

# DEPARTMENT OF REGULATORY AGENCIES

## Division of Insurance

### 3 CCR 702-4

#### LIFE, ACCIDENT AND HEALTH

##### Amended Regulation 4-2-11

##### RATE FILING AND ANNUAL REPORT SUBMISSIONS HEALTH INSURANCE

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##### **Section 1 Authority**

This regulation is promulgated pursuant to the authority of §§ 10-1-109, 10-3-1110, 10-16-107(1), 10-16-107(1.5), and 10-16-109, C.R.S.

##### **Section 2 Scope and Purpose**

The purpose of this regulation is to ensure that health insurance rates are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings and to require an annual rate report. This regulation provides a listing of the items required to be included in this Annual Rate Report.

##### **Section 3 Applicability**

This regulation applies to all companies operating in the State of Colorado, as defined in Section 4. This regulation concerns all health insurance rate filings, including, but not limited to, comprehensive health insurance, long term care, supplemental health, limited benefit health, prepaid dental, limited service licensed provider networks, disability, and Health Maintenance Organization (HMO) coverages.

##### **Section 4 Definitions**

- A. "Anticipated" or "Targeted Loss Ratio" means, for purposes of this regulation, the ratio of expected benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over this same period. The anticipated loss ratio should be calculated on an incurred basis as the ratio of incurred losses to earned premiums. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefit or loss ratio calculations must be displayed without the inclusion of active life reserves.

- B. "Company" means, for purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S., and includes, but is not limited to, licensed property and casualty insurance companies; licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; HMOs; prepaid dental companies; and limited service licensed provider networks.
- C. "Excessive Rates" means, for purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the benefits provided.
- D. "Filing Date" means, for purposes of this regulation, the date that the rate filing is received at the Division of Insurance.
- E. "Inadequate Rates" means, for purposes of this regulation, rates that are insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace.
- F. "Indemnity Benefits" means, for the purpose of the twenty percent (20%) limitation imposed on HMOs, the following benefits: out-of-area services, supplemental benefits (such as vision and dental provided on a non-contractual fee-for-service basis) and point-of-service benefits. It does not include any benefits provided by an HMO for which there exists a hold harmless agreement between the providers and the HMO.
- G. "On-Rate-Level Premium" is the premium that would have been generated if the present rates had been in effect during the entire period under consideration.
- H. "Pod" means any subdivision or subgrouping of a network, if arrangements between the plan and participating providers or the policy itself have specific incentives for the use of providers and services within the subdivision or subgrouping of the network.
- I. "Premium" means, for purposes of this regulation, the amount of money paid by the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.
- J. "Prior Approval" is a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collection of premium, advertising, or any other use of the rate.
- K. "Qualified Actuary" is a person who meets the qualifications in Regulation 1-1-1.
- L. "Rate" means, for purpose of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, and the insured's share of the carrier's claim settlement, operational and administrative expenses, and cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.
- M. "Rate Filing" means, for purposes of this regulation, is a filing that contains all of the items required in this regulation and the bulletin entitled "Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers", and 1) for individual products, the proposed base rates and all rating factors, the underlying rating assumptions, and support for changes in these rates, factors and assumptions; and 2) for group products, the underlying rating factors and assumptions, and support for changes in these factors and assumptions.

- N. "Retention" means, for the purposes of this regulation, the percentage of total premium determined by either 100% minus the percentage of total premium anticipated to be paid for policyholder benefits or 100% minus the anticipated loss ratio.
- O. "Trend" or "Trending" means any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.
- P. "Use of Rates" means, for purposes of this regulation, the date that the rates are: 1) distributed to agents or made available to others outside the company; or 2) quoted to any party outside the company.
- Q. "Unfairly Discriminatory Rates" means, for purposes of this regulation, charging different rates, for the same benefits provided, to individuals, or groups, with like expectations of loss. For individual policies, rates which differ for new and renewal policies are not necessarily considered unfairly discriminatory. In addition, a rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

## **Section 5      General Rate Filing Requirements**

Failure to supply the information required in Sections 5, 6 and 7 of this Regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. All filings that are not returned on or before the 15th business day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing company on or before the 30<sup>th</sup> business day after receipt. Correction of any deficiency, including deficiencies identified after the 30th business day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner. Nothing in this Regulation shall render a rate filing subject to prior approval by the Division of Insurance that is not otherwise subject to prior approval as provided by statute.

### **A.      General Requirements**

#### **1.      Required Submissions:**

- a. All companies must submit rate filings whenever the rates charged new or renewal policyholders or certificateholders differ from the rates on file with the Division of Insurance. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in the trend or other rating assumptions.
- b. All companies must submit a rate filing on at least an annual basis to support the continued use of rating variables which change on a predetermined basis, such as trend, durational factors, or the Index Rate for small group business, for continued appropriateness. These rate filings must contain detailed support as to why the assumptions continue to be appropriate.
- c. All companies must submit a rate filing within 60 days after Division of Insurance approval of the assumption of a block of business. This rate filing should provide detailed support for the rating factors the assuming company proposes to use, even if the rating factors are not changing. The new filing must demonstrate that the rating assumptions continue to be appropriate.
- d. A separate rate filing is required for each major line of business. Rate filings should not be combined with form filings. Each type requires a separate filing.

- e. Where a company complies with the loss ratio guarantee requirements of § 10-16-107(1.5), C.R.S., the rate will not be considered excessive. However, such rates are still subject to the statutory requirement that rates shall not be inadequate or unfairly discriminatory, and are subject to review by the Commissioner on these grounds. Companies filing loss ratio guarantees are therefore subject to this regulation in all respects.
2. **Timing and Submission:** Unless a filing is specifically identified as requiring prior approval (e.g. Medicare supplemental), all filings are classified as “file and use.” “File and use” requires the company to file the rates and rating data with the Division of Insurance concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates except as provided for in Section 7(C) of this regulation for large group contracts. If a rate change has been implemented without being filed with the Division of Insurance, corrective actions may be ordered, including fines, refunds to policyholders, and/or rate credits. All filings must be filed with the Rates and Forms Section of the Division of Insurance.
3. **Withdrawn, Returned, or Disapproved Filings:** Filings that have either been withdrawn by the filer or returned by the Division of Insurance as incomplete or disapproved as unjustified, and subsequently are resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, the rates may not be used or distributed. Nothing in this Regulation shall render a rate filing subject to prior approval by the Division of Insurance that is not otherwise subject to prior approval as provided by statute.
4. **Duplicates and Return Postage:** All filings must be submitted in duplicate, and include an envelope, with sufficient prepaid postage, large enough to contain one complete set of the material. These filings must be collated so that each copy of the filing contains all required documents. If the company fails to comply with these requirements, the company will be notified that the filing has been returned as incomplete. If a filing is returned due to lack of completeness, the rates may not be used or distributed.
5. **Company Specific:** A separate filing must be submitted for each company. A single filing, which is made for more than one company or for a group of companies, is not permitted. This applies even if a product is comprised of components from more than one company, such as an HMO/indemnity point-of-service plan.
6. **Required Inclusions:** The level of detail and the degree of consistency incorporated in the experience records of the company are vital factors in the presentation and review of rate filings. Every rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid company experience should be used whenever possible. This information may include the company’s experience and judgment; the experience or data of other companies or organizations relied on by the company; the interpretation of any statistical data relied on by the company; descriptions of methods used in making the rates; and any other similar information. In addition, the Commissioner may request additional information necessary to adequately support the rate change request.

## B. Forms and Actuarial Certification

1. **Required Forms:** A fully completed Filing Transmittal Form and Form HR-1 must be completed for each rate filing. These forms are available in the Division of Insurance bulletin entitled “Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers”. This Bulletin may be found on the Division of Insurance’s website, [www.dora.state.co.us/insurance/](http://www.dora.state.co.us/insurance/).

2. Actuarial Certification: A signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory. (The requirements for the actuarial certification for Medicare Supplement rate filings may be found in Section 14(H) of Colorado Insurance Regulation 4-3-1.)

## **Section 6 Actuarial Memorandum**

The rate filing must contain an actuarial memorandum, either signed by, or prepared under the supervision of, a qualified actuary, containing, at a minimum, the following sections:

- A. Summary: A brief written summary of the reason for the rate filing, the marketing method(s), and the premium classifications and product descriptions. In addition, the summary must state whether the premiums will be charged on an issue age, attained age, renewal age or other basis.
- B. Rating Period: The memorandum must identify the period for which the rates will be effective. If the rating period is not clearly identified, it will be assumed to be for twelve months.
- C. Underwriting: The memorandum must include a brief description of the extent to which this product will be underwritten, if a new product, or the changes, if any, to the underwriting standards, if an existing product. The memorandum should include the expected impact on the claim costs by duration and in total. The company shall state separately the effects of different types of underwriting: medical, financial or other. An example of an acceptable brief description is: "This policy form is subject to limited underwriting with yes/no questions. The expected impact is: duration 1 = .15; duration 2 = .05; duration 3 = .03 decrease in claim costs."
- D. Effect of Law Changes: The memorandum should identify and quantify any changes to the rates, expenses, and/or medical costs that result from changes in law(s) or regulation(s). This quantification must include the effect of specific mandated benefits and anticipated changes.
- E. Rate History: The memorandum must include a chart showing the rate changes implemented in at least the three years immediately prior to the date of the filing. The cumulative effect of all rate filings, submitted in the prior year, on renewal rates should be specified, including the range of increases the renewing policyholder may experience, i.e., the minimum, average, and maximum.
- F. Coordination of Benefits: Each rate filing must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.
- G. Relation of Benefits to Premium: The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. This relationship will be presumed to be reasonable if the company complies with the following:
  1. Medicare Supplement and Long Term Care Policies: See Section 7 (D) and (E) of this regulation.
  2. Retention Percentage: The Actuarial Memorandum must list and adequately support each specific component of the retention percentage (1 minus the target loss ratio). Each of these specific components must be expressed as a percentage of the total premium charged, and should sum to the total company retention percentage. Each component should be expressed as the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The load for profit/contingencies should reflect the target load, and not the expected results or operating margin. The Division will evaluate each component for reasonableness and consistency with other similar rate filings. Any change in these components from the previous rate filing must be adequately supported. It should be noted that broad groupings of these components are not permitted.

3. Loss Ratio Guidelines: The Division uses these percentages as guidelines for the acceptability of the Company's target loss ratio.
- a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage, as defined in Subsection G(2) of this section. The Division will evaluate these components for reasonableness. Policy forms priced at, or above, these loss ratios may be unacceptable, if one or more of the retention components is not supported.
  - b. For the following types of business, if the company prices the product at or above any of the following minimum anticipated loss ratios.
 

Comprehensive Major Medical (Individual)	65%
Comprehensive Major Medical (Small Group)	70%
Comprehensive Major Medical (Large Group)	75%
Specified or Dread Disease	60%
Disability Income	60%
Dental/Vision	60%
Stop Loss	60%
  - c. For conversion products, if the anticipated loss ratio is at least 125%.
  - d. For individual products issued to HIPAA eligible individuals, if the premiums for these products are, at most, two times the premiums for the underlying, underwritten product.
- H. Lifetime Loss Ratio: The memorandum must state whether or not the product was priced initially using a lifetime loss ratio standard. If the product was priced using a lifetime loss ratio standard, then any subsequent rate change request must be based on the same lifetime loss ratio standard with consideration given to the variance in the expected loss ratios over the duration of the policy. The rate filing must include the expected loss ratio, as originally priced, for each policy duration. The rate filing must also include a chart showing actual and expected loss ratios for both the experience and rating periods. For each year of the experience period the chart must show the actual and expected loss ratios, and the ratio of these two loss ratios. For each year of the rating period, the chart must show the projected and expected loss ratios, and the ratio of these two loss ratios. It is expected that the company is pricing these products to achieve a loss ratio greater than or equal to the expected loss ratio for the rating period, unless there has been a material change in assumptions which would justify a deviation from this expectation. These changes must be identified and clearly supported in the rate filing.
- I. Provision for Profit and Contingencies: The memorandum must identify the amount or percentage of the provision for profit and contingencies, and how this provision is included in the final rate. If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load in excess of 7% after tax.
- J. Complete Explanation as to How the Proposed Rates were Determined: The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if adequate support for each rating assumption is not provided. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis, but must completely explain how the proposed rates were determined. The memorandum must adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

- K. **Trend:** This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. The trend assumptions shall be, if practical, separately quantified into two categories, medical and insurance, as defined below:
1. Medical trend is the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.
  2. Insurance trend is the combined effect of underwriting wearoff, deductible leveraging, and antiselection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.
- L. **Credibility:** The Colorado standard for fully credible data is 2,000 life years and 2,000 claims a year. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.
1. The memorandum must discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. The memorandum must also identify and discuss the source, applicability and use of collateral data used to support partially credible Colorado data. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is  $\text{SQRT}\{(\#\text{life years or claims})/\text{full credibility standard}\}$ . The full credibility standard is defined above.
  2. The memorandum should also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.
- M. **Data Requirements:** The memorandum must, at a minimum, include earned premium and loss experience data, submitted on a Colorado-only basis for at least 3 years, if available, and on a national, regional or other appropriate basis, if the Colorado data is not fully credible, or provide an acceptable reason(s) as to why this data was not provided. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. If the Colorado experience is not fully credible, the data may be supplemented with national data, or other relevant data. The filing should clearly discuss the reliance upon non-Colorado data, and the credibility of the Colorado data. The experience period must include consecutive data no older than six months prior to the date of the filing, or a clear and acceptable reason as to why such data was not included. The loss data must be on an incurred basis, including both the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments.
- N. **Side-by-Side Comparison:** Each memorandum must include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison should include three columns: the first containing the current rate, rating factor, or rating variable; the second containing the proposed rate, rating factor, or rating variable; and the third containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.

- O. Loss Ratio Projections: The memorandum must contain a section projecting the loss ratio, over the rating period, both with and without the requested rate change. For long tail lines, such as long term care and long term disability, the projections should include a timeframe as to when the target loss ratio will be achieved.
- P. Other Factors: The memorandum must clearly display all other rating factors and definitions, including the area factors, age factors, gender factors, etc., and support for each of these factors in a new rate filing and support for changes to any of these factors in renewal rate filings. In addition, the Division expects each company to review each of these rating factors at least every five years and provide detailed support for the continued use of each of these factors in a rate filing.

## **Section 7 Additional Rate Filing Requirement by Line of Business**

The following subsections set forth the requirements by separate lines of business, which must be complied with in addition to the above general requirements:

- A. Individual: Renewal rates for individual health insurance plans may not be affected by the health status or claims experience of the individual insured. A "claims experience factor," or any other part of the renewal rate calculation, which is based in whole or in part upon the health status or claims experience of the individual insured is prohibited. Group policies issued to valid multi-state associations, meeting the requirements of § 10-16-214 (2), C.R.S., will be considered individual policies for rating purposes only.
- B. Small Group Major Medical: The provisions of §§ 10-16-105 and 10-16-107, C.R.S., and Colorado Insurance Regulations 4-6-5, 4-6-7, and 4-6-8, shall apply to the filing of rates for small employer health benefit plans. The factors usually included in the determination of a trend percentage are not considered a small group rating variable and must be included in the calculation of the index rate. A company may, in a single rate submission, file up to a maximum of twelve different index rates for effective dates in the subsequent twelve-month period; however, only one index rate can be effective at any given time. Only the factors defined in Regulation 4-6-7 may be used to adjust the filed index rate, and changes should be clearly set forth in the side-by-side comparison. Each rate filing should contain all tables necessary to recalculate the small group renewal rates, even if the factors in the table have not changed. It should be clearly indicated that the factors in these tables are unchanged.
- C. Large Group Major Medical: Large group major medical health care coverage contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should also contain an example of how the large group health rates are calculated. A company may issue rate quotes using the rating factors contained in the filing concurrent with the submission of the filing to the Division of Insurance. While the final rate charged the large group may differ from the initial quote, all rating variables must be on file with the Division of Insurance.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each company must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division of Insurance. The company shall

make all such information available for review by the Commissioner upon request. All such requests will be made at least three (3) business days prior to the date of review.

The rates for subgroups must be determined in an actuarially sound manner using credible data. The methodology for determining these rates must be on file with the Division of Insurance and any changes in the methodology must be filed with the Division.

- D. Medicare Supplemental: A Medicare supplemental insurance policy is defined in § 10-18-101(4), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-3-1 and §§ 10-18-101 to 109, C.R.S. If the requirements of both Regulation 4-3-1 and this Regulation are not met, the filing will be considered incomplete and returned to the company. Medicare supplemental filings require prior approval. (The requirements for the actuarial certification for Medicare Supplement rate filings may be found in Section 14(H) of Regulation 4-3-1.) Rating requirements may be found in Sections 10(E)(2), 13 and 14(G) – (J).
- E. Long Term Care: Long Term Care insurance is defined in § 10-19-103(5), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-4-1 and §§ 10-19-101 to 115, C.R.S. If the requirements of both Regulation 4-4-1 and this regulation are not met, the filing will be considered incomplete and returned to the company. The filing must also:
  - 1. Demonstrate that investment income has been considered in the development of the rate;
  - 2. provide the expected loss ratios for both the experience period and the projection period;
  - 3. provide the ratio of the actual loss ratio to the expected loss ratio for each year of the life of the policy on both a durational and calendar year basis; and
  - 4. provide a discussion as to how the original pricing assumptions have changed historically, and how the assumptions for the future period compare to the original pricing assumptions and the current rating assumptions.
- F. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate.
- G. Health Maintenance Organization (HMO): The rates for all HMO point-of-service (POS) benefits must be separately determined and supported. The Actuarial Memorandum supporting any rate filing for a policy which includes POS or other indemnity benefits must include a statement that all indemnity benefits are not expected to exceed twenty percent (20%) of the net medical and hospital expenses incurred. HMOs that exceed the 20% limitation in the prior calendar year may be prohibited from offering a point-of-service plan for new issues until compliance can be demonstrated.
- H. Limited Service Licensed Provider Network (LSLPN): Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost-plus or retrospective rating basis.

## **Section 8      Annual Rate Report**

All foreign companies (whose reported Colorado health insurance written premiums were in excess of \$20,000,000 in the preceding calendar year) and all Colorado domestic companies (without regard to yearly earned premium), subject to this regulation, must file an annual report as described in this section, with the following exceptions:

- Companies writing only disability income policies;

- Companies whose only in-force health policies are non-cancelable policies, if the premiums cannot be increased; and
- LSLPNs who contract exclusively with national, state or local governments and whose rate, premium or reimbursement rate is determined by the contracting governmental entity.

All other companies, subject to this regulation, may be required to file this Annual Report upon request from the Division of Insurance. This report must comply with the following requirements:

- A. **Timing and Submission:** The Division of Insurance must receive all annual reports on or before June 1 of each year. Failure to file this report by June 1 will result in a late penalty not to exceed \$100 per day. Reports not discussing each of the required items from Part B of this Subsection, completely, may be subject to a fine for an incomplete report.
- B. **Scope and Certification:** the report should be organized by major line of business. For the purposes of this requirement, a “major line of business” includes at least the following categories: individual, small group, large group, Medicare risk, and Medicaid risk. For each of the company’s major lines of business, the report should discuss the following topics:
  1. **Reason for filing:** The report must provide the reason for filing the report. Acceptable reasons include 1) the company is a Colorado domestic company, and 2) the company is a foreign company with over \$20 million in written Colorado health insurance premium during the prior calendar year. If the report is being prepared by a foreign company, the total amount of written Colorado health insurance premium during the prior year should be included as part of the reason for filing.
  2. **Business written:** The report should contain a brief description of each of the major lines of business written or inforce during the prior calendar year.
  3. **Rate filings filed:** The report must list by date and major line of business a brief description of all rate filings filed with the Division of Insurance during the prior calendar year.
  4. **Certification:** The report must be signed by a qualified actuary. For each major lines of business, including those for which a filing has not been made in the prior calendar year, the report must include a certification which states that the current rate(s) or premium for such line(s) of business are not excessive, inadequate or unfairly discriminatory. For HMOs, the qualified actuary must also certify that the indemnity benefits provided did not exceed 20% of the net medical and hospital benefits provided during the prior calendar year. Long term care insurance for which the company can issue a certification as set forth in Subsection 8(D)(4) of this regulation is exempt from this requirement.
  5. **Automatic factors:** The report must specifically: 1) list all automatic rating factors in use, including trend and inflation; 2) describe how each of these factors were determined; 3) provide support for the continued use of these factors; and 3) state that, in the actuary’s opinion, the continued use of any such factors used in calculation of the rates is still appropriate.
  6. **Appropriateness of rates charged:** The report must include a brief analysis of the appropriateness of rates charged to Colorado policyholders or certificate holders in the prior calendar year for each major line of business. This analysis should include a table containing the earned premium, incurred losses, and number of policyholders for each major line of business. This analysis shall compare the anticipated to actual results for the prior calendar year by comparing the actual to expected loss ratios and any other information as deemed appropriate for this analysis.

7. Reinsurance arrangements: The report must include a discussion of the reinsurance arrangements in place and the reasonableness of these arrangements as regards the protection against claims volatility these arrangements provide the company.
  8. Future rate changes planned: The report must describe the steps, if any, taken or proposed to be taken, for each major line of business, to adjust the current year or future rates due to these findings. If a company states in this report that an indicated increase will not be implemented in the following year, nothing in this regulation shall be construed to prohibit the company from implementing a supportable rate increase in future years.
- C. The Division of Insurance has determined that the information contained in these reports may be considered confidential pursuant to § 24-72-204, C.R.S., and/or § 10-16-107(3)(e)(II), C.R. S. If a carrier desires confidential treatment of this "Annual Rate Report", a Vaughn Index must be completed. Please see the bulletin entitled, "Guidelines for Rate, Rule, Loss Cost and Form Filings Containing Confidential Information". This Bulletin may be found on the Division of Insurance's website, [www.dora.state.co.us/insurance/](http://www.dora.state.co.us/insurance/). It should be noted that HMOs are not afforded automatic confidential treatment in the filing of this report and must also complete a Vaughn Index.
- D. Additional Information: In addition to the above, the report for companies writing certain categories of business must include the following information:
1. Health Maintenance Organizations:
    - a. Non-Developed Rates: If the HMO accepts business on a risk basis and does not develop rates (common for Medicaid and some Medicare business), the actuary should include:
      - (1) A separate certification that the premium or reimbursements received for such business are sufficient to satisfy all medical expenditures, guaranteed provider benefits, internal and external expenses associated with the business, and all other costs associated with the risk transfer, or a quantification as to the amount of any deficiency; and
      - (2) A description of any changes to the plan, provider risk arrangements or any other material aspect of the benefits provided under these plans.
    - b. Provider Compensation: The manner in which the providers are compensated has a material effect on the rating process. In the report, therefore, the actuary should provide all of the following:
      - (1) Clearly describe the type and scope of capitated or other provider risk sharing arrangements (if material to the rating assumptions), including the existence of any multiple capitation contracts, and any other material aspect of the benefits provided.
      - (2) State the degree to which the actuary has evaluated the financial position of the risk-assuming provider entities and the results of that evaluation.
      - (3) State whether or not the rates include an adequate provision for contractual incentive payments.
      - (4) For all provider agreements which materially impact the rating assumptions, note whether or not the payments to these providers

assumed in the rate development have, in fact, been confirmed by an executed agreement. For example, if the rates assume that all primary care will be performed by physicians who will be paid a fixed per member per month capitation in compensation for their services, the actuary should note whether or not the contract between the HMO and the physician group which agrees to this rate of compensation has been executed and will be in effect for the period the rates are effective. If the actuary is not aware or cannot determine if the amounts of provider compensation assumed in the rates is supported by actual, executed contracts, the actuary should still identify these assumptions and note that there is no confirmation that the supporting contracts have been executed.

- (5) Indicate the impact the above arrangements/findings have on the rates.
  - c. Pods: If the HMO uses pod ratings or classifications, the actuary should adequately support the rate differentials through use of historical loss/expense experience and prospective provider compensation arrangements.
  - d. Prospective Changes: The report should include a description of any other current and anticipated changes that would affect the HMO's financial solvency, organizational structure, or market share.
  - e. Indemnity Benefits. The filing must demonstrate that indemnity benefits do not exceed twenty percent of net medical and hospital expenses incurred during the previous calendar year.
2. Small Groups: Pursuant to § 10-16-105(6.5), C.R.S., all companies who sell or offer for sale policies subject to the requirements of this regulation shall submit an annual actuarial rate certification to the Division of Insurance on or before March 1 of each calendar year. The small group certification, required under § 10-16-105 (6.5), C.R.S., may be included in this annual report provided the company submits written notification to the Division of Insurance on or before March 1, and clearly indicates, in the annual filing, that the annual filing satisfies the annual filing requirements in this section and the small group certification requirements in § 10-16-105 (6.5), C.R.S. The certification must be signed by a qualified actuary and must contain at least the following:
- a. The name of the company and the identification number assigned by the National Association of Insurance Commissioners;
  - b. A list of all plans of health benefits and policy forms to which the certification applies;
  - c. A statement that covers at least the points listed in the following illustration:  
  
"I am familiar with the small group rating laws and regulations of the state of Colorado. In my opinion, as of January 1 of the year of this certification, the premium rates and rating methodology to which this certification applies are not excessive, inadequate or unfairly discriminatory," and
  - d. The name and title of the qualified actuary signing the certification and the name of the firm with which the actuary is associated.
3. Limited Service Licensed Provider Networks (LSLPN): The annual certification must certify as to the appropriateness of the charges or rates and shall accompany the annual

rate filing along with adequate supporting information. This certification must state that the rates are not excessive, inadequate or unfairly discriminatory.

For all provider agreements which materially impact the rating assumptions, the report must note whether or not the payments to these providers assumed in the rate development have in fact been confirmed by an executed agreement. For example, if the rates assume that all services will be performed by providers who will be paid a fixed PMPM capitation in compensation for their services, then the actuary should note whether or not the contract between the LSLPN and the provider group which agrees to this amount of compensation has been executed, and will be in effect for the period the rates are effective. If the actuary is not aware or cannot determine if the amount of provider compensation assumed in the rates is supported by actual, executed contracts, then the actuary should still identify these assumptions and note that there is no confirmation that the supporting contracts have been executed.

Non-Developed Rates: If the LSLPN accepts business on a risk basis and does not develop the rates (common for Medicaid business), then the actuary should include a:

- a. Separate certification that the premium or reimbursements received for such business will be sufficient to satisfy all medical expenditures, guaranteed provider benefits, internal and external expenses associated with the business, and all other costs associated with the risk transfer, or a quantification as to the amount of any deficiency, and a
- b. Description of any changes to the plan, provider risk arrangements or any other material aspect of the benefits provided under these plans.

The report should state the degree to which the actuary has evaluated the financial position of the risk assuming provider entities, the results of that evaluation, and whether or not the rates include an adequate provision for contractual incentive payments.

4. Long Term Care Insurance: The annual report must include a statement as to whether or not the actuary expects premiums to be level over the life of the policy. In lieu of the requirements of Subsections (8)(A) and (B) of this regulation, the actuary may certify that the premiums have remained level for existing policyholders and are expected to remain level over the life of the policy.

#### E. Prohibited Rating Practices

The Division of Insurance has determined that certain rating activities lead to excessive, inadequate or unfairly discriminatory rates, and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with §§ 10-16-107, 10-16-109, and 10-3-1110(1), C.R.S., the following are prohibited:

1. Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating; and
2. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income, unless such factors are adequately supported by acceptable data.

**Section 9 Severability**

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

**Section 10 Enforcement**

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of certificates of authority. Among others the penalties provided for in § 10- 3-1108, C.R.S. may be applied.

**Section 11 Effective date**

This regulation is amended effective December 1, 2007.

**Section 12 History**

Regulation 4-2-11, effective November 1, 1992.

Regulation Repealed and Re-promulgated, effective February 1, 1999.

Regulation amended effective January 1, 2001.

Regulation amended effective December 1, 2005.

Regulation amended effective December 1, 2007.