission format provides a familiar platform for filers and reviewers to navigate with ease. This improved filing turnaround time results in products arriving to market faster in this global economy

SERFF establishes a uniform process with the adoption of other Speed to Market tools such as the Uniform Product Coding Matrices and Uniform Transmittal Documents built into the application.

The NAIC provides technical support and training to state staff, eliminating the need to acquire state funds to support the use of SERFF. In addition, the NAIC provides a sophisticated disaster recovery schema to ensure that all filing data can be made available to the states in the event of a disaster. SERFF provides a flexible option of compliance with Public Access laws and using SERFF as a single system for rates, rules and forms eliminates the cost of alternative internal storage and reporting systems.

Many companies have also performed considerable cost analysis. Consistently, the costs have been proven to be less than that required to support the paper filing process, as it eliminates filing cabinet storage costs, as well as internal IT and database maintenance costs. It minimizes the number of phone calls required due to sophisticated tracking and packaging of all communication within the filing and eliminates copying and shipping costs. All of this streamlining in the filing process also reduces the cost, in worker hours, necessary to submit filings. And, by getting a product to market faster, the filers can benefit from earlier sales of new products. Earlier sales will increase the pool of potential customers.

Not only do insurers find the ease of use and increase in Speed to Market inherent in the process of SERFF filing submission and review, but nearly half of the states have found SERFF so helpful they have mandated its use.

As of 2009, 49 states, the District of Columbia, Puerto Rico and nearly 3,000 insurance companies, third-party filers, rating organizations and other companies have committed to SERFF. Reflecting on the past several years, SERFF has had tremendous growth and has proven itself to be the premier choice for submitting and reviewing rate and form filings.

- 2001: 3,694 Filings
- 2002: 25,528 Filings
- 2003: 76,932 Filings
- 2004: 143,818 Filings
- 2005: 183,362 Filings
- 2006: 269,101 Filings
- 2007: 381,377 Filings
- 2008: 554,261 Filings

SERFF Features and Functionality

The following is a summary of some of the features and tools within SERFF along with the best practices recommended for each feature. Adhering to established best practices will enable a user to get the maximum benefit of this Speed to Market tool.

- **My Workfolder**

My Workfolder is a user specific “short list” of priority filings to assist in managing workload. My Workfolder may contain open or closed filings and a filing moved to My Workfolder will remain in My Workfolder until it is removed by the user, regardless of SERFF, State or Company Status. My Workfolder is an excellent organizational tool to assist users with quick access to the filings designated by the user as priority filings and is the default page upon each login. My Workfolder allows users to keep all priority filings close at hand for quick, easy retrieval.

Best Practice: The state reviewer should prioritize assigned filings with his/her manager and then move those priority filings into My Workfolder while completing the review. This keeps these priority filings at hand and helps the reviewer stay focused on the most important work. Once the work on the priority filing has been completed, the filing should be removed from My Workfolder.

- **Message Center**

The Message Center contains notifications about key activity on SERFF filings. Messages can be viewed in the Messages link under the Filings tab. There are a number of messages that are generated to notify a user when an event occurs related to a filing.

- Reviews received messages for all events on filings to which they are assigned.
- Reviewers received messages for all events on filings to which they are assigned.
- State Managers receive messages for all events on all filings in their instance.
- Receivers only see messages on new filings.
- Filers receive messages for all events on filings to which they are assigned.
- Industry Managers receive messages for all events on all filings in their instance.

Messages are identified by a distinct subject line. Once the message is opened, additional information is displayed and the user can link directly to the filing referenced via a link in the message body.

Each message in the Message Center will have a green pushpin icon when it is received to indicate it has not yet been read. Once a user views a message, the green pushpin will disappear from the message in the Message Center. If two users receive a message on the same filing, and one user opens the message, it will not affect the Read/Unread pushpin icon for the other user. The message for the other user will be displayed with a push-pin icon indicating that the message has not been read.

The following filing events generate a message:

State –

- Receipt of Filing
- Creation of Review Notes
- Receipt of Note to Reviewer
- Receipt of Filing
- Creation of Reviewer Note
- Receipt of Note to Reviewer
- Receipt of Response Letter or Amendment
- Assignment of Filing
- Post-submission request for confidentiality
- Activity on IIPRC Filings
- Additional EFT funds have been submitted

Filer –

- Assigned/Changed Reviewer
- Note to Filer received
- Filer Note created
- Objection Letter received
- Disposition received
- Filing submitted with Default Public Access
- Public Access status change
- Reopened Filing
- IIPRC Filing Acknowledgement
- Effective/Implementation Date Updated

- Filing State Info Changed
- Billing Low Block Warning

Users also have the ability to create Reminder Messages to be sent to their Message Center on user-defined dates. The messages can contain any information input by the user and will be delivered into the user's Message Center on the pre-set date defined by the user.

It is important to keep the Message Center clear of old messages. All information within in a message is contained in the filing. The Message Center should only be a tool to notify of changes with a filing, not a historical record of changes. In order to easily view new messages on current changes effectively, the Message Center needs to be cleared of all read messages when they are no longer needed.

If used correctly, the Message Center is an excellent tool for achieving Speed to Market in regulation. It will alert the user of any changes on the filing so there is no need for daily searches on all possible changes. If not cleared, however, the tool becomes a useless collection of change notifications that are too difficult to sort through to be used as a time saving tool in the review process.

Best Practice: Delete messages as they are read. The filing contains a historical record of changes so there is no need to retain messages for this purpose. Use the Message Suppression feature to receive only the messages important to the individual state's workflow. Evaluate the messages being received. Should any changes be desired in messages received, such as a Filing Manager preferring not to receive messages on all filings in their instance, contact the Help Desk for assignment of roles that best accommodate the messages and notifications needed.

- **General Instructions**

General Instructions contain overall filing information advising companies how they should submit SERFF filings to a particular state instance. General Instructions can be found on the Filing Rules tab. As well, a link to instance specific General Instructions can be found at the top of each filing the company views.

States should complete the General Instructions with the most current filing information available to date. This is the opportunity for the state to outline exactly how a state prefers to receive a filing, including any unique state requests or necessary information to be submitted with the filing. It is important to be as specific and thorough as possible in updating the General Instructions to ensure industry users submit the most complete and accurate filing.

As all SERFF training reinforces, it is essential that filers review the General Instructions before completing each filing. This is the states' opportunity to communicate the necessary documentation, format and content for filings to their state instance and the filers' chance to submit a clean filing the first time. As General Instructions are intended to house dynamic information, filers are encouraged to review General Instructions before each filing is submitted, as instructions have the potential to be changed daily.

To affect the greatest Speed to Market, General Instructions should be reviewed by the state on a quarterly basis. Clear, complete General Instructions facilitate clear, complete filings. Having up-to-date General Instructions reduces time spent between the filer and the reviewer clarifying expectations and necessary processes specific to a state. The more clear an instance's General Instructions, the better filings states will receive across the board on initial submission and the less time reviewers will spend requesting additional or corrected data.

Best Practice: Review **General Instructions** on a quarterly basis to ensure they are current, complete and easy to understand. Use the fielded data in General Instructions as it will allow the filer to search for specific instructions across several states, thus aiding in the preparation of a multi-state filing.

- **Requirements**

A Requirement is a request from the state for Supporting Documentation to aid in the review of a filing. States use the Requirements list when creating their Submission Requirements. A Requirement can be used in multiple Submission Requirements, but is instance specific. All documentation necessary to review a filing should be included in a Requirement.

Any document that is to be completed and sent with a filing should either be attached directly to a Requirement or a link to the form should be included in the Requirement. All documents and forms, either attached or linked, should be in an interactive PDF format for easy completion and upload by the filers. Assistance from SERFF is available to states for interactive PDF creation should it be necessary.

Requirements are one of the most essential elements in Speed to Market offered in SERFF. If a Requirement is easy to understand, includes clear instructions on the necessary Supporting Documentation item and includes interactive PDFs or links to interactive PDFs, the completeness and correctness of filings submitted skyrockets. If a filer has all of the filing requirements necessary to create the filing on the filing draft and those Requirements have attachments or links to necessary forms, in an interactive PDF format, any time needed to research filing requirements is eliminated and the forms can be completed directly from SERFF. If the Requirements are clear on top of that, all time wasted in state communication answering filer questions on unclear or incomplete instructions, and time wasted in Filing Correspondence between the filer and reviewer getting the Supporting Documentation items submitted or corrected disappear, too. Well defined, inclusive Requirements are one of the steps a state can take to gain the most time back from the time that is expended and in turn have the greatest impact on Speed to Market via SERFF.

Best Practices: Review **Requirements** on a quarterly basis to ensure they are current, complete and easy to understand. All Requirements, if a state specific form is included, should be an interactive PDF, or have a link to an interactive PDF on the state website.

- **Submission Requirements**

The Submission Requirements are a set of specific Requirements for a particular combination of TOI, Sub-TOI and Filing Type. Each Submission Requirement, located on the Supporting Documentation Schedule, must be satisfied or bypassed before a filer can submit a filing for state review.

The following information is stored in Submission Requirements:

- State Instance
- Type of Insurance
- Sub-Types of Insurance
- Filing Types
- Requirements

States should ensure that all Submission Requirements are up-to-date and reflective of current laws, statutes, bulletins and Speed to Market initiatives. Clear, complete Submission Requirements reduce man-hours spent in explaining pieces necessary for submission to filers and creating Objections on filings with incomplete or incorrect Supporting Documentation. Good Submission Requirements will significantly increase the number of clean filings submitted by filers upon initial submission. A Submission Requirement must be created for each Type of Insurance, Sub-Type of Insurance and Filing Type combination before a filer has the option to choose that combination for filing submission. If a Submission Requirement has not been created, the filer will not be able to submit for that Type of Insurance, Sub-Type of Insurance and Filing Type combination regardless of the electronic setting for that Type and Sub-Type of Insurance.

Filers should always read the Submission Requirements thoroughly before satisfying and submitting filings. Clean, clear Submission Requirements are the number one way to expedite the review of a filing. Organized, complete filings are more easily reviewed and will therefore move through the review process more quickly. All Submission Requirements on the Supporting Documentation Schedule of a filing must be satisfied or bypassed in order to submit a filing for review.

Submission Requirements should be reviewed on a quarterly basis to ensure they contain the most current Requirements for the filers' use.

Best Practice: Review submission requirements on a quarterly basis to ensure they are current, complete and active. Use TOI, Sub-TOI and Filing Type to differentiate submission requirements among the products accepted in the state. Clarify, add, or remove requirements that are not producing clear, complete results from the filers.

- **Filing Correspondence**

All correspondence on a filing should be done via the Filing Correspondence tab. This creates a documented trail of communications between the state and the filer regarding the filing. Any e-mails or paper letters sent to filers or reviewers will not be logged with the permanent file record and might not be received by the intended user.

The use of Notes to Filers, Notes to Reviewers, Amendment Letters, Objection Letters and Response Letters are vital to the integrity of the filing. E-mail or paper correspondence between a filer and a reviewer undermine the filing integrity and the Speed to Market value of filing via SERFF. SERFF is built to accommodate any correspondence needs that could arise for all rate and form filings and the use of Filing Correspondence for all communication supports Speed to Market by ensuring delivery and easily accessible storage of all communications.

Best Practice: Use the appropriate type of filing correspondence for ALL communication with filers. Use an Objection Letter if you expect the company to respond with additional documentation for the filing. Keep all correspondence within SERFF. Use Reviewer Notes to record any phone calls or conversation outside of SERFF so that a complete record of filing correspondence is within SERFF.

- **Objections and Responses**

If a filing does not meet all of a state's filing requirements, an Objection Letter is created by the state. Objection Letters should be created for incorrect Supporting Documentation, necessary changes to Form or Rate Schedule Items, missing or wrong data in the static SERFF fields or inaccurate Filing Fees.

An Objection Letter requires the filer or another user at the company to submit a Response Letter, which may include one or more Schedule Item revisions or additions. The reviewer will create Objections while reviewing the filing, which will be inserted into an Objection Letter and sent to the filer indicating what needs to be revised and/or added.

Objections can be created throughout the review of a filing and the reviewer can compile some or all of those Objections into one Objection Letter when they are ready to communicate the Objections to Industry. Objections are an electronic means to document issues with a filing. Objections ('electronic sticky notes') can be compiled into an Objection Letter to be submitted to the industry or can remain as Objections for the reviewer's use. The state can send the filer an Objection Letter containing one to several Objections informing the filer of what needs to be amended, added and resubmitted.

An Objection Letter must be created and then submitted before the filer will be able to view the reviewer's Objections. Until an Objection is added to an Objection Letter and the Objection Letter is submitted, the Objection will only be viewable by the state user. Likewise, Schedule Items may be updated by a user at the company, but those changes will remain in draft form and not be viewable to the reviewer until the draft changes or additional updates are added to a Response or Amendment Letter.

When an Objection Letter is submitted on a filing, the filer will receive a message in their Message Center stating that an Objection Letter has been received. The filer will then Change Schedule Items to comply with the Objections sent on the Objection Letter and then add those draft Schedule Item changes to a Response Letter. The changes to the filing will not be viewable by the state until those Schedule Item changes are added to a Response Letter and the Response Letter has been submitted. Once the Response Letter is submitted by the filer, the reviewer will receive a message in their Message Center alerting them that a Response Letter has been received on that filing.

The Objection and Response Letters are a part of the permanent record of the filing as are the previous and current Schedule Items. Schedule Items that have been changed will be grayed out and the notation “*previous version*” will appear on the old version(s) of that Schedule Item.

Although multiple Objections may be submitted on one Objection Letter, only one issue should be noted in each Objection. A single Objection, however, can impact multiple Schedules. The use of Objections and Objection Letters allows the filer to more easily understand what the issue is on the filing and to what schedule item that issue applies, if necessary. It also allows the filer to respond to each issue individually helping to ensure all items of concern are addressed by a filer on a filing. This use of Objection and Response Letters streamlines the communication and update process with regard to problem items and drastically reduces the back and forth communication on a filing. This streamlined communication also greatly contributes to the success of Speed to Market by cutting out a majority of the time previously necessary to communicate clearly what issues were on a filing and communicating how those issues were resolved.

Best Practice: Create individual Objections for each issue on the filing, rather than creating one Objection containing multiple issues. Do not submit issues on multiple items in one Objection. Submit Objection Letters for all incorrect or incomplete filings. Require the filer to respond to each Objection via a Response Letter only. Do not close filings for issues that could be corrected with a Response.

- **Status Options**

The Status Options are excellent tools used to assist the states and insurers in managing their filings. They are specific keywords to help in tracking progress in the filing submission and review process. The use of state status indicators not only helps the state reviewer track their progress on the filing review, but it also communicates the progress of filing review to the Industry Filer.

Insurers have the option to create Company Statuses to track the progress of the overall filing. Aside from the required Disposition and Objection Statuses, state users may also use the State Status to track overall filing review progress and Schedule Item Statuses to track the review progress of individual Schedule Items. The Configuration Manager is responsible for adding and editing Status Options for their instance.

Statuses are also invaluable in running more specific searches and exports as state and industry users can search by specific filing statuses to narrow results for follow up and reporting. The time saved in faster reporting creation can be used to review filings more expeditiously.

Best Practice: Use Statuses to keep an up-to-date picture of the review process. Keep filing and schedule item statuses current throughout the review of a filing. Use statuses to track reviewed items in a filing and to create reports to assist in review tracking. Create and use state statuses that are easy to understand by the filer.

- **Quick Text**

Quick Text is reusable text and is available in all Correspondence. Quick Text is a collection of remarks or language commonly used by a specific instance. Quick Text is a useful resource for saving time on keystrokes and lookup; especially for bulletins, statutes, or regulations that you may reference frequently and refer to when creating Objections, Objection Letters, Dispositions, Notes to Filer, or Reviewer Notes. Quick Text is created only once, but can be edited on the fly for ease of use.

The use of Quick Text also increases uniformity between the multiple reviewers in a single state as it standardizes the language used for similar issues. This standardized language contributes to faster comprehension of filing issues by filers reducing the additional need for clarification communication. As well, it saves time in review by eliminating the time spent in keystrokes when keying identical things over again in multiple filings.

Best Practice: Create and use Quick Text for ALL language input used on a regular basis for all correspondence. Name Quick Text entries in a way that will allow them to be easily identified by multiple reviewers. Make Quick Text entries specific to

avoid having to modify the text after it has been added to the correspondence. Use Quick Text categories to easily narrow the choices during the review process.

- **PDF Pipeline**

PDF Pipeline provides users with the ability to create a single PDF file of their entire filing or selected parts of their filing at their discretion. The PDF Pipeline is generated by the user, on demand. The results will be displayed instantly and the user can save the PDF locally to their network or view and review filing submissions in an outline format as opposed to a tabular format. This functionality is especially useful in providing a contiguous format for users reviewing larger filings, who prefer a document type layout as opposed to the tabular layout of the standard SERFF structure. All schedule items and correspondence including Notes to Reviewer, Notes to Filer and Reviewer Notes are available to Pipeline. The PDF Pipeline enhances the ability to quickly create a complete copy of a filing to assist with online review.

Best Practice: Ensure all current and new users are aware of the alternate format the PDF Pipeline provides for viewing filings during review. Avoid storing Pipelined filings in SERFF as it means storing duplicative information.

- **Electronic Funds Transfer**

For states that require filing fees at the time of submission, SERFF supports electronic funds transfer (EFT) to allow the filing submission to be accompanied by payment. The time and hassle of tracking payments on each filing is eliminated via EFT as the fee payment must be addressed in order to submit the filing and documentation of payment is kept directly with the filing. Since payment is sent directly with the filing, review may begin immediately, as opposed to waiting for a paper check to catch up with the electronic filing. This confirmed receipt and ability for immediate review enhance Speed to Market by eliminating time spent waiting for and matching payments.

Best Practice: Implement EFT for all filings to eliminate time lost in matching payments to filings and waiting on receipt of payment before filing review can begin.

- **Dispositions**

A Disposition is the final result of the review of the filing.

The Configuration Manager can dictate whether any assigned Reviewer can create a Disposition or if only the Primary Reviewer has the ability to create a Disposition for an instance.

All filings, regardless of final decision, must be closed with a Disposition. A filing is still considered open and review has not been completed on a filing until a Disposition has been created and submitted. When a Disposition is created for a filing, the SERFF status of that filing is changed to "Closed." The filing is then removed from the "My Open Filings" view for both state and industry users. Users can find any closed filings by using the Advanced Search functionality in SERFF.

The Disposition is created in the Filing Correspondence Tab and remains a permanent part of the filing record. The filer receives a message in their Message Center indicating that there is a Disposition on their filing once a Disposition is created and submitted by the reviewer. The filer can then go into their Filing Correspondence Tab and read the final outcome of the review process. The use of a Disposition to close a filing helps get products to market more quickly by giving the filers a clear answer on their filing and the electronic delivery of the letter means the filers are notified immediately upon review decision.

Best Practice: Use a Disposition to close all filings regardless of final review status. Filings are not closed until a Disposition is created on the filing. Do not use Dispositions for filings where a Response Letter could correct a filing.

- **Public Access**

SERFF facilitates Public Access allowing freedom of information requests to be met. Public Access privacy may be requested and denied or granted on all or part of a filing via SERFF with the click of a button and SERFF's Public Access piece allows the public to view the filings with minimal state involvement, resources or time. As state laws vary greatly on the public's access to filing information, SERFF's Public Access is flexible to accommodate the differing Public Access laws in each state. States need to ensure they configure SERFF's Public Access settings to mirror how they have to comply with their individual state laws. The sophisticated functionality allows filers to request confidentiality on part or all of a filing and states to override the confidentiality requests where appropriate. The one click Public Access overrides and several Public Access settings increase Speed to Market by significantly reducing the time away from review that analysts have spent in the past creating and maintaining Public Access systems or replying to Public Access requests.

Best Practice: Ensure Public Access settings are correct in SERFF. The settings should reflect the individual states Public Access statutes and laws as applied to the majority of filings received. Setting Public Access to reflect the state Public Access laws across a majority of filings reduces the amount of time spent by reviewers in setting Public Access manually. Only filings that are exceptions to the general rule should be updated manually. Override, where applicable, Public Access to correctly mark the Public Access on all confidentiality requests. Any legislative changes in Public Access that affect the majority of filings should be updated in the general Public Access settings in SERFF directly following the new statute or law implementation.

- **Paper Filing Tracking and Disaster Recovery Plans**

In developing an automated solution for rate and form filings that facilitates Speed to Market, recognition was given to the fact that historical filings must be retained for periods of time up to indefinite storage. SERFF provides functionality for paper filing tracking to eliminate the need to support multiple systems for the same business function. All historical paper filings can be uploaded into SERFF for storage and longer ranged reporting capabilities. Speed to Market is then serviced with point and click access to historical filings for comparison or reference as opposed to searching through paper filing systems which are notoriously difficult to manage and maintain.

Mailed filings are not a good basis for long-term storage. In order to effectively support public access and reduce storage costs, many states and insurers are converting their hardcopy filings to electronic documents for permanent retention. SERFF offers the opportunity for both states and companies to store those scanned filings, outside of the department or company, alongside their electronic filings. With the added ability to store historical paper filings in SERFF, the electronic, off-site storage system creates an all-inclusive disaster recovery plan available for rate, rule and form filings.

This access to filings in disaster recovery situations assures the insurers and states meet the retention compliance standards set by state law. Industry users will need a separate data hoster to maintain files in SERFF. Data hosting for state users is provided by the NAIC.

The storage of paper and electronic filings together in one place also facilitates the reporting capabilities across all filings, regardless of the submission process used. By uploading paper filings into SERFF, users can create more comprehensive reports still with the ease of use available in SERFF.

Best Practice: Upload all paper filings into SERFF to utilize the Paper Filing Tracking as a disaster recovery plan, eliminate the need for paper storage areas and maintenance and for complete reporting on all filings, both paper and electronic, via SERFF.

- **Training/Tutorials**

Multiple training options are available to users to help them find the full potential in the functionality of SERFF as a Speed to Market tool. Training decreases the users' time in learning to navigate the system and teaches all of the time saving and uniformity features SERFF has to offer, allowing the reviewer and filer more time to focus on the creation, submission and review of a filing.

- State Training: On-site or Web-based training for state users is provided by the NAIC. To request state training, contact the SERFF Help Desk at SERFFHelp@naic.org.
- Tutorials: Regularly scheduled Web-based demonstrations of new and/or helpful functionality presented to state or industry users. E-mails are sent to all users who have the tutorial notification flag marked on their ID for the monthly functionality tutorials. For questions on tutorials, contact the SERFF Help Desk at SERFFHelp@naic.org.
- On Demand Tutorials: Pre-recorded tutorials accessed via SERFF Online Help at the user's pace and convenience.
- Newsletter: Tips and tricks are sent regularly with our monthly SERFF Newsletter
- User Guide: Manuals with step-by-step visual aides are available for use on the SERFF website.
 - ⇒ State User Guide: www.serff.com/documents/v5_manual_regulator.pdf
 - ⇒ Industry User Guide: www.serff.com/documents/industry_manual.pdf
- Website: Many helpful tips and frequently asked questions may also be found at www.SERFF.com.

- E-Reg Conference: Users can learn all kinds of useful information by attending the NAIC/NIPR E-Reg Conference hosted by the NAIC and NIPR annually. Users will receive e-mail notification on conference dates and how to register for the conference.

Best Practice: Stay abreast on all new and under utilized functionality via the **Training** tools offered, such as regular Web-based tutorials, On Demand tutorials, the SERFF Newsletter and the User Guide. Ensure new users have access to all of the available **Training** tools, as well as requesting new user training from SERFF. Attend the E-Reg Conference; this annual conference offers a myriad of training sessions at all skill levels.

Proper use of the SERFF application, via adherence to the best practices outlined above, will ensure the optimum utilization of the tool to increase Speed to Market. As the NAIC membership, comprised of state insurance departments, finds SERFF to be the premier Speed to Market tool, the advice of your peers is a great indicator to the efficiency and speed SERFF contributes to the filing review process. Proper use of SERFF has demonstrated repeatedly its impact on uniform filing submission and review and increased turn-around times from product inception to product approval.

Future Expectations

Speed to Market tools are designed to be living tools that will grow and change as the needs of insurance regulation grows and changes. Although the focus of the Speed to Market tools will not change, the tools themselves will continue to be updated to reflect the needs of this dynamic industry.

Speed to Market tool design, development and implementation are iterative processes that encourage the participation of regulators and industry users. Thus, input is required from state departments and industry filers alike. To that end the NAIC highly encourages participation in committees and suggestions to allow these tools to work to their most effective potential. Parties interested in continuing to promote uniformity and state based insurance regulation may visit the NAIC website and look under committee activity for more information.

All strategic objectives continue to be guiding principles. In other words, the tools must facilitate Speed to Market, uniformity, and minimize costs involved in meeting rate and form filing regulatory requirements.

CHAPTER NINE

Regulatory Data Resources

Insurance data are compiled by insurers and reported to various entities for a variety of reasons. Although the terms “financial data” and “statistical data” are sometimes interchanged, they comprise two distinct types of insurance data, each generated from insurance transactions, but representing different kinds of information, collected at different points in time, for very different purposes.

Financial Data

Insurance financial data are accounting data, used by regulators primarily to monitor insurers’ financial condition. Insurers are required by law or necessity to file financial reports with insurance departments, federal tax and investment securities agencies, the NAIC, insurance rating agencies, financial lending institutions, and trade and advisory organizations. These reports provide a snapshot view of a company’s financial condition on the reporting date, Dec. 31 for example, of a report year.

In conjunction with monitoring insurers’ financial condition, financial data are used to monitor risk-based capital requirements, determine insurer profitability and liquidity, assess premium taxes, and certify the adequacy of certain balance sheet items like loss reserves and assets. An examination of insurers’ written premiums by line of business can also indicate, on some level, the degree to which competition exists in a particular market.

Financial Data Collection

- Financial Annual Statements

Financial data are easily accessible, uniformly reported and defined, and available to users on a regular schedule. Insurers report financial data directly to insurance regulators and others on a prescribed set of NAIC forms called “annual statement blanks.” The blanks are delineated by line and column for entry of specific data elements. There is an extensive set of instructions for insurance financial professionals to reference as they post numbers or other required information in each field. State and federal laws require insurer financial reporting by a specific date and for a specific time period—at least annually. Most companies are also required to provide quarterly reports that may contain less detail. Like tax filings, there are penalties and fines if the reports are filed late. Any changes to the reporting forms or the instructions are made in public forums and with a considerable amount of input from insurance regulators and accountants, insurance industry professionals and other data users.

- Advantages of Collecting Financial Data

Despite their primary use as information for the assessment of individual company financial condition, financial data are the data referenced most often in insurance research studies that examine insurance market activity. Insurance market studies can be conducted as general market oversight, to assess the health of a particular market, as an evaluation tool used by insurers or others to assess competitiveness and market elasticity and in response to some problem or event that arises over a relatively short period of time. Typically, market studies conducted in response to a problem are related to either the affordability or availability of insurance. While “affordability” is a subjective term, affordability problems in an insurance market are considered to occur when the competitive prices that insurers charge are so high that consumers and businesses are generally unwilling or unable to purchase the coverage.

Availability problems result when the cost of providing a coverage is too high for insurers to price it competitively and make a profit, so they temporarily or permanently stop writing it. This can leave consumers without a source for the coverage they need or enable the insurers that remain in the market to charge higher prices to the point that affordability problems result. Availability problems can also arise if the regulator attempts to artificially constrain prices.

An economic cycle generally results from the dynamics of insurance pricing. When insurance prices are high and coverage is scarce, the market is considered to be in a “hard” part of the cycle. When high insurer claim costs, low returns on investment

income, or lack of competition push prices so high that consumers purchase less coverage or “go bare,” new insurers often enter the market with lower prices creating a “soft” market. New entrants seeking market share via lower prices do so with the risk of underwriting losses. Insurers may hope to offset these underwriting losses through investment gains or a reduction in operating expenses.

Financial data offer market analysts readily available, consistent data with which historical trends can be developed. Research is conducted that intends to analyze the underlying causes for insurers to raise rates or discontinue providing coverage.

- Financial Data Elements
 - Financial data include:
 - Assets (stocks, bonds, equipment, receivables and real estate)
 - Liabilities (loss reserves, loans, commissions and payables due, and taxes)
 - Income from premium payments, fee income and investment earnings
 - Expenses for operations, acquisitions, underwriting, and loss adjusting
 - Policyholders’ surplus

- Financial Data Resources
 - I-SITE

Technology makes financial data even faster and easier to come by for insurance regulators. Insurers now report financial data electronically through the Internet. Insurance regulators have immediate access to the data through their own state financial databases and through the NAIC’s international database via the Intranet I-SITE application. Insurer data are available by individual company and by group, and aggregate or summarized reports can be created using various application tools.

Insurer financial examinations are automated using specialized software applications to assess financial condition. The results of these financial examinations can also be accessed via I-SITE.

Data quality is assessed by programmed crosschecks and edits that assure accuracy and validity within established tolerance levels.

- Market Share Reports

Insurer market share reports are used to measure the size of an insurer or insurance market and its concentration. Market share can be compiled on various bases. The most common basis is by annual level of premium written or earned, although the size of a company can also be measured in terms of exposures (the number of insured units of risk) or policy counts.

The change in market premium share for companies over time can provide analysts with information regarding an individual insurer’s growth within a line of business or the growth of the market itself.

- *Report on Profitability by Line and By State*

The purpose of the *Report on Profitability by Line by State* (Profitability Report) is to estimate and allocate profitability in property/casualty insurance by state and by line of insurance. Combined with other information, this can be utilized in further analysis of competition and market performance. “Other information” that might be considered in evaluating these results include: market concentration; the market share of involuntary or residual market mechanisms; the rate of growth, leverage and capitalization; the rate of inflation; exposure to risk; and investment policies. Please note that the Profitability Report cannot and should not be used to determine whether current rates are adequate to cover future costs. At the same time, historical profits do provide some indication as to whether premiums have been sufficient to cover costs in the past.

➤ *Competition Database Report*

The *Competition Database Report* (Competition Report) provides a single source of reference measures that serve as a starting point for examining the competitiveness of state insurance markets. Examiners look to several factors to determine the competitiveness of a market, including market concentration, market entries and exits, market growth, availability, and profitability. The data used to calculate the measures in this report are found in property/casualty insurer annual statement filings received by the NAIC, and in all cases, are shown on the basis of insurer groups rather than individual insurers. The data for this report are composed of both personal lines and commercial lines of business.

Disadvantages of Using Financial Data for Market Analysis

There are significant limitations in trying to examine insurance market activity and make informed regulatory decisions using financial data only. For most lines of business, the premiums and losses reported in financial statements are not necessarily generated from the same set of insurance policies. Policy experience generated before or after the reporting period is not included. Also, financial statements do not include information about the insured risks that generate the reported premium and losses. For this reason, insurers and advisory organizations cannot use financial statement data to develop insurance rates, nor can regulators determine the adequacy of rates and insurer rating plans from financial reports. In addition, market analysis is often needed at a level that is much finer than the available financial data. For example, “Other Liability” data are inadequate for studying the competitiveness of the liability insurance market for a particular class of risks.

Statistical Data

Statistical insurance data can often be used for ratemaking. The availability of reliable data on insurance costs is central to the development and regulation of insurance pricing. Every insurance transaction generates data that contribute in some way to the insurer’s cost to provide the coverage and pay the claims. Loss costs are the main component of an insurance rate. In order to make profitable underwriting and marketing decisions, insurance companies and advisory organizations must develop loss costs from data that match information from the policies sold with information from the claims associated with those policies. The more detailed policy and claim data are, the more refined the analysis can be.

In statistical data analysis, larger and more consistent statistical data have a greater probability of producing accurate predictions about risk than smaller ones. Most insurance companies, however, do not have enough individual loss experience to produce a statistically credible database for making pricing decisions, so they combine their data with other insurers’ data to produce more accurate analyses of historical experience and predictions of future costs. While some of these data are financial in nature, statistical data contain many elements of information that are not reported on financial statements.

Exposure data, for instance, are essential in ratemaking and are generally not captured in financial data reporting. An insurance exposure represents a unit of risk for which the filer is exposed to paying a loss. Exposure counts are the number of cars, houses, \$100s of payroll, or other units of risk for which an insurer provides coverage. The characteristics of an exposure (physical, geographic, etc.) affect the potential size or frequency of a loss. Statistical reporting captures detailed exposure information, along with the earned premium, based on the exposure.

Ratemaking requires determining how much money was paid or will likely be paid on a claim and how frequently the same kinds of claims will be filed. Many small claims can affect rates as significantly as a few large claims. Detailed data from claim files are collected through statistical reporting systems. Claim counts are reported and for every claim filed and processed, numerous details about the claimant(s), exposure, loss and loss adjustment expenses are captured, including dollar amounts incurred and paid.

These types of statistical data can be combined to calculate the basic components of rate development:

- Average premium: Premium amount collected per exposure.
- Pure premium: Loss amount incurred per exposure.
- Claim severity: The dollar amount of loss incurred per claim.
- Claim frequency: The number of claims filed per exposure.
- Loss ratio: The loss amount incurred for each dollar of premium collected.

In a financial statement, all data is reported as of a specific date. In contrast, individual transaction dates are among the types of data captured in statistical reports. Dates that premiums are collected, claims are filed, and losses are paid, for example, are essential for loss development analysis and reserving. Statistical reporting systems also capture data in sub-lines and classes of business that are not broken out in financial statements.

Statistical Data Resources

Whether or not a jurisdiction has adopted the *Model Regulation to Require Statistical Data Reporting for Property and Casualty Insurance* (#751), all states have laws and/or rules regarding statistical data reporting. Statistical data are essential to regulatory rate monitoring in competitive rating and prior-approval states. Those states with competitive regulatory frameworks need statistical data for monitoring competition and insurer market conduct. In prior-approval states, statistical data trends can be examined to ensure rates are not excessive, inadequate or unfairly discriminatory.

With exposure counts by geographic territory, regulators can assess the availability of insurance to consumers with different characteristics or in different locations. If coverage does not seem to be available to certain consumers or in certain areas, the regulator can look to other types of data to determine what might be causing the problem.

The NAIC publishes the *Statistical Handbook of Data Available to Insurance Regulators* (Statistical Handbook) that guides regulators in requesting statistical reports that are both useful and cost efficient. The Statistical Handbook contains statistical reporting information and reporting plans that have been adopted for 20 property/casualty lines of business. Each statistical plan defines the data elements, formats, and time frames for insurer reporting.

Some states (e.g., Texas and California) collect their own statistical data for certain lines of business, but for the most part regulators do not get statistical data directly from insurers. Statistical details from every company on every policy and every claim would be an overwhelming amount of information for most insurance departments to maintain, so property and casualty industry statistical agents are designated to carry out the data collection, scrubbing and compiling functions. Everyone needs to remember that collection and compilation of statistical data is a regulatory function that has been delegated by law to statistical agents and is permitted by the limited anti-trust exemption contained in the McCarran-Ferguson Act. The most common format for reporting statistical data to regulators is in aggregated, summarized compilations that statistical agents develop jointly. Several years of data are typically included. Depending on the content, public access to statistical data compilations may be subject to state limitations on disclosure related to trade secret laws.

Standard Summary Reports

Two different summary statistical reports are delivered to insurance departments throughout the year. The most detailed is the *Statistical Compilation of Annual Statement Information*, which provides the essential match of premium and loss data from the same policies that is required to most effectively evaluate whether rates meet statutory requirements. The statistics are detailed by coverage, territory, and classification.

Fast Track Monitoring Reports present quarterly trend data on premium, losses and calculated loss ratios, by state and countrywide, as early as 60 days after the end of each quarter. To expedite the reporting of data to regulators, the information is collected for major lines of business only, from the major carriers in each line. Despite the limited detail, trend analysis using Fast Track Reports provides regulators with some of the earliest indications of market problems.

- Reporting Bases and Time Frames

Statistical data are compiled on any of three general bases:

- Policy Year: In the *Statistical Compilation of Annual Information*, all premiums, exposures and loss development related to all policies written during a specified year are traced. Policy-year losses include losses from accidents that are covered by policies with effective dates during a specified period of time. For this reason, the availability of annual statistical data will generally lag at least two calendar years behind the reported data year. Losses may continue to be evaluated in later years in order to account for subsequent

development as claims are settled, but any changes will still be reported as losses for the year the policy was written.

- Calendar/Accident Year: Exposures and related premiums earned during a specific year and losses that result from accidents that occurred in that year. The losses for accidents that do not occur in the calendar year the exposure was written are not included in the report, *even if they are covered by policies in effect during the year*. Losses from accidents that occur in the calendar year are included in the report, even if the policy was written in the prior year; however, *the policy exposure and premium earned in the prior year are not included*. (Example: A policy is effective Dec. 1, 2003, through Nov. 30, 2004. Losses related to an accident that occurs between Jan. 1, 2004, and Nov. 30, 2004, would *not* be included in a 2003 C/A year report. Likewise, premium/exposure earned Dec. 1, 2003, through Dec. 31, 2003, would *not* be included in a 2004 C/A year report.
- Calendar Year: Premiums earned during a year and losses incurred in the same year, regardless of the effective dates of the policies on which those transactions occurred and regardless of when the losses occurred. The calendar-year basis is a standard accounting technique prescribed by law for financial reporting. It deals with transactions that occur within the year and when compiled at year-end, represents a closed report that is not subject to further adjustment. Fast Track Report data are reported on this basis.

Matching written exposures to premium and loss transactions necessarily delays the availability of policy year data, and is the biggest drawback to using the *Statistical Compilation of Annual Statement Information* to interpret current events. However, analytical trends developed from policy-year data more accurately reveal patterns in market behavior that lead to specific availability and affordability problems than those developed from accounting data. Statistical data analysis using policy-year data is most valuable when it is used in the development of measures designed to preempt the recurrence of market problems.

- Special Data Calls

Insurance regulators can request special or customized statistical data compilations, in addition to the standard reports, to examine specific events that occur in the marketplace. A Special Data Calls chapter that includes a format for catastrophe reporting is included in the NAIC *Statistical Handbook of Data Available to State Insurance Regulators*. Reports can be requested on a regular or one-time basis, but the states are encouraged to design requests for data using the same or a similar set of specifications that another state has already created.

Many insurance departments post specifications for special data calls on their websites. The NAIC also maintains a “Special Data Calls” webpage that links a user directly to an insurance department’s information on statistical data calls. This facilitates uniformity in state data requests, which helps to reduce the costs to insurers and statistical agents to provide the data. Some of the data reporting requirements presented are based on individual state laws, and reporting may be required annually without the insurance department issuing a new “call” for data.

- Statistical Data Quality

Data support every function of an insurance company’s operations; therefore, quality data is essential to an insurer’s profitability. Historically, penalties for delinquent statistical reporting and poor data quality have not been as severe as those for inaccurate or delinquent financial reporting. But professional and technological advances have improved data collection and management.

Increasingly, insurance data management is being viewed as a critical business function with professional standards and principles that constitute best practices to ensure data quality. Statistical agents and insurers employ electronic data transmission and storage systems that use the functionality of common extensible markup language (XML) to facilitate data exchange in a consistent manner from multiple sources. Uniform data reporting formats, standard data definitions and sophisticated data editing systems are designed to reduce initial reporting errors, or detect and make corrections much more quickly.

Statistical agents and insurers are subject to regulatory market conduct examinations that assess effectiveness of procedures and practices for data reporting, collection and submission of statutorily required reports. Data quality standards have also been developed (with input from all facets of the insurance industry) and added to the *Statistical Handbook of Data Available to State Insurance Regulators*. When statistical agents submit statistical data compilations to a state, they are required to identify the companies that are *not* included due to poor data quality or delinquent reporting. The states, statistical agents or both may take action against insurers, including the assessment of penalties and fines, for a substantial number of errors or chronic reporting delays.

Conclusion

Financial and statistical data are just two of many types of information regulators and others need to carry out the myriad regulatory and market-monitoring activities required to ensure market stability, stimulate competition, and protect insurance consumers. Understanding when and how insurance data are collected, identifying reliable data sources, becoming informed about the various data types and elements available, and determining the intended use for data before making a request, are the key steps to obtaining the most appropriate data to satisfy any reasonable regulatory data need.