Bulletin 96-3

BULLETIN

To: All Insurers and Health Maintenance Organizations Requesting Further Information on the Implementation of House Bill 250 - The Kentucky Health Care Reform Act

From: George Nichols III Commissioner of Insurance

Date: May 14, 1996

Re: Implementation of SB 343 - An Act Relating to Health Care; Part 2 Health Insurance Reforms

The purpose of this Bulletin is to advise you of the requirements for providing rates for health plan benefits on and after the effective date of SB 343, July 15, 1996. In the Department we are very much aware of the time constraints under which you are working to meet these requirements. Therefore, it is my intent that the content and organization of this bulletin provide a basis for you to make necessary filings in a timely, effective manner. In turn, I ask for your cooperation in organizing your rate filings exactly as directed.

The rate filing requirements of this bulletin will apply only to new filings to be effective in 1996. As time is available, regulations will be adopted to enumerate the requirements for subsequent filings.

OVERVIEW

Effective July 15, 1996 the Department will be the primary regulator for health benefit plan forms and rates. A Health Advisory Council will be formed to "review and discuss with the commissioner any issues, which impact the provision of health insurance in the state." The Council will include representatives of carriers, providers and consumers. Each company is encouraged to communicate areas of concern to Council representatives for discussion.

Other important information for implementation of the insurance reform modifications is contained in the following sections. Any remaining questions should be referred to Department staff for clarification.

STANDARD PLANS

Section 20 of SB 343 states that the standard plans defined by the Health Policy Board continue until amended/replaced by the Department. Also, the Department may approve additional standard plans.

Initially, the standard plans that have previously been defined for implementation under HB 250 will be continued as of July 15, 1996. This will include the most recent benefit mandates and revisions to standard plan language explained in the Health Care Reform Updates of April 8 and April 29, 1996. In addition, the Kentucky Health Policy Board will be considering the adoption of a standard amendment to address other statutory revisions to the plans.

The Health Insurance Advisory Council will be reviewing the standard plans and providing recommendations for changes and/or replacements. You will be notified immediately about any new or changed standard plan.

CONTINUATION OF PRE-STANDARD PLANS

A provision of Section 11(2)(f) of SB 343 allows any person or group covered by a pre-standard plan as of July 15, 1996 to elect to renew those benefits until July 15, 1997. This option is available only if benefits remain exactly the same, except for the addition of any recent mandated benefits, and renewal is guaranteed.

It must be understood that each individual and small group (employers with 2-50 eligible employees) policyholder can continue this coverage from July 15, 1996 to the next policy anniversary month or normal premium renewal month. On that anniversary or premium renewal month the policyholder can renew the coverage for another 12 months. At the end of that 12 month period the policyholder would have to elect any of the standard plans available at that time under SB 343, with any approved rate increase, under this optional continuation of benefits under a pre-standard plan. All coverage and rates must be guaranteed for the respective periods indicated.

Individual and small group policies are exempt from modified community rating during this continuation under pre-standard plans. Your rate determination methodology previously used for these policies would not change.

Note that separate rate increases may be requested to be effective ' July 15 and on the anniversary or rate renewal date immediately following July 15. These increase requests should be made in a single filing with detailed information as to how they would be implemented.

Large group policies and association policies that are on pre-standard plan benefits as of July 15, 1996 may continue that coverage in the same manner as applicable to other business. However, rate changes would be available only on anniversary dates and would be determined according to rate determination information already on file.

An exception to this would be groups of 51-100 lives, previously considered as being small groups under HB 250, for which rates had been frozen during continuation of coverage under the pre-standard plan benefits. These groups should not have had a rate change since before July 15, 1995 and, therefore, could be subject to a rate change at any time on or after July 15, 1996. The new rates would be guaranteed for 12 months and would be determined according to the rate determination information for large groups on file.

FORM FILING

The Kentucky Health Policy Board will be asked to approve a standard amendment to implement statutory and technical revisions to the standard plans. That amendment will be forwarded to carriers as soon as possible.

RATE FILING

The rate filing provisions of SB 343 Section 16 apply to all health benefit plans, as defined in Section 7(4), effective July 15, 1996. This applies to pre-standard as well as standard plans, including premium determination for large groups (more than 50 employees) and all association business. Rate filings may be deemed approved after 30 days, but that period may be extended an additional 30 days by the commissioner. During the remainder of 1996 two additional 30 day period extensions are available upon notice by the commissioner.

Any health benefit plan rate filing involving an average annual (to be pro-rated for other than annual periods) premium rate increase more than 3% in excess of the change in medical CPI for urban South region consumers, as published by the Bureau of Labor Statistics, will automatically trigger a hearing. Explanation of the application of this " medical CPI plus 3%" is provided in detail in a following section.

RATE GUARANTEE PERIODS AND FILING FREQUENCY

All health benefit plan coverage under SB 343 will use a 12 month rate guarantee period. No rate increase may be filed to be effective within 12 months following the effective date of the latest prior rate increase for the same policies or contracts.

For business subject to modified community rating this means that a rate filing resulting in an increase, on a composite basis as explained in the last paragraph of the following section on "Medical CPI Plus 3%", can't be made within 12 months of the latest rate filing also determined to have been an increase on a composite basis. Informational filings for composite rate decreases can be filed at any time.

In order to minimize the effect of this requirement on new and renewing policies during the first six months the revised modified community rates are in effect, each filing may be made on a six-month-trended basis. These filed rates will be applicable to new/renewing business during the first six months the rate schedule is in effect. This type of rate filing must also include a trend factor for rates applicable to new/renewing business during the next six months of this 12 month period covered by the filing. Therefore, the rates for the second six month period will equal the rates for the first six month period multiplied by the filed trend factor. This trend factor will be subject to the "Medical CPI Plus 3%" test discussed in the following section. Marketing rates during each six month period will be level. The Gross Base Rates Index values on the Premium Parameter Worksheet assume the use of the six-month-trended basis and represent the marketing rates for July 15 - December 31, 1996.

Association and large group rate methodology may not be changed if the change results in a net premium increase within 12 months of a prior rate methodology change resulting in a net premium increase. However, the rate bases may include trend increases for marketing/renewal rates. Any trend increase in excess of the "medical CPI plus 3%" explained in a following section would call for a hearing. A decrease in the trend factor or change in rate methodology resulting in a net premium decrease could be filed at any time as an informational filing.

APPLICATION OF "MEDICAL CPI PLUS 3%"

SB 343 subsection 16(2)(c) provides that, for a filing containing an "average premium rate increase" resulting in a percentage increase over existing rates greater than the "percentage change in the medical care consumer price index for all urban consumers for the South region as published by the

federal Bureau of Labor Statistics, plus three percent (3%), since the last filing of the insurer for any of the same policies or contracts, the commissioner shall hold a hearing ..."

Determination of the change in CPI index will be measured from (1) effective date of rate filing for existing rates, to (2) effective date of proposed rates. The change will be calculated as follows assuming:

a = index value on date (1) (effective date of existing rates)
b = most recent index value available at the time of filing
x = number of months from date (1) to date (2) above
y = number of months from date (1) to date (3) (date of "b")

Increase = (b/a) (x/y) - 1

An illustration using actual historical index values:

Date (1) = -January 1, 1995 Date
(2) = January 1, 1996 Date
(3) = July, 1995 (assumes filing submitted in September)
a = 214.0 x = 12
b = 219.8 y = 6
Increase = (219.8/214.0) (12/6) - 1 = .05494 or a 5.5% increase

This particular illustration was used so you could have a reference for the information contained in Attachment A. The monthly index values are shown in the attachment going back to January 1987. Column (2) is the increase for the 12 month period ending with the current month. Column (3) is the increase for the same 12 month period based on a projection using the index change during the first six months of that period as applied to the formula from above. This shows that the actual index change for that 12 month period, 4.8%, was less than the projected change, 5.5%. Column (4) shows the ratio of actual to expected. This is an easy reference for testing the accuracy of this particular projection.

Medical care CPI index information for South Urban Consumers can be obtained from the Atlanta office of the Department of Labor Bureau of Labor Statistics by calling (404) 347-4416.

In order to determine the change of rates for modified community rate filings under SB 343, the rate factors entered on the premium parameter worksheet will be used. Therefore, it is mandatory that the rate factors be entered on the worksheet for the existing rates as well as for the rates being filed. For each standard plan a composite rate will be determined based on the existing rate factors and the filed factors. This will be based on an assumed population distribution which has been included on the Premium Parameter Worksheet diskette.

MODIFIED COMMUNITY RATING

The following changes are applicable to modified community rating (MCR) effective July 15, 1996:

1. The upper limit for groups subject to MCR reduces from 100 to 50 eligible employees.

2. A discount for healthy lifestyle can utilize any objective, definable basis (rather than just for not using tobacco) and the discount can be any percentage amount not greater than 10% (rather than set at 10% only).

3. Although the premium variance based solely on age has not changed, it will be implemented as a 4:1 maximum ratio for all coverages. Alliance and Non-Alliance, subject to MCR.

4. Rating for industry and/or occupation is allowed with the highest rating factor limited to not more than 15% in excess of the lowest factor (e.g. lowest factor .95, highest factor 1.0925).

5. Rating for gender is allowed but the factor for a gender can't be more than 50% higher than the factor for the other gender in the same age bracket (e.g. male factor .7, female factor 1.05) .

6. The maximum ratio for rates based on case characteristics is 5:1. Case characteristics include only age, gender, occupation/industry and geographic area.

7. Association business, as limited according to Section 9(5), is exempt from MCR.

8. Section 9(6) allows each carrier to phase in rates under the new MCR methodology over a four year period. This phase-in adjustment would be applicable only to renewal business, not new business. Details of the implementation of this rate adjustment will be explained in a separate section of this bulletin.

(Note: the risk adjusters bo be used for SB 343 MCR business will be adjusted from the HB 250 risk adjusters consistent with the change in rating variables)

Three features of modified community rating which remain unchanged deserve mention anticipating possible questions. The January 1, 1996 attained age brackets (see below) and the seven geographic areas defined by the Health Policy Board will not change at this time. Also, the four tier family composition feature continues as the only family composition tiering available for standard plans under MCR.

Age Brackets for Modified Community Rating and Risk Adjustment

Under 30	**30-39**	**40-49**	**50-54**	**55-59**	**60-64**	**65+**

RATE METHODOLOGY PHASE-IN UNDER SB 343

Subsection 9(6) of SB 343 provides for a grading of rates into the new MCR methodology over a four year period. The index community rate in this subsection is the rate according to the new methodology. Through June, 1998 an adjustment of 30% above or below the MCR rate is allowed. This grades to 20% through June, 1999 and 10% through June, 2000. After that, the rates under SB 343 MCR methodology are to be used without adjustment.

This phase-in would be applicable only to policyholders changing from a prior rate methodology (pre-HB 250 or HB250 MCR) to a SB 343 standard plan under MCR with the same carrier. Also, the SB 343

standard plan benefits must be similar to the prior benefits. So, the phase-in adjustment **is not** used if a policyholder (a) had no coverage under a health benefit plan immediately before being covered under a SB 343 standard plan subject to MCR, (b) changes carrier at the time of initially being covered under SB 343, or (c) selects a standard plan under SB 343 for which the benefits are not similar to the immediately preceding coverage.

Briefly, the phase-in will adjust the current billed premium for any change in benefits and/or family composition tiering and compare this adjusted premium with the premium calculated using the SB 343 MCR methodology. There would be no adjustment for change in census. The change in premium is checked to see if it is within the range filed by.the company (maximum increase or decrease; see below for further discussion). The result of any adjustment from that comparison is then checked to see if it is within 30% of the SB 343 MCR premium. If not, the final adjustment is made so that the billed premium is 70% or 130% of the MCR premium.

Each company is required to file a maximum premium increase percentage and a maximum decrease percentage for use in the initial comparison of the adjusted current premium to the SB 343 MCR premium. The maximum increase can be any percentage value in the range, 0% through 20%, and the maximum decrease can be any percentage value in the range, -20% through 0%. This maximum increase and decrease percentage filed by a carrier will be used for all policies during the four-year phase-in period.

The following table illustrates determination of composite phase-in premiums in September 1996 for a group of 10 lives, assuming the carrier uses a maximum increase of 15% and a maximum decrease of -5%.

Example	Adjusted Premium	MCR Premium	% Changed	Max Adj Premium	Billed Premium
A	$1,930	$2,047	6.1%	$2,047	$2,047
B	1,930	2,391	23.8%	2,220	2,220
C	1,930	1,840	-4.7%	1,840	1,840
D	1,930	1,400	-25.1%	1,834	1,820

If this group policyholder continues the same standard plan coverage on the next anniversary, September, 1997, the same adjusted premium will be used for comparison purposes. The MCR premium will be the premium according to the census on that date. The phase-in premium will again be determined using the same maximum increase/decrease percentage and +/-30% test.

In September 1998, the same adjusted premium will be used for comparison with the MCR premium according to the census at that time. The maximum increase/decrease percentage remains the same, but the acceptable range of rates around the MCR rate reduces to +/-20%. The same procedure will be used in 1999 with the acceptable range of rates reducing to +/-10%. For September 2000 the MCR premium would be billed without any phase-in testing.

Any time a policyholder changes standard plan prior to the end of the phase-in period, the phase-in testing will be discontinued and the MCR premium will be billed.

RATE FILING PROCEDURES
General Comments

We realize that the time available for you to develop and file rates for July 15 has been shortened considerably. The Department review process will necessarily be shortened from what it should be also. Therefore, in order to handle these rate filings effectively, the Department will conduct the review on the following basis:

1. Each rate filing will be reviewed as it is received for required forms, format, supporting documentation and fees; if correct, the review will immediately proceed to step (2) ; if not correct, the exceptions will be communicated as directed in the cover letter of the filing **(note: if the exceptions are not corrected within 30 days of notification, the filing will be returned to the carrier as incomplete).**

(2) When each rate filing is completed for step (1), the actuarial review of the filing will be initiated. If any additional information is needed as a result of this review, the request will be made as directed in the cover letter of the filing.

Specific filing requirements

The following list of requirements applies to all rate filings for health benefit plans with exceptions noted. Rate filings for pre-standard plans may be submitted with plan groupings as has been done in the past**. Modified community rate filings must be separate for each combination of product type (FFS, PRO, HMO and POS), line (Individual and Group), and product (e.g. same product type and line, but different networks).** A large group rate filing will include all health benefit coverages under standard plans.

FIVE (5) COPIES ARE REQUIRED FOR ALL MATERIAL INCLUDED IN A RATE FILING. EXCEPT ONLY TWO (2) COPIES OF EACH DISKETTE ARE REQUIRED.

Refer to this list before sending any filing. It will be used for the initial Department review as discussed in (1) above. Complete and accurate filings will save time for everyone.

1. Cover letter - clearly explain the type and content of the filing; specifically highlight any changes in product, plan options, geographic areas, or any other significant element of the company's program compared to the most recent filing;

provide name(s) of person(s) to be contacted, with fax number or address, for additional information under the (1) initial review and (2) actuarial review discussed above.

2. Check for $100.00 fee for each filing.

3. Face sheet Form F-l LH properly completed.

4. Actuarial Memorandum, according to Actuarial Standard of

Practice No. 8 for Regulatory Filings for Rates and Financial Projections for Health Plans and to Interpretative Opinion 3, Professional Communications of Actuaries, with the following specifically indicated in the memo with the respective letter, (a) through (j), for easy identification:

(a) qualification of the actuary signing the memorandum,

(b) thorough, detailed explanation of rate development, including all assumptions and claim cost trend projected, with specific identification of the trend factor,if used, to be applied to determine marketing rates for the second six months period during the 12 month period for which this filing is applicable (as explained in the earlier section on Rate Guarantee Periods and Filing Frequency),

(c) detailed explanation of determining small group composite rates and groups to which composite rates would apply; composite rate determination must start with list bill rates for the applicable census (Non-Alliance only),

(d) comparison of (i) composite increase in proposed rates compared to existing rates, with (ii) the calculation of increase in CPI plus 3% limit as discussed in a previous section; if (i) exceeds (ii), provide a detailed explanation why this is being requested,

(e) reasonably complete listing of SIC Codes with respective industry ratings (subject to *15%* maximum variance from low to high), using code 5300 for general retail sales as 1.00, for small group industry ratings and detailed explanation of occupational ratings to be used for individual policies,

(f) detailed discussion of basis of determining any healthy lifestyle discount and the discount percentage(s) applicable to the filed rates,

(g) administrative cost breakdown for each element contained in marketing, claims handling and general administration, including salaries, bonuses, incentives and rent (with explanation of allocation),

(h) commissions,

(i) taxes (with explanation of allocation), and

(j) investment income (with explanation of allocation).

(Note that the following, provided in SB 343 Subsection 16(3), are to be considered in the process of approving or disapproving a filing: benefits provided are reasonable in relation to the premium or fee charged, fees paid to providers for the covered services are reasonable in relation to the premium or fee charged, previous premium rates or fees for the policies or contracts to which the filing applies, the effect of the rate or rate increase on policyholders, enrollees, and subscribers, whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory, and other factors as deemed relevant by the commissioner.

5. Diskette with premium parameter worksheet information (the Department would prefer that multiple filings for one company be sent on one diskette in Lotus 4, with each filing product on a separate sheet); all rates filed are monthly list bill rates; print company name clearly on the label before filing (for MCR filings only).

6. Hard copy printout, in the required format, of the premium parameter worksheet (see Attachments B for format) - company name must appear on each printout (for MCR filings only) .

7. Hard copy printouts, in required format, of all rider rates -company name and name of rider must appear on each printout (diskettes and printouts of base plan rates will be required after actuarial review is complete), all rates filed are monthly list bill rates (see Attachments B for format), (for MCR filings only).

SPECIAL NOTE FOR ACCOUNTABLE HEALTH PLANS FILING ONLY; The initial rate filings **for Non-Alliance as well as Alliance business,** with all the applicable items in the above check list, should be sent as soon as possible to the Department of Insurance after submitting rate material to the Alliance.

Rate filing diskettes

Enclosed with this bulletin are two diskettes, plus two additional diskettes for those carriers who are applying to offer coverage through the Alliance. Before doing anything with the diskettes, please make at least one copy as a back-up. **SAVE A COPY OF EACH DISKETTE FOR FUTURE USE.**

The diskette labeled "Non-Alliance PPW "contains the Premium Parameter Worksheets for Non-Alliance business. Existing rate factors ("prior filing factors") for standard plans and the proposed factors must be entered in the respective spaces of the PPW applicable to the filing. There are eight sections on the worksheet representing FFS, PPO, HMO, and POS Individual and Group. Logical range names have been assigned to these eight sections so they can be located easily.

The company name and any product identification must be entered in the appropriate space in the upper left portion of each section used. As factors are entered, variances from index values and the percentage change from the prior filing factors will be calculated automatically. Likewise, values for the gender, 4:1 and 5:1 tests will automatically appear in the lower left portion of the section. As the maximum and minimum industry/occupation factors are entered, the test value will be calculated. Finally, the load and trend .information must be entered in detail at the bottom of the section.

Note that when all current and prior rate factors have been entered a composite percentage change is calculated for each plan option. This will be a guide to see if the proposed filing is within the "CPI plus 3%" increase that would not automatically call for a hearing as provided under SB 343 Subsection 16(2)(c).

Also, in a separate column, calculations of composite variance from index values will be generated for each plan as an aid in the review process. A copy of the diskette containing PPWs and hard copy printouts of the PPWs must be included in the initial rate filing as explained in items 5 and 6 of the filing requirements check list.

The Gross Base Rate represents the fully loaded (for all expenses, taxes and margin) list bill monthly rate for Single life coverage under the Standard High plan option for a male age 40-49 residing in geographic area 6. This means that a rate factor of "1" must be entered for the Standard High plan option factor, the Single Male age 40-49 factor, and for the geographic area six factor, unless the product will not be marketed in area 6. As mentioned previously, this Base Rate assumes use of the six-month-trended basis as discussed on page 4.

For a product which will not be marketed in area 6, a "normalized" Gross Base Rate must be determined. It is equal to (a) the appropriate rate (single male, age 40-49, Standard High) in an area that is to be marketed, divided by (b) the Index value for that area. The area factor for that area must then be set equal to the Index value.

Rate factors must be entered for the mandated Standard High and Low plan options. Any plan options which will not be marketed should have no factor entered.

The diskette labeled "Non-Alliance MCR Rates" contains the format for printing hard copies of base and rider rates for Non-Alliance business only. This format must be used for filing all rate printouts, making sure that all rates for each plan option appear on a single page as illustrated in Attachment B. The company name and any applicable product identification should appear on each printout. The worksheet has been designed so that when the company name/product identification is entered in the Enhanced High section of any product, it will automatically be copied to the appropriate space of all other base benefit and rider sections under that product. Logical range names have been assigned to each section of the worksheet so they can be located easily.

As mentioned in the check list of rate filing requirements, only the rider rates printouts must be part of the initial rate filing package. Printouts of the base plan benefits rates will be required after the actuarial review is completed.

As an aid in identifying mandated and non-mandated supplemental riders which have been approved by the Health Policy Board and the specific plan options applicable for each, refer to Attachment C.

The diskette labeled "Alliance PPW" is to be used as explained above for Non-Alliance rate filings. This diskette, rather than the one previously provided to you by the Alliance, must be used by AHPs in order that all filings are on the same format. A copy of this diskette is to be sent to the Department as soon as possible, with all other items in the initial filing requirement check list, after submitting rate material to the Alliance. **Note - when the PPW was introduced last year the Gross Base Rate Index value for Alliance Group PPWs did not include commission. This is now changed so that the Gross Base Rate Index value does include the *5%* commission.** So, the Gross Base Rate will be consistent with the hard copy printout of monthly list bill rates.

The diskette labeled "Alliance Rates" should be used in the same manner as for Non-Alliance business as explained above.