DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Regulation 4-2-11

RATE FILING ~~AND ANNUAL REPORT~~ 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 and to require an Annual Rate Report~~. ~~This regulation provides a listing of items required to be included in this Annual Rate Report.~~

Section 3 Applicability

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

Section 4 Definitions

A. "Administrative ratio" means, for purposes of this regulation, the ratio of actual total administrative expenses, not including dividends, to the value of the actual earned premiums, not reduced by dividends, over the specified period, which is typically a calendar year.

B. “Benefits ratio” means, for purposes of this regulation, the ratio of policy benefits, not including dividends, to the value of the earned premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves.

C. “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.

D. “Dividends” means, for purposes of this regulation, both policyholder and stockholder dividends.

E. “Effective date” means, for purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.

F. “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 services rendered.

~~F~~G. “File and use” is a filing procedure that requires rates and rating data to be filed 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. Under no circumstance shall the carrier use the rates for the collection of premiums until after the proposed effective date specified in the rate filing.

~~G~~H. “Filing date” means, for purposes of this regulation, the date that the rate filing is received at the Division of Insurance.

~~H~~I. “Inadequate rates” means, for purposes of this regulation, rates that are clearly 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.

~~I~~J. “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.

~~J~~K. “Lifetime loss ratio”:

1. “Lifetime loss ratio,” for purposes of this regulation, is equal to:

   a. The sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by:

   b. The sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.

2. The lifetime loss ratio should be calculated on an incurred basis as the ratio of accumulated and expected future incurred losses to accumulated and expected future 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.

3. An appropriate rate of interest should be used in calculating the accumulated values and the present values of incurred losses and earned premiums.

4. Any policy form or forms for which the anticipated loss ratio in any policy duration is expected to differ more than 10% from the lifetime loss ratio shall be assumed to have been priced on a "lifetime loss ratio standard", for purposes of this regulation.

~~K~~L. "Non-developed rates" are rates that are not developed primarily from statistics, experience data or studies but are established by agreement with a governmental entity through a bidding process or by some other means and include, but are not limited to: rates for Medicare, Title XVIII of the federal "Social Security Act;" Medicaid, Title XIX of the federal "Social Security Act;" and the State Children's Health Insurance Program (SCHIP), Title XXI of the federal "Social Security Act."

~~L~~M. "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.

~~M~~N. "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.

~~N~~O. "Premium" means, for purposes of this regulation, the amount of money paid by the insured member, subscriber, or policyholder 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.

~~O~~P. "Prior approval" is a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collections of premium, advertising, or any other use of the rate. Under no circumstance shall the carrier use the rates for the collection of premiums until after the proposed effective date specified in the rate filing.

~~P~~Q. "Qualified actuary" is a person who meets the qualifications in Colorado Insurance Regulation 1-1-1.

~~Q~~R. "Rate" means, for purposes 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.

~~R~~S. "Rate filing," for purposes of this regulation, is a filing that contains all of the items required in this regulation and ~~the b~~Bulletin~~b~~ B-4.18 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.

~~S~~T. "Rate increase" shall have the same meaning as defined in § 10-16-102(36.5), C.R.S., and includes an increase in any current rate or factor used to calculate premium rates for new or existing policyholders or certificateholders.

~~T~~U. "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 (or 100% minus the lifetime loss ratio, for products priced on a lifetime loss ratio standard).

~~U~~V. "Targeted" or "anticipated loss ratio" shall have the same meaning as defined in § 10-16-102(43.7), C.R.S. Note: active life reserves do not represent claim payments, but provide for timing differences. Targeted loss ratio calculations must be displayed without the inclusion of active life reserves.

~~V~~W. "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.

~~W~~X. "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; or if after allowing for practical limitations, differences in rates fail to reflect equitably the differences in expected losses and expenses. 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.

~~X~~Y. "Use of the rates" means, for purposes of this regulation, any use of the rates or factors including collection of premiums, distribution to agents, disclosure or premium quotes to parties outside the company, advertising, or any other use of the rates or factors.

Section 5 General Rate Filing Requirements

All rate filings shall be submitted electronically by licensed entities. 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 or disapproved on or before the 30th calendar 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 45th calendar day after receipt. Correction of any deficiency, including deficiencies identified after the 45th calendar 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 Commissioner that is not otherwise subject to prior approval as provided by statute.

A. General Requirements

1. Prior Approval: Any proposed rate increase for other than dental insurance or a rate increase of 5% or more annually for dental insurance, which is effective on or after January 1, 2009, is subject to prior approval by the Commissioner and must be filed with the Division of Insurance at least 60 calendar days prior to the proposed implementation or use of the rates. If the Commissioner approves the rate filing within 60 calendar days after the filing date, the carrier may use the rates immediately upon approval, but only in communications or advertisements to agents or to other parties outside the company. Under no circumstance shall the carrier use the rates for the collection of premiums until after the proposed effective date specified in the rate filing. If the Commissioner does not approve or disapprove the rate filing within 60 calendar days after the filing date, the carrier may implement and make use of the rates. Corrections of any deficiency

identified after the 60th calendar day will be required on a prospective basis and no penalty will be applied for a non-willful violation identified in this manner if the rates are determined to be excessive, inadequate or unfairly discriminatory. Rates for Medicare supplement insurance are subject to prior approval as specified in Colorado Insurance Regulation 4-3-1, but are not subject to the 60 day filing requirement of this paragraph. All filings must be filed with the Rates and Forms Section of the Division of Insurance. The Commissioner shall disapprove the rate filing if any of the following apply:

a. The benefits provided are not reasonable in relation to the premiums charged;

b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 5, 6 and 7 of this regulation. In determining if the rate is excessive or inadequate, the Commissioner may consider profits, dividends, ~~Annual Rate Reports,~~ annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;

c. The actuarial reasons and data do not justify the requested rate increase; or

d. The rate filing is incomplete.

2. File and Use: Any rate filing not specified in Paragraph 1 of this subsection is classified as file and use. If a rate change has been implemented or used without being filed with the Division of Insurance, corrective actions may be ordered, including fines, refunds to policyholders, and/or rate credits. Under no circumstance shall the carrier use the rates for the collection of premiums until after the proposed effective date specified in the rate filing. All filings must be filed with the Rates and Forms Section of the Division of Insurance.

3. Non-Developed Rates: Non-developed rates are not subject to the filing requirements of Sections 5, 6 and 7 of this regulation.

4. 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 when the rates are changed on an existing product even though the rate change only pertains to new business. For example: Non-renewable short term disability or any other type of non-renewable product. The rate filing must be compliant with this regulation including providing overall experience data for this existing product.

~~c~~d. All companies must submit a rate filing within 60 calendar days after Commissioner approval of the assumption, ~~or~~ acquisition ~~or merger~~ of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring 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~~e. 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.

5. Withdrawn, Returned, or Disapproved Filings: Filings that have either been withdrawn by the filer, 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 Commissioner that is not otherwise subject to prior approval as provided by statute.

6. Submission of rate filings: All health, sickness and accident insurance (Title 10, Article 16), health care coverage (Title 10, Article 16), Medicare supplement insurance (Title 10, Article 18), long-term care insurance (Title 10, Article 19) and health excess/stop loss insurance (Title 10, Article 16) rate filings must be filed electronically in a format made available by the Division of Insurance, unless exempted by rule for an emergency situation as determined by the Commissioner. 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.

7. 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.

8. 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.

9. Confidentiality: All rate filings submitted shall be considered public and shall be open to inspection by the public, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. If the carrier desires confidential treatment of any information submitted as required in this regulation, a "Confidentiality Index" must be completed. Please see the bulletin 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. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings and must also complete a Confidentiality Index.

B. Required Forms and Actuarial Certification

1. Required Forms: A ~~fully completed NAIC Uniform Transmittal Document and~~ Form HR-1 must be completed for each rate filing. Only one Form HR-1 is allowed to be submitted in a rate filing. ~~These~~This form~~s~~ ~~are~~is available in Division of Insurance Bulletin B-~~1.155~~4.18 entitled “Requirements for the Filing of Rate and Forms for Life, Accident and Health Carriers.” This bulletin can be found on the Division of Insurance’s website, 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 can be found in Section 14(H) of Colorado Insurance Regulation 4-3-1. The requirements for the actuarial certification for certain long-term care rate filings can be found in Sections 10(B) and 18(B) of Colorado Insurance Regulation 4-4-1.

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 in the designated order shown below:

A. Summary: A brief written summary of the filing including, but not limited to, the following:

   1. Reason(s) for the rate filing;

   2. Marketing method(s);

   3. Premium classification;

   4. Product descriptions;

   5. A listing of all policy/rider forms impacted (for standardized Medicare supplement, also identify plans); and

   6. A statement as to whether the premiums will be charged on an issue age, attained age, renewal age or other basis.

B. Assumption, ~~or~~ Acquisition or Merger: The memorandum must state whether or not the products included in the rate filing were part of an assumption, ~~or~~ acquisition or merger of policies from/with another company. If so, then the memorandum must include the full name of the company/companies) from which the policies were assumed, ~~or~~ acquired or merged, and the closing date of assumption, ~~or~~ acquisition or merger.

C. Rating Period: The memorandum must identify the period for which the rates will be effective. At a minimum, the proposed effective date of the rates must be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve months, starting from the proposed effective date.

D. 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.”

E. 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.

F. Rate History: The memorandum must include a chart showing the rate changes implemented including the actual effective date of each rate change 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. The rate history should be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. The previous SERFF filing number should also be provided.

G. Coordination of Benefits: Each rate filing must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

H. 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~~E) and 7(~~E~~F) of this regulation.

2. Retention Percentage: The actuarial memorandum must list and adequately support each specific component of the retention percentage. If the product was not initially priced using a lifetime loss ratio standard, the retention percentage is equal to 1 minus the targeted loss ratio. If the product was initially priced using a lifetime loss ratio standard, the retention percentage is equal to 1 minus the lifetime loss ratio. Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total company retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin. The Commissioner 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. Benefits Ratio Guidelines: The Commissioner uses these percentages as guidelines for the acceptability of the company's targeted loss ratio or lifetime 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 H(2) of this section. The Commissioner will evaluate these components for reasonableness. Policy forms priced at, or above, these benefits 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 benefits rates.~~The Division recommended benefit ratio guidelines are as listed below. Targeted loss ratios below these guidelines shall be actuarially justified.

Comprehensive Major Medical (Individual)	65%
Comprehensive Major Medical (Small Group)	70%
Comprehensive Major Medical (Large Group)	75%

Specified or Dread Disease	60%
Limited Benefit Plans	60%
Disability Income	60%
Dental/Vision	60%
Stop Loss	60%

c. ~~For~~The benefit loss ratio guideline ~~F~~for conversion products~~, if the anticipated loss ratio is~~ shall be at least 125%. Adequate support shall be submitted if the loss ratio is below the 125% guideline.

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.

I. 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 investment income and the variance in the expected benefits ratios over the duration of the policy. The rate filing must include the average policy duration in years as of the endpoint of the experience period and the expected benefits ratio, as originally priced, for each year of the experience period. The rate filing must also include a chart showing actual and expected benefits ratios for both the experience and rating periods. For each year of the experience period the chart must show the actual and expected benefits ratios, and the ratio of these two benefits ratios. For each year of the rating period, the chart must show the projected and expected benefits ratios, and the ratio of these two benefits ratios. It is expected that the company is pricing these products to achieve a benefits ratio greater than or equal to the expected benefits 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.

J. 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.

K. 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 of Insurance 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.

L. 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.

M. 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 c~~Collateral data used to support partially credible Colorado data, including published data sources (including affiliated companies) must be provided and applicability of the use of such data must be discussed. 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 SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.

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.

N. Data Requirements: The memorandum must, at a minimum, include earned premium, loss experience data, average covered lives and number of claims, submitted on a Colorado-only basis for at least 3 years~~,~~. National or other relevant data shall also be provided in order to support the rates, ~~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~~. ~~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.~~ Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product. If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product must be provided, if available. If no experience for the new product is available, experience for a comparable product must be provided, if available. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. The experience period must include consecutive data no older than nine months prior to the proposed effective 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.

O. 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.

P. Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. For products priced using a lifetime loss ratio standard, such as long-term care and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

Q. Other Factors: The memorandum must clearly display or clearly reference 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 Commissioner 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 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, 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 8 Annual Rate Report~~

~~A. 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 Rate Report with the following exceptions:~~

~~1. Companies writing only disability income policies;~~

~~2. Companies whose only in force health policies are non-cancelable policies, if the premiums cannot be increased; and~~

~~3. 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 the Annual Rate Report upon request from the Commissioner. The Annual Rate Report must comply with the provisions of this section and must contain the information specified in Subsections C. and D. of this section.~~

~~B. Timing and Submission: All Annual Rate Reports must be filed electronically in a format made available by the Division of Insurance. The Division of Insurance must receive all Annual Rate 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 completely discussing each of the required items under Subsection C. of this section, or not containing all of the information required in Subsection D. of this section, may be subject to a fine for an incomplete report. Companies should submit the reports for all lines of business using only one SERFF filing submission.~~

~~C. All Annual Rate Reports filed by companies identified in Subsection A of this section must contain all of the information specified in this subsection. The information required in this subsection shall be organized by major line of business and multiple reports for the company should be submitted using only one SERFF filing. For the purposes of this requirement, a "major line of business" includes at least the following categories: individual, small group, and large group,. Medicare risk, and Medicaid risk. For each of the company's major lines of business, the report shall discuss the following topics:~~

~~1. Reason for filing: The report shall provide the reason for filing the report. Acceptable reasons include:~~

~~a. The company is a Colorado domestic company; and~~

~~b. 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 shall be included as part of the reason for filing.

2. Business written: The report shall contain a brief description of each of the major lines of business written or in force during the prior calendar year.

3. Rate filings filed: The report shall 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 shall 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 shall 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 shall 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 D (4) of this section is exempt from this requirement.

5. Automatic factors: The report shall specifically:

a. List all automatic rating factors in use, including trend and inflation;

b. Describe how each of these factors were determined;

c. Provide support for the continued use of these factors; and

d. 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 shall include a brief analysis of the appropriateness of rates charged to Colorado policyholders or certificateholders in the prior calendar year for each major line of business. This analysis shall 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 benefits ratios and any other information as deemed appropriate for this analysis.

7. Reinsurance arrangements: The report shall 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 shall 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.

D. Additional Information: In addition to the above, the Annual Rate Report for companies writing certain categories of business shall 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 shall 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 shall 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 shall adequately support the rate differentials through use of historical loss/expense experience and prospective provider compensation arrangements.

d. Prospective Changes: The report shall 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 shall demonstrate that indemnity benefits do not exceed twenty percent (20%) 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 the Annual Rate 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 shall be signed by a qualified actuary and shall 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 they meet the requirements of the insurance laws and regulations of Colorado;"

d. The name and title of the qualified actuary signing the certification and the name of the firm with which the actuary is associated; and

e. The original signature of the qualified actuary and the date of the signature. Signature stamps or signatures on behalf of the actuary are not acceptable.

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 shall 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 shall 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

b. A description of any changes to the plan, provider risk arrangements or any other material aspect of the benefits provided under these plans.

The report shall 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 Rate Report shall 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 8(C) of this regulationsection, 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. The Commissioner has determined that the information required in Subsections C and D of this section may be considered confidential pursuant to § 24-72-204, C.R.S. If a carrier desires confidential treatment of the information specified in Subsections C. and D. of this section, a "Confidentiality Index" must be completed. Please see Colorado 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".

Section 98 Annual Cost Report

A. Pursuant to § 10-16-111(4)(a), C.R.S., all companies subject to this regulation shall file an Annual Cost Report as described in this section. This report must comply with the requirements of this section and must contain the information specified in Subsection C. of this section and shall be filed electronically via the Division of Insurance's website (www.dora.state.co.us/insurance).

B. Timing and Submission: All Annual Cost Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website 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 containing all of the information specified in Subsection C. of this section may be subject to a fine for an incomplete report.

C. Annual Cost Reports filed by companies identified in Subsection A. of this section shall contain, where applicable, the following premium and cost information for the previous calendar year:

1. Earned premium, not reduced by dividends;

2. Medical trend percent itemized by medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology;

3. Pharmacy medical trend percent itemized by pharmaceutical price increases, utilization changes, cost shifting, and the introductions of new brand and generic drugs;

4. Policyholder dividends and stockholder dividends paid;

~~5. Salaries, stock options, and bonuses for all CEO's, and all executive officers;~~

~~6. Insurance producer commissions;~~

~~7. Payments to legal counsel;~~

~~8. Net income or loss;~~

~~9. Administrative expenditures with breakdowns for advertising or marketing expenditures, paid lobbying expenditures, and staff salaries;~~

~~10. Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;~~

~~11. Charitable contributions;~~

~~12. Investment income or losses on investments;~~

~~13. All reserve amounts, including active life reserves, claims reserves, and premium deficiency reserves;~~

~~14. The amount of total adjusted capital and the carrier's authorized control level risk-based capital;~~

~~15. Taxes itemized by category;~~

~~16. Administrative ratio;~~

~~17. Actual benefits ratio;~~

~~18. The number of lives insured under each benefit plan the carrier offers to small employers; and~~

~~19. The cost of providing or arranging health care services.~~

~~D. The information provided in Subsection C of this section shall be provided on a Colorado only basis. A carrier licensed in multiple jurisdictions may satisfy the requirements of Subsection C of this section by filing the Colorado allocated portion of national data if the actual Colorado only data is not otherwise available. If any of the items of information listed in Subsection C of this section are not applicable to the carrier, the carrier shall indicate in the filing which items are not applicable and the reason why such items are not applicable.~~

~~The information provided to the Division of Insurance in Subsection C of this section will be aggregated for all carriers and will be published on the Division of Insurance's website, www.dora.state.co.us/insurance.~~

Section ~~11~~8 Prohibited Rating Practices

The Commissioner 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:

A. 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;

B. 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; and

C. For individual health insurance plans, the use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss. It is the expectation of the Commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups should be rated in a like manner. The use of zip codes in determining rating factors can result in inequities. Unless different rating factors can be justified based upon different provider groups or other actuarially sound reasons, the following guidelines shall be followed whenever zip codes are used in determining a company's rating factors:

1. All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor, with the following possible exceptions:

   a. The following zip codes in Elbert County: 80101, 80106, 80107, 80117,

   b. The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136,

   c. The following zip codes in El Paso County: 80132, 80133,

   d. The following zip codes in Boulder County: 80025, 80026, 80027, 80028.

2. In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:

   a. The following zip codes in Jefferson County: 80401-80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465.

   b. The following zip codes in Adams County: 80614, 80640.

3. All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.

If a company uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the company may be found to have rates that are unfairly discriminatory. The Commissioner would prefer that a company use federal MSA's, rather than zip codes, in their rating structure. The Commissioner expects companies to review the appropriateness of area factors at least every five years and provide detailed support for the continued use of the factors in rate filings and upon request.

Section ~~12~~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 ~~13~~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 ~~14~~11 Effective date

This regulation is amended effective ~~July 1, 2009~~January 1, 2010.

Section ~~15~~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.