

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 4-2-11

RATE FILING SUBMISSIONS FOR 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), 10-16-109, and 10-18-105(2), 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.

Section 3 Applicability

This regulation applies to all companies, as defined in Section 4 (D), operating in the State of Colorado. 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, Medicare supplement, Health Maintenance Organization (HMO) coverages and stop loss carriers for employers with self insured health plans.

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 in addition to the above general requirements:

- A. Individual: Renewal rates for individual health insurance plans shall 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.

- B. Small Employer Group Health Benefit Plans: 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.
1. 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 Colorado Insurance 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.
 2. Pursuant to § 10-16-105(6), C.R.S., all small group insurers or other entities must file a complete and detailed description of rating practices and renewal underwriting practices. This paragraph shall not apply to non-developed rates.
 3. The Commissioner has determined that the information required under Paragraph 2 of this Subsection B may be considered confidential pursuant to § 24-72-204, C.R.S., and/or § 10-16-105(6.6), C.R.S. If a carrier desires confidential treatment of the information specified in Paragraph 2 of this subsection, a "Confidentiality Index" must be completed. Please see Division of Insurance Bulletin B-1.15 entitled, "Guidelines for Rate, Rule, Loss Cost and Form Filings Containing Confidential Information". This bulletin can be found on the Division of Insurance's website, 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 "Confidentiality Index".
- C. Large Group Health Benefit Plans: Large group major health benefit plan 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. 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 of Insurance.

- D. Valid Multi-State Association Groups: Pursuant to § 10-16-107(6), C.R.S., any health benefit plan issued or renewing on or after ~~July 1, 2009~~ ~~May 1, 2010~~, for any valid multi-state association under § 10-16-214(2), C.R.S., shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or their dependent.
- E. Medicare Supplement: A Medicare supplement 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 Colorado Insurance Regulation 4-3-1 and this regulation are not met, the filing will be considered incomplete and returned to the company. Medicare supplement filings require prior approval. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14(H) of Colorado Insurance Regulation 4-3-1). Rating requirements can be found in Sections 10(E)(2), 13 and 14(G) – (J).
- F. 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 Colorado Insurance 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 benefits ratios for both the experience period and the projection period on an annual basis;
 3. Provide the ratio of the actual benefits ratio to the expected benefits 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.
- G. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate.
- H. 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.
- I. 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 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 in § 10-3-1108, C.R.S. may be applied.

Section 11 Effective date

This regulation is amended effective ~~January 1, 2010~~ May 1, 2010.

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.
Emergency Regulation 08-E-4 was effective July 1, 2008.
Regulation amended effective October 1, 2008.
Regulation amended effective February 1, 2009.
Regulation amended effective July 1, 2009.
Regulation amended effective January 1, 2010.
Regulation amended effective May 1, 2010.