



**Bulletin No. B-4.35**

**Submitting Rate & Form Filings Involving the Patient Protection and Affordable Care Act (ACA also known as PPACA) of 2010**

**I. Background and Purpose**

The purpose of this bulletin is to provide guidance on ensuring rates and policy forms are submitted properly, ensuring efficiency, compliance with Colorado laws and regulations and speed to market.

Bulletins are the Colorado Division of Insurance’s (“Division”) interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

**II. Applicability and Scope**

This bulletin is intended for all insurers selling health insurance coverage that is potentially required to comply with the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [together referred to as the “Affordable Care Act” (ACA) or the Patient Protection and Affordable Care Act (PPACA)].

**III. Division Position**

Existing law requires insurers to submit rate and policy form filings, which are in compliance with Colorado laws and regulations.

**A. Definitions:**

1. ACA eligible Type of Insurance (TOI) /Sub-TOIs

H06 Health - Conversion	H06.000 Health – Conversion
H15G Group Health - Hospital/Surgical/Medical Expense	H15G.002 Large Group Only
	H15G.003 Small Group Only
H15I Individual Health - Hospital/Surgical/Medical Expense	H15I.001 Health - Hospital/Surgical/Medical Expense
H16G Group Health - Major Medical	H16G.002A Large Group Only – PPO
	H16G.002B Large Group Only – POS
	H16G.002C Large Group Only - Other
	H16G.003A Small Group Only – PPO
	H16G.003B Small Group Only - PPO Basic
	H16G.003C Small Group Only - PPO Standard

	H16G.003D Small Group Only – POS
	H16G.003E Small Group Only - POS Basic
	H16G.003F Small Group Only - POS Standard
	H16G.003G Small Group Only – Other
H16I Individual Health - Major Medical	H16I.005A Individual - Preferred Provider (PPO)
	H16I.005B Individual - Point-of-Service (POS)
	H16I.005C Individual – Other
H21 Health - Other	H21.000 Health – Other
HOrg02G Group Health Organizations - Health Maintenance (HMO)	HOrg02G.001 Conversion
	HOrg02G.003A Large Group Only – PPO
	HOrg02G.003B Large Group Only – POS
	HOrg02G.003C Large Group Only – HMO
	HOrg02G.003D Large Group Only – Other
	HOrg02G.004A Small Group Only - PPO Basic
	HOrg02G.004B Small Group Only - PPO Standard
	HOrg02G.004C Small Group Only - POS Basic
	HOrg02G.004D Small Group Only - POS Standard
	HOrg02G.004E Small Group Only – Other
	HOrg02G.004F Small Group Only – HMO
HOrg02I Individual Health Organizations - Health Maintenance (HMO)	HOrg02I.005A Individual - Preferred Provider (PPO)
	HOrg02I.005B Individual - Point-of-Service (POS)
	HOrg02I.005C Individual – Other
	HOrg02I.005D Individual – HMO
HOrg03 Health – Other	HOrg03.000 Health – Other

The Division considers all health benefit plans, as defined by 10-16-102(21), C.R.S., as subject to ACA. Health coverage that is not a health benefit plan may be included in these TOIs. Other health coverage within these TOIs will need to provide sufficient information to show that the other health coverage is an excepted benefit per 42 U.S.C. §300gg-91(c) such as showing the policy is a short term policy or indemnity only.

2. “Grandfathered Plan” has the same definition as 45 CFR Part 147.140(a).
3. “Individual Market” has the same meaning as 42 U.S.C. §300gg-91(e). Note that non-employer group plans are included in the individual market only for purposes of complying with this bulletin. Non-employer group plans should still be filed using group TOI codes and Colorado group rating and product requirements.
4. “Non-grandfathered Plan” is any health benefit plan that is not a grandfathered plan.
5. “Small group market” has the same meaning as 10-16-102(42), C.R.S.

**B. Requirements for both FORM and RATE filings:**

1. When a filing is submitted under one of the ACA eligible Type Of Insurance (TOI)/Sub-TOI codes, the PPACA field on the General Information tab in SERFF is required to be completed with one or a combination of the following options that will appear in the General Information Tab: ‘Non-Grandfathered Immed Mkt Reforms’, or ‘Grandfathered Immed Mkt Reforms’. The ACA help link will also appear on the General Information tab in SERFF. This field refers to the type of policy and not necessarily the reason for the filing.

If the filing is not ACA related, the value ‘Not PPACA-Related’ can be chosen but a detailed explanation needs to be completed under the Filing Description field on the General Information tab.

2. Carriers must submit SERFF filings with the appropriate Colorado State Specific Codes. All ACA related filings will use State Specific Code: 649 – Health Care Reform 2010, 644 - Grandfathered plans and 645 – Non-Grandfathered plans. Colorado State Specific Codes are to be completed in the first question under the State Specific Tab in SERFF. State specific codes can be found in Bulletin B-4.18. If the appropriate codes are not entered the filing may be rejected.
3. Colorado accepts both ‘Grandfathered’ and ‘Non-Grandfathered’ options in one filing submission. Insurers writing ACA health coverage have the ability to select both options in a SERFF filing. If a filing has already been submitted but the PPACA field was not properly marked to indicate the filing is for both “Grandfathered” and “Non-Grandfathered” options, the insurer can submit a Post- Submission Update to make the correction or change the PPACA designation.
4. Once the filing has been reviewed and it is determined the filing is ACA-related but not properly coded with Colorado State Specific Codes, the Division will require carriers to submit a “Post-Submission Update” to indicate whether the filing is either “Grandfathered and/or Non-Grandfathered” status. The appropriate ACA Colorado State Specific Codes should be reflected in each filing.
5. All the information listed on the Form Schedule tab in SERFF must be completed.
6. The effective date of the form which is required by §10-16-107.2, C.R.S., must be entered on the “General Information” tab in the field labeled: “Implementation Date Requested”. The “Implementation Date Requested” field must be stated as an effective date that is at least 31 days after the properly submitted form filing. NOTE: The notations of “Upon Approval” or “31 days from the submission date”, will not be acceptable and may be considered an incomplete filing which could be rejected. For prior approval rate filings the effective date must be at least 60 days after the submitted filing date.
7. When submitting the Annual form certification as required by §10-16-107.2, C.R.S., a separate form listing may be submitted and no effective date is required in the “Implementation Date Requested” field in SERFF.

**C. Requirements for FORM filings only:**

1. When submitting a form filing, the ACA mandated benefits must be noted on the “General Information” tab, and the “PPACA Uniform Compliance Summary” scheduled item in SERFF. The “PPACA Uniform Compliance Summary” must be submitted with all form filings except filings submitted for ONLY applications.
2. When submitting a new form filing through SERFF, the “Form Schedule” tab must be completed with the appropriate information.
3. When submitting ACA filings, insurers will need to list all the mandated benefits required by ACA:
  - i. Elimination of Lifetime Dollar Limits on Essential Health Benefits
  - ii. Elimination of Annual Dollar Limits on Essential Health Benefits
  - iii. Elimination of Pre-existing condition exclusions for enrollees under age 19
  - iv. Extension of Dependent Coverage for Children Until Age 26
  - v. Preventive Services
  - vi. Prohibition of Rescissions, except for fraud or intentional misrepresentation of a material fact.

#### **D. Requirements for RATE filings only:**

1. When submitting a rate filing, the ACA mandated benefits and the rating impact for each benefit and a combined rate change must be listed in the Actuarial Memorandum according to Colorado Regulation 4-2-11 Section 6. E. Effect of Law Changes.
2. When submitting a new form filing through SERFF, the “Form Schedule” tab must be completed with the appropriate information.
3. Carriers are required to complete all of the required fields in SERFF including the Rate Review Detail tab. These fields are marked with a red star. In addition to the required fields carriers are required to fill out the following fields:
  - i. General Information Tab
    - a. Implementation Date Requested
    - b. Overall Rate Impact
    - c. Group Market Type
  - ii. Form Schedule
    - a. Lead Form Number
    - b. Form Number
  - iii. Rate/Rule Schedule
    - a. Report Rate Filing to HHS
    - b. Filing Method
    - c. Rate Change Type
    - d. Overall Percentage of Last Rate Revision
    - e. Effective Date of Last Rate Revision
    - f. Filing Method of Last Filing
    - g. Overall % Indicated Change
    - h. Overall % Rate Impact
    - i. Written Premium Change for this Program
    - j. # of Policy Holders Affected for this Program
    - k. Written Premium for this Program
    - l. Maximum % Change (where required):
    - m. Minimum % Change (where required):
  - iv. Rate Review Detail Data
    - a. All fields
4. Carriers are required to complete the Rate Summary Worksheet with the HHS Rate Increase Summary and the Consumer Disclosure Form with the HHS Preliminary Justification for every non-grandfathered individual and small group market rate filing. Rate filings that include grandfathered and non-grandfathered data must include both forms as well. These forms will be used in the rate review process and also for public disclosure. If the carrier does not provide the worksheets, the bypass reason must be filled out. The only acceptable bypass reasons are “Grandfathered rates only” or “Large group rates”. Note that association business sold to non-employer groups is considered to be in the individual market and must supply both forms.

#### **IV. Additional Division Resources**

##### **A. For More Information**

Colorado Division of Insurance  
Rates and Forms Section  
1560 Broadway, Suite 850  
Denver, CO 80202  
Tel. 303-894-7499  
Internet: <http://www.dora.state.co.us/insurance>

##### **B. Related Division Regulations**

##### **V. History**

- Issued October 29, 2010
- Reissued September 16, 2011



**Appendix 1**  
**Federal Rate Justification Forms**

Per the instructions, health insurance issuers proposing rate increases above the threshold fill in only those cells that are highlighted in GREY. The other cells are auto-populated.

**A. Base Period Data**

Start Period:  End Period:

Service Categories	Member Months	Total Allowed	Net Claims	Cost Sharing	Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Outpatient				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Professional				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Prescription Drugs				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Other				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
Capitation				\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
<b>Total</b>		\$ 0.00	\$ 0.00	\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!

**B. Claim Projections**

**B1. Adjustment to the Current Rate**

Start Period:  End Period:

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient		#DIV/0!	#DIV/0!	
Outpatient		#DIV/0!	#DIV/0!	
Professional		#DIV/0!	#DIV/0!	
Prescription Drugs		#DIV/0!	#DIV/0!	
Other		#DIV/0!	#DIV/0!	
Capitation		#DIV/0!	#DIV/0!	
<b>Total</b>		#DIV/0!	#DIV/0!	#DIV/0!

**B2. Claims Projection for Future Rate**

Start Period:  End Period:

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Cost Sharing
Inpatient		#DIV/0!	#DIV/0!	
Outpatient		#DIV/0!	#DIV/0!	
Professional		#DIV/0!	#DIV/0!	
Prescription Drugs		#DIV/0!	#DIV/0!	
Other		#DIV/0!	#DIV/0!	
Capitation		#DIV/0!	#DIV/0!	
<b>Total</b>		#DIV/0!	#DIV/0!	#DIV/0!

**B3. Medical Trend Breakout**

Factor	Impact
Utilization	
Unit Cost	
Other Factors	

**C. Components of Current and Future Rates**

	Future Rate		Prior Estimate of Current Rate		Difference	
	PMPM	%	PMPM	%	PMPM	%
1. Projected Net Claims	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!
2. Administrative Costs		#DIV/0!		#DIV/0!	\$ 0.00	#DIV/0!
3. Underwriting Gain/Loss		#DIV/0!		#DIV/0!	\$ 0.00	#DIV/0!
4. Total Rate	#DIV/0!	#DIV/0!	\$ 0.00	#DIV/0!	#DIV/0!	#DIV/0!
5. Overall Rate Increase		#DIV/0!				

**D. Components of Rate Increase**

Claims Components	Impact on Rate	Percent
1. Inpatient	#DIV/0!	#DIV/0!
2. Outpatient	#DIV/0!	#DIV/0!
3. Professional	#DIV/0!	#DIV/0!
4. Prescription Drugs	#DIV/0!	#DIV/0!
5. Other	#DIV/0!	#DIV/0!
6. Capitation	#DIV/0!	#DIV/0!
7. Cost Share	#DIV/0!	#DIV/0!
8. Correction of Prior Net Claims Estimate	#DIV/0!	#DIV/0!
9. Total	#DIV/0!	#DIV/0!
<b>Claims Restatement for Current Rate Period</b>		
8.a. Prior Net Claims Estimate for Current Rate Period		\$ 0.00
8.b. Re-Estimate of Net Claims PMPM for Current Rate Period		#DIV/0!

**E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years**

Calendar Year	New Form	Requested	Implemented
		N	
		N	
		N	

**F. Range and Scope of Proposed Increase**

Number of Covered Individuals	Threshold Rate Increase
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	Range of Rate Increase
Minimum % Increase	
Maximum % Increase	

# Appendix 2

Field Name	Description	Required
<b>The General Information Tab</b>		
<b>PPACA</b>	This field is used to identify filings that are being submitted to comply with the requirements of the Patient Protection and Affordable Care Act (PPACA).	Yes
<b>Product Name</b>	Title of the policy	Yes
<b>Implementation Date</b>	This is the date the company is requesting their product to be available to sell. It is not necessarily the date the filing officially becomes effective. The State Insurance Department will determine the definitive effective date.	Yes
<b>Overall Rate Impact</b>	This is the statewide average percentage change to the accepted rates for the coverage included for each company.	Yes
<b>Market Type (if applicable)</b>	An identification of the targeted group or individuals. (This is a required field for PPACA-related filings only, but is encouraged to be completed on all LAH filings)	Yes
<b>Individual Market Type</b>	If Individual is selected on Market Type then the filing author will select Individual or Non-Employer Group-Individual under Individual Market type (for PPACA-related filings only).	Yes
<b>Group Market Size</b>	If Group is selected under Market Type fields for Group Market Size fields are presented. (This is a required field for PPACA-related filings only, but encouraged to be completed for all LAH filings)	Yes
<b>Filing Description</b>	This area can be used in lieu of a Cover Letter. A detailed description of the reason for the filing must be completed.	Yes
<b>Form Schedule</b>		
<b>Form Name</b>	The name entered by the filer.	Yes
<b>Form Number</b>	The number entered by the filer.	Yes
<b>Edition Date</b>	The date entered by the filer.	Yes
<b>Form Type</b>	There are many types of forms. Reference the Form Type Legend for an overview. (i.e. policy, contract, advertisement, etc.)	Yes
<b>Action</b>	The Action selected by the filer. (Initial (LAH), Other (LAH) or Revised (LAH))	Yes
<b>Replaced Filing Number</b>	The form number that is being replaced by a previously submitted form.	Yes
<b>Previous Filing number</b>	The previous Filing Number.	Yes
<b>Rate /Rule Schedule</b>		
<b>Report Rate Filing to HHS?</b>	For a state reviewer working on a PPACA eligible rate filing, a check box will display on the Rate/Rule Schedule tab as: 'Report Rate Filing to HHS?' If the industry user adds rate data, this check box will be defaulted to checked. If the industry user did not add rate data, this check box will be defaulted to not checked. The state user will have the ability to change this check box as needed. If the state has to override the industry choice, then post-submission updates will be required by the company to add the appropriate fields needed for reporting to HHS.	Yes
<b>Rate Change Type</b>	Increase, Decrease, or Neutral	Yes
<b>Overall Percentage of Last Rate Revision</b>		Yes
<b>Effective Date of Last Rate Revision</b>		Yes
<b>Company Rate Information</b>		
<b>Company Rate Change</b>	The industry filer will identify the type of rate change. This field is only applicable to PPACA related rate filings.	Yes
<b>Overall Percentage Indicated Change (when applicable)</b>	This field is only to be completed when an actuarial indication is included in the filing submission.	Yes
<b>Overall % Rate Impact</b>	This is the statewide average percentage change to the accepted rates for the coverage's included for each company.	Yes
<b>Written premium change for this program</b>	This is the statewide change in written premium based on the proposed overall percentage rate impact for each company.	Yes
<b>Number of policyholders affected for this program</b>	This is the number of policyholders affected by the overall percentage rate impact for each company.	Yes
<b>Written premium for this program</b>	This is the statewide written premium for each company.	Yes

Field Name	Description	Required
<b>Company Rate Information</b>		
<b>Maximum % Change &amp; Minimum % Change</b>	This information should be completed if required by the state to which the filing is being submitted.	Yes
<b>Product Type</b>	For each company on a PPACA related Rate filing, a table of Product Types will display. These fields will be used by the states that applied for and received Premium Review Grant Funds to report to HHS.	Yes
<b>Number of Policy Holders</b>	For each company on a PPACA related Rate filing, a table of Product Types will display and at least one column (pair) of values must be entered for the new fields: Number of Covered Lives and Number of Policy Holders). These fields will be used by the states that applied for and received Premium Review Grant Funds to report to HHS.	Yes
<b>Number of Covered Lives</b>	For each company on a PPACA related Rate filing, a table of Product Types will display and at least one column (pair) of values must be entered for the new fields: Number of Covered Lives and Number of Policy Holders). These fields will be used by the related Rate filing, a table of Product Types will display and at least one column (pair) of values must be entered for the new fields: Number of Covered Lives and Number of Policy Holders). These fields will be used by the states that applied for and received Premium Review Grant Funds to report to HHS.	Yes
<b>Product Type</b>	For each company on a PPACA related Rate filing, a table of Product Types will display. These fields will be used by the states that applied for and received Premium Review Grant Funds to report to HHS.	Yes
<b>Number of Policy Holders</b>	For each company on a PPACA related Rate filing, a table of Product Types will display and at least one column (pair) of values must be entered for the new fields: Number of Covered Lives and Number of Policy Holders). These fields will be used by the states that applied for and received Premium Review Grant Funds to report to HHS.	Yes
<b>Number of Covered Lives</b>	For each company on a PPACA related Rate filing, a table of Product Types will display and at least one column (pair) of values must be entered for the new fields: Number of Covered Lives and Number of Policy Holders). These fields will be used by the states that applied for and received Premium Review Grant Funds to report to HHS.	Yes
<b>Rate Schedule Items</b>		
<b>Document Name</b>	This is the name of the data being filed.	Yes
<b>Affected Form Numbers: (Separate with commas)</b>	This is the list of changes to the Rate/Rule manual.	Yes
<b>Rate Action</b>	The type of rate action being submitted. New, Other, Revised	Yes
<b>Rate Action Information</b>	If rate data is being replaced or withdrawn, the Previous State Filing Number field is displayed. This field will not display if a 'Rate Action' of new is selected.	Yes
<b>Attach Document</b>		Yes
<b>Submitted</b>	This is the Date that the attachment was submitted.	Yes
<b>Rate Review Detail</b>		
<b>HHS Issuer id</b>	The unique identifier as assigned by the HHS HIOS system. This will be required upon submission for a PPACA-related rate filing. This is a five digit code issued by the HHS HIOS system. Issuers who have submitted data for display on HealthCare.gov have obtained their ID from the HIOS system. For those issuers who have not yet submitted data into HIOS or have not yet received their ID, please enter '00000'.	Yes
<b>Product Names</b>	The "street" name of the insurance product as sold by the insurance company. This will be one string but may have commas in the data for other systems benefit. This will be required on submission on PPACA rate related filings.	Yes
<b>Trend Factors</b>	Text description of trend factors and rating factors used in developing the rate.	Yes
<b>New Policy Forms</b>	A policy is a 'New' issue if it has never been issued before. HHS wants the names of all new policies listed here.	Yes
<b>Affected forms for Closed Blocks</b>	Demonstrates if the rate for the policy is "open", "closed". An open policy is one that is available for sale to new enrollees.	Yes
<b>Other Affected Forms</b>	The insurer will list other affected forms.	Yes
<b>Change Period</b>	Demonstrates the time for which the premium change is effective. If there are multiple different change periods on products within the filing, the filer should select 'Other'. The choices are Annual, Semi-annual, Quarterly or Other. This is a required field. If an increase is for a calendar year or effective for an elapsed year's time from effective date of the increase one should use 'annual'. If a jurisdiction allows rolling increases on say a quarterly basis, but they are implemented to a given policyholder on a cumulative basis upon their anniversary it is called 'quarterly'.	Yes
<b>Member Months</b>	The member months used for the purpose of the rate development. If a company files more than one rate change in a single filing, the member months will be the aggregate sum of the 2 (or more) rate changes. The number of member months reported should reflect the number of member months used for the experience period of the rate development.	Yes

Field Name	Description	Required																				
<b>Rate Review Detail</b>																						
<b>Percent Change Requested- (Min, Max, Weighted Average)</b>	<p>The percentage of rate change requested in a rate filing can be a positive or negative number. This is demonstrated as a range of min- max and a weighted average representing all products in the rate filing. The weighted average should be calculated by weighting the increase using volume of premiums  Example: In this case there are two possible proposed increases 10% or 20% that apply to the block.</p> <table border="0" data-bbox="462 310 1317 443"> <thead> <tr> <th></th> <th style="text-align: center;">Premium</th> <th style="text-align: center;">Weighting of the Premium</th> <th></th> </tr> </thead> <tbody> <tr> <td>Minimum increase requested: 10%</td> <td style="text-align: center;">\$10M</td> <td style="text-align: center;">10% of \$10M =</td> <td style="text-align: center;">\$1M</td> </tr> <tr> <td>Maximum increase requested: 20%</td> <td style="text-align: center;"><u>\$20M</u></td> <td style="text-align: center;">20% of \$20M =</td> <td style="text-align: center;"><u>\$4M</u></td> </tr> <tr> <td>Total:</td> <td style="text-align: center;">\$30M</td> <td></td> <td style="text-align: center;">\$5M</td> </tr> <tr> <td colspan="4"><math>\\$5M/\\$30M = .1667</math> Weighted Average = 16.67%</td> </tr> </tbody> </table>		Premium	Weighting of the Premium		Minimum increase requested: 10%	\$10M	10% of \$10M =	\$1M	Maximum increase requested: 20%	<u>\$20M</u>	20% of \$20M =	<u>\$4M</u>	Total:	\$30M		\$5M	$\$5M/\$30M = .1667$ Weighted Average = 16.67%				Yes
	Premium	Weighting of the Premium																				
Minimum increase requested: 10%	\$10M	10% of \$10M =	\$1M																			
Maximum increase requested: 20%	<u>\$20M</u>	20% of \$20M =	<u>\$4M</u>																			
Total:	\$30M		\$5M																			
$\$5M/\$30M = .1667$ Weighted Average = 16.67%																						
<b>Total Earned Premium</b>	The total dollar amount collected for the purpose of premium payments for the one year period that ends with the effective date for the proposed premium. The frame of reference is the requested effective date of the new premium.	Yes																				
<b>Total Incurred Claims</b>	Total Projected Incurred Claims are the Total Incurred Claims for the one year period that ends with the effective date for the proposed premium. The frame of reference is the requested effective date of the new premium. This may include projected incurred-but-not-reported claims for said period.	Yes																				
<b>Annual Dollars-(Min, Max, Weighted Average)</b>	The dollar amount of the Prior Annual Rate on a PMPM basis is demonstrated as a range of min-max and a weighted average representing all products included in the filing. This is the PMPM premium for the highest, lowest and average using the rates prior to those proposed in the filing for the one year period that ends with the effective date for the proposed premium. The frame of reference is the effective date of the new premium.	Yes																				
<b>Projected Earned Premium</b>	Total Projected Earned Premium is the Total Earned Premium projected for the current one year period beginning with the effective date for the proposed rates including the new rates. The frame of reference is the requested effective date of the new premium.	Yes																				
<b>Projected Incurred Claims</b>	Total Projected Incurred Claims are the Total Incurred Claims projected for the current one year period under the new rate structure that begins with the effective date for the proposed premium. The frame of reference is the requested effective date of the new premium.	Yes																				
<b>Annual Dollars(Min, Max, Weighted Average)</b>	The dollar amount of the Requested Annual Rate on a PMPM basis is demonstrated as a range of min- max and a weighted average representing all products included in the filing. This is the PMPM premium for the highest, lowest and average using the new rates proposed in the filing for the current one year period beginning with the effective date of the proposed rates. The frame of reference is the effective date of the new premium.	Yes																				

# Appendix 3

## Listing of Federal Regulations

<b>Citation</b>	<b>Web Link</b>
42 U.S.C. §300gg-91	<a href="http://www.gpo.gov/fdsys/pkg/USCODE-2009-title42/pdf/USCODE-2009-title42-chap6A-subchapXXV-partC-sec300gg-91.pdf">http://www.gpo.gov/fdsys/pkg/USCODE-2009-title42/pdf/USCODE-2009-title42-chap6A-subchapXXV-partC-sec300gg-91.pdf</a>
45 CFR Part 147.140	<a href="http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=45&amp;PART=147&amp;SECTION=140&amp;TYPE=PDF">http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=45&amp;PART=147&amp;SECTION=140&amp;TYPE=PDF</a>