Public Protection Cabinet

Department of Insurance

Division of Health and Life Insurance and Managed Care

(Amendment)

806 KAR 17:150. Health benefit plan rate filing requirements.

RELATES TO: KRS 304.1-050, 304.3-270, 304.4-010, 304.17A-005, 304.17A-095, 304.17A-0952, 304.17A-0954, [~~304.17A-096, 304.17A-132, 304.17A-134, 304.17A-139, 304.17A-149,~~] 304.17A-410, 304.17A-430, [~~304.17A-450,~~] 304.17A-500, 304.17A-750, 304.17A-764, 304.17A-834, 304.17B-021, 304.17B-023(3)

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-095(7)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the Commissioner [~~Executive Director~~] of Insurance to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code, as defined in [~~by~~] KRS 304.1-010 through KRS 304.99-154. KRS 304.17A-095(7) authorizes the commissioner [~~executive director~~] to promulgate an administrative regulation to obtain relevant information for health benefit plan rate filings and establish the format of the filing [~~filings~~]. The purpose of this [~~This~~] administrative regulation is to establish [~~establishes~~] the format and procedure for the submission of a health benefit plan rate filing.

Section 1. Definitions. (1) "Base new business rate" means the premium rate for each product benefit plan for each class of business, prior to any adjustment for case characteristics or health status.

(2) "Base new business rate change" means:

(a) For a product benefit plan, the percentage change in the base new business rate measured from the first day of the prior rating period to the first day of the proposed rating period; and

(b) For a product within a market segment class of business, the percentage change equal to the premium weighted average base new business rate change for all of the product benefit plans within that market segment class of business.

(3) "Base premium rate" is defined in KRS 304.17A-005(3).

[~~(4) "Basic health benefit plan" is defined in KRS 304.17A-005(4).~~]

(4) [~~(5)~~] "Class of business" means all or a distinct grouping of small employers or individuals as shown on the records of the small employer or individual insurance carrier.

(5) "Commissioner" is defined in KRS 304.1-050(1). [~~(6) "Covered person" is defined in KRS 304.17A-500(3~~).]

[~~(6) "Covered person" is defined in KRS 304.17A-500(3).~~]

(6)[~~(7)~~] "Date of filing" means the date the department [~~office~~] confirms that the appropriate filing fee and all information required by this administrative regulation have been received by the department [~~office~~].

(7) “Department’ is defined in KRS 304.1-050(2). [~~(8) "Duration" means a policy year of twelve (12) months, measured from the date of issuance of a policy, with each succeeding twelve (12) month period being a new duration.~~]

(8)"Duration" means a policy year of twelve (12) months, measured from the date of issuance of a policy, with each succeeding twelve (12) month period being a new duration.

(9) "Employer-organized association" is defined in 304.17A-005(12)[~~KRS 304.17A-0954(1)(c)~~].

[~~(10) “Executive director” is defined in KRS 304.1-050(1).~~]

(10)[~~(11)~~] "FFS" means a fee for service product type.

(11)[~~(12)~~] "Guaranteed Acceptance Program" or "GAP" is defined in KRS 304.17A-005(19).

(12)[~~(13)~~] "Health benefit plan" is defined in KRS 304.17A-005(22).

(13)[~~(14)~~] "Health benefit plan region" or "geographic region" means each one (1) of the eight (8) allowable rating regions for health benefit plans identified in HIPMC-R33, Health Benefit Plan Regions[~~, which is incorporated by reference in 806 KAR 17:005~~].

(14)[~~(15)~~] "HMO" means a health maintenance organization product type.

(15)[~~(16)~~] "Index rate" is defined in KRS 304.17A-005(27) [~~304.17A-005(25~~]).

(16)[~~(17)~~] "Insurance purchasing outlet" is defined in KRS 304.17A-750(4).

(17)[~~(18)~~] "Large group" is defined in KRS 304.17A-005(32) ~~304.17A-005(30)~~].

(18)[~~(19)~~] "Material change" means any change to a rate filing, except that a change in value of an existing rate factor other than trend shall not be considered a material change.

[~~(20) “Department” is defined in KRS 304.1-050(2). ~~]

(19) [~~(21)~~] "POS" means a point of service product type.

(20) [~~(22)~~] "PPO" means a preferred provider organization product type.

(21) [~~(23)~~] "Small group" is defined in KRS 304.17A-005(45) [~~304.17A-005(42)~~].

(22) [~~(24)~~] "Target loss ratio" means a loss ratio that an insurer files, that [~~which~~] projects and guarantees a loss ratio on an annual basis.

Section 2. Scope. (1) A health benefit plan rate filing to which the standards of KRS 304.17A-095 apply, shall include the information required by Sections 3 through 10 of this administrative regulation.

(2) The period of time that [~~in which~~] the commissioner [~~executive director~~] shall have to approve or disapprove a filing shall not begin until the date of filing.

(3) An insurer shall not market or use the proposed rates until the date of filing.

(4) A filing and fee shall not be deemed received until the department [~~office~~] confirms that:

(a) Information required by Sections 3 through 10 of this administrative regulation has been received; and

(b) The appropriate fee, as set forth in 806 KAR 4:010, has been paid.

Section 3. Health Benefit Plan Rate Filing Procedures. (1) A health benefit plan rate filing shall be submitted electronically through the System For Electronic Rate and Form Filing (SERFF) or an electronic manner approved by the department[~~to the office~~] for a:

(a) New rate filing; or

(b) Material change to a previously approved rate filing.

(2) The following shall be included and properly completed in a health benefit plan rate filing submission:

(a) Form HIPMC-R32, the Health Benefit Rate Filing Information Form[~~, which is incorporated by reference in 806 KAR 17:005~~];

(b) The following filing fee or the domiciliary state fee, whichever is greater:

1. One hundred (100) dollars [~~$100~~] for an original or new filing; or

2. Fifty (50) dollars for an amendment to a filing;

(c) Form HIPMC-F1, Face Sheet and Verification Form, that [~~which~~] is incorporated by reference in 806 KAR 14:007 [~~806 KAR 17:005~~];

(d) Signed actuarial memorandum prepared in accordance with Sections 6 and 7 of this administrative regulation;

[~~(e) An Income and Expense Worksheet, which is incorporated by reference in 806 KAR 17:005~~];

(e) [~~(f)~~] Except for large groups, Certification Form HIPMC-R34[~~, which is incorporated by reference in 806 KAR 17:005~~]; and

[~~(g) If a rate for a basic health benefit plan is included, Form HIPMC-RF-25, Basic Health Benefit Plan Summary Sheet-Form and Rate Filings, which is incorporated by reference in 806 KAR 17:005~~].

[~~(3) Two (2) copies of all written material shall be submitted to the office.~~]

(3) [~~(4)~~] A [~~One (1)~~] copy of all [~~written~~] material shall be submitted electronically to the Kentucky Attorney General's Office by the insurer at the same time as the submission to the department [~~office~~] and shall include:

(a) An amendment;

(b) An update; or

(c) A response to an inquiry from the department [~~office~~].

(4) [~~(5)~~] An electronic copy[~~Two (2) copies~~] of all correspondence with the department [~~office~~] or other state agency concerning a filing shall be submitted to the department [~~office~~].

[~~(6) A photocopy of the most recent annual financial report shall be attached to the filing as an exhibit~~].

Section 4. Filing Format. (1) A separate health benefit plan rate filing shall be submitted for each market segment as follows:

(a) Individual;

(b) Small group;

(c) Association;

(d) Large group; [~~and~~]

(e) Except as otherwise authorized pursuant to KRS 304.17A-0954(2), each employer-organized association; and[~~.~~]

(f) Self insured employer organized association

(2) A large group rate filing may include each product type offered as follows:

(a) FFS;

(b) PPO;

(c) POS; and

(d) HMO.

[~~(3) A rate filing for a market segment other than large group may be submitted separately for each product type listed in subsection (2) of this section or in the following combinations:~~]

[~~(a) FFS and PPO; or~~]

[~~(b) POS, HMO, and PPO~~.]

Section 5. Employer-organized Association Rate Filings for Fully Insured and Self Insured. (1)(a) An employer-organized association rate filing shall include the name of each employer-organized association that generated the rating experience contained in the filing; and

(b) If more than one (1) employer-organized association is named in the filing as identified in paragraph (a) of this subsection and each employer-organized association provides the insurer with written permission to have rates based on experience other than its own, the insurer:

1. May have the experience of all employer-organized associations named in the filing combined for rate determination; and

2. Shall include proposed rates for the combination of associations in one (1) filing.

(2) Each employer-organized association rate filing shall contain documentation demonstrating that the entity is an employer-organized association pursuant to KRS 304.17A-0954(1)(c).

(3) An [~~If an~~] insurer [~~is~~] proposing to begin marketing a health benefit plan to an employer-organized association, shall file a rate filing [~~may be based on the standard plan benefits~~], including appropriate formulas and rate factors within the limitations outlined in KRS 304.17A-0954. The filing shall include:

(a) Factors for all plans to be offered; and

(b) A detailed description of the methodology for incorporating the actual experience of an employer-organized association in determining rates for that association.

(4) If the insurer receives written permission from an employer-organized association regarding combining experience with other employer-organized associations, the insurer shall submit a copy of the [~~two (2) copies of the written~~] permission to the commissioner [~~executive director~~] with the rate filing. The [~~written~~] permission shall include the following:

(a) A statement giving the insurer permission to rate the employer-organized association on experience other than the experience of the employer-organized association [~~association's own experience~~];

(b) Name, address, and telephone number of the employer-organized association giving permission to the insurer;

(c) Name, address, and telephone number of the insurer to which permission is given;

(d) Month, day, and year that permission is given to the insurer; and

(e) Number of eligible association members.

Section 6. Actuarial Memorandum. (1) The actuarial memorandum for each rate filing shall be prepared in accordance with the most recent edition of the following located at http://www.actuarialstandardsboard.org/standards-of-practice/:

(a) Actuarial Standard of Practice No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans [~~(Doc. No. 010, 1990 Edition)~~], American Academy of Actuaries;

(b) Actuarial Standard of Practice No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans [~~(Doc. No. 052, adopted October, 1996)~~], American Academy of Actuaries; and

[~~(c) Actuarial Standard of Practice No. 31, Documentation in Health Benefit Plan Ratemaking (Doc. No. 060, adopted October, 1997), American Academy of Actuaries; and~~]

(c)[~~(d)~~] Actuarial Standard of Practice No. 41, Actuarial Communication [~~(Doc. No. 086, adopted March, 2002)~~], American Academy of Actuaries.

(2) The actuarial memorandum for a rate filing, other than a large group rate filing, shall include the following:

(a) Qualifications of the signing actuary;

(b) A statement identifying the date that the proposed rates shall be used;

(c) A discussion of the rate development, that [~~which~~] shall include a detailed explanation of the following:

[~~1. The effects of each of the following mandated benefits which shall include the percent-age cost and actual dollars attributable to the rates and the number of policyholders who are affected:~~]

[~~a. For benefit plans offering pharmacy benefits, coverage for amino acid modified preparations and low-protein modified food products for the treatment of inherited metabolic disorders in accordance with KRS 304.17A-139(4);]~~

[~~b. Hearing aids and related services in accordance with KRS 304.17A-132;]~~

[~~c. Anesthesia and hospital or ambulatory surgical facility services in connection with dental procedures in accordance with KRS 304.17A-149; and~~]

[~~d. Medical and surgical benefits with respect to mastectomies pursuant to KRS 304.17A-134;~~]

1. [~~2.~~] The claim cost development, that [~~which~~] shall include an explanation of the following:

a. Methodology;

b. Assumptions including the following:

(i) Trend, including supporting analysis, that [~~which~~] supports the trend level selected;

(ii) Benefit change;

(iii) Utilization or cost-per-service change;

(iv) Demographic change;

(v) Change in medical management;

(vi) Change in provider contracts; and

(vii) Any other assumption used by the actuary in the claim cost development; and

c. Experience by month, including exposures or members, earned premium, paid claims, incurred claims, and incurred loss ratio, for the past three (3) years for this product, or for a similar product if the [~~this~~] filing is for a new product;

2a. [~~3.a.~~]. Development and printout of the following shall be shown by age, gender, and tier combination using the lowest industry factor and the lowest area factor, and separately using the highest industry factor and highest area factor:

(i) Base premium rates;

(ii) Index rates; and

(iii) Corresponding highest premium rates; [~~and~~]

[~~(iv) If offered, any applicable GAP premium rates for the standard plan option.~~]

b. If the filing contains more than one (1) product type, a development and printout as identified and described in clause a of this subparagraph for each product type separately.

c. If the filing contains proposed rates for more than one (1) class of business, a development and printout as identified and described in clauses a. [~~a~~] and b. [~~b~~] of this subparagraph for each class of business separately;

[~~4. For an insurer that has existing GAP enrollees: ~~]

[~~a. Index rates for the non-GAP classes of business may be set by excluding the experience of the GAP enrollees;~~]

[~~b. Index rates for the GAP class of business shall be set by considering the block of experience for the new GAP class of business and the former class of business, which included GAP enrollees; and ~~]

[~~c. Rates for the GAP class of business may not exceed 150 percent of the index rates established in clause b of this subparagraph; ~~]

3. [~~5.~~] Factors used for each case characteristic, including age, gender, industry or occupation, and geographic region, with a separate summary of the maximum factor and the minimum factor for each case characteristic.

a. A health benefit plan region other than the eight (8) identified in HIPMC-R33, Health Benefit Plan Regions, [~~which is incorporated by reference in 806 KAR 17:005,~~] shall not be used for a geographic region factor adjustment; and

b. Any healthy lifestyle discount factor, if applicable, shall be included and an explanation of the determination of that factor, and the condition for when [~~under which~~] that factor is applicable;

4. [~~6.~~] The anticipated pricing loss ratio, including a detailed justification of load factors, including percentages allocated for the:

a. Administrative expense assumption, including an explanation of:

(i) Any change from the factor used for an existing rate [~~rates~~]; and

(ii) How these costs are allocated among each benefit plan design, including demonstrative documentation as an exhibit;

b. Commission assumption, including an explanation for any change from the factor used for an existing rate [~~rates~~]rates;

c. Federal, state, and local government tax assumptions, including an explanation for a change from the factor used for an existing rate [~~rates~~];

d. Investment income assumption, including an explanation for any change from the factor used for an existing rate [~~rates~~];

e. Profit and contingency assumption, including an explanation for a change from the factor used for an existing rate [~~rates~~];

f. Assessments pursuant to KRS 304.17B-021; and

g. Other identified load factors;

(d) A detailed explanation, including an example of the following:

1. The method for determining a small group composite rate;

2. The conditions under which a small group composite rate is recalculated; and

3. The group size that is eligible for a composite rate calculation;

(e) Each health benefit plan description and the applicable benefit factor adjustment, or other methods of calculating rates for a different benefit plan if the method is not multiplicative, for each benefit plan applicable to the[~~to which this~~] filing [~~applies~~];

(f) Detailed discussion of the manner in which the projected amount of net assessments and payments under KRS 304.17B-021 and 304.17B-023(3) are to be used in establishing the proposed rates in the filing as required by KRS 304.17A-095;

(g) Information regarding how fees are paid to providers as follows:

1. Justification of fees paid to providers in relation to the rate requested, including any assumption used regarding provider discounts in the rate filing; and

2. Average discount to providers during experience period and average discount for physician payments, hospital payments, laboratory payments, pharmacy payments, mental health payments, and other payments for the rate filing period;

(h) If a trend rate is used, include the time period to which the trend applies, not to exceed twelve (12) months, and the applicable annual trend rate and the periodicity of the factor;

(i) Explanation of the anticipated effect of the requested rates on the current policyholders, subscribers, or enrollees;

(j) Information regarding each class of business, which shall include:

1. Identification of each class of business;

2. Justification of each separate class of business; and

3. A demonstration that each index rate for the class of business with the highest index rates is within ten (10) percent of the corresponding index rate from the class of business with the lowest index rates[~~, excluding a GAP class of business~~]; and

(k) Prospective certification of the following, which shall be filed as an attachment to the actuarial memorandum for a rate filing other than a large group filing, and signed by the qualified actuary who prepared and signed the actuarial memorandum:

1. That the information is prepared in accordance with American Academy of Actuaries Actuarial Standard of Practice No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans, applicable to the following markets:

a. Individual;

b. Association; and

c. Small group; and

2. That the proposed rates meet the requirements of KRS 304.17A-0952 or 304.17A-0954, as applicable.

Section 7. Large Group Rate Filings. (1) The actuarial memorandum for a large group rate filing shall include the following information:

(a) The information identified in Section 6(2)(a), (b), (c)1, [~~2,~~] 4 [~~6~~] (f), (g), (h), [~~and~~] (i) and (j) of this administrative regulation;

(b) Development of rating basis, including each adjustment for the following:

1. Age;

2. Gender;

3. Family composition;

4. Benefit plan;

5. Industry;

6. Healthy lifestyle; and

7. Any other adjustment included in the development;

(c) A formula for new and renewal business, including a definition of each term used in the formula;

(d) Credibility criteria used in conjunction with experience rating;

(e) Detailed explanation of a change in the manual rating formula or experience rating formula;

(f) Detailed explanation of a change in factors that would be used in a formula;

(g) Any periodic trend rate applied in the formula;

(h) The composite effect of a change in formula and formula factors; and

(i) Detailed explanation of any trend assumption used in experience rating.

(2) Certification Form HIPMC-R34, Certification Form[~~, incorporated by reference in 806 KAR 17:005~~], shall not be required for a large group rate filing.

Section 8. Guaranteed Loss Ratio Filing for New Products or Products without Credible Experience.

(1) A filing accompanied by a guaranteed loss ratio statement shall meet all requirements of KRS 304.17A-095(6).

(2) Individual, small group, and employer-organized association market filings shall meet the following requirements regarding guaranteed loss ratios by duration:

(a) The guaranteed loss ratio for the first duration shall not be less than sixty (60) percent of the guaranteed lifetime loss ratio specified in the policy.

1. Expected loss ratios may vary by month within the first duration; and

2. The average of the loss ratios for all months shall be equal to the guaranteed loss ratio for the first duration;

(b) The guaranteed loss ratio for a specific duration shall not be less than the guaranteed loss ratio for the previous duration;

(c) The guaranteed loss ratio for the third duration shall not be less than the guaranteed lifetime loss ratio identified in the policy;

(d) The average of the first six (6) guaranteed loss ratios by duration shall not be less than the guaranteed lifetime loss ratio identified in the policy;

(e) The guaranteed lifetime loss ratio shall not be less than that identified in KRS 304.17A-095(6)(a)5; and

(f) The guaranteed loss ratios by duration shall be guaranteed for any policy issued under the policy form and shall be identified in the policy.

(3) A refund shall be calculated pursuant to the following formula:

(a) Refundable premium for any year shall be the sum of the current year's refundable premium for each duration. Each duration's refundable premium shall be calculated by subtracting the three (3) items in subparagraphs 1, 2, and 3 of this paragraph from the current year's earned premium by duration and multiplying the result by the ratio of earned premium by duration and earned premium by duration minus the items identified in subparagraphs 1 and 2 of this paragraph and minus any premium related expenses identified in subparagraph 3 of this paragraph:

1. State and local premium taxes allocated to that duration;

2. Assessments pursuant to KRS 304.17B-021 allocated to that duration; and

3. The sum of incurred claims, preferred provider organization expenses, case management and utilization review expenses, and reinsurance premiums, minus reinsurance recoveries, allocated to that duration, divided by the guaranteed loss ratio in the policy, for that duration;

(b) If the annual earned premium is less than $2,500,000, the minimum refund shall be calculated by refundable premium multiplied by the annual earned premium, divided by $2,500,000;

(c) If the annual earned premium is equal to or greater than $2,500,000, the minimum refund shall be the refundable premium;

(d) The refund to be paid to a policyholder pursuant to KRS 304.17A-095(6)(d) shall be calculated by dividing the earned premium for that policyholder by the total earned premium for the year, and multiplying that percentage of the aggregate refund of the policy form by the aggregate refund; and

(e) The amount of the refund shall include the computation of interest in accordance with KRS 304.17A-095(6)(d) in determining whether payment shall be made to the policyholder or to the Kentucky State Treasurer.

(4) An audit shall be conducted in accordance with KRS 304.17A-095(6)(b), which shall include the following:

(a) Guaranteed lifetime loss ratio;

(b) Guaranteed loss ratios by duration;

(c) Analysis of prior year estimated items, including uncollected premiums and unpaid claim liabilities, and description of method of allocation by duration;

(d) Earned premium by duration and description of method of allocation by duration;

(e) State premium tax by duration and description of method of allocation by duration;

(f) Local premium tax by duration and description of method of allocation by duration;

(g) Assessments by duration and description of the method of allocation by duration;

(h) Incurred claims by duration and description of method of allocation by duration;

(i) Preferred provider organization expenses and description of method of allocation by du-ration;

(j) Case management and utilization review expenses and description of method of allocation by duration;

(k) Reinsurance premiums less reinsurance recoveries and description of method of allocation by duration;

(l) A description of reinsurance and identity of reinsurer;

(m) A statement that incurred claims do not include administrative expenses, late payment charges, punitive damages, legal fees, or any other related administration expenses;

(n) A statement that incurred claims have been reduced for the full amount of all provider discounts, rebates, coordination of benefits savings, subrogation savings, and any other savings;

(o) A statement of refund checks not being issued before approval of the audit;

(p) Calculation of minimum refundable premium, actual refunded premium, and refund carryover;

(q) Calculation of percent of earned premium that shall be refunded;

(r) Method used to calculate a policyholder's actual refund;

(s) Historical experience for the policy form since inception;

(t) Auditor's certification; and

(u) Actuarial certification.

(5) An initial rate filing shall be a formal filing, and a subsequent rate filing may be submitted by actuarial certification.

Section 9. Minimum Guaranteed Loss Ratio Requirements for an Amended Policy Form or a Previously Filed Minimum Guaranteed Loss Ratio.

(1) If amending a policy form or a previously filed minimum guaranteed loss ratio, a filing accompanied by a guaranteed loss ratio statement shall meet the requirements of KRS 304.17A-095(6).

(2)(a) An insurer shall provide a minimum guaranteed loss ratio statement each time rates are amended for a policy form or if amending a previously filed minimum guaranteed loss ratio. The statement shall identify amounts by which rates are amended and include an actuarial certification verifying that rates continue to meet the requirements of the minimum guaranteed loss ratio; and

(b) Most recently filed with the department [~~office~~].

(3) The initial rate filing and subsequent statements shall include an actuarial certification, which includes information to demonstrate meeting the requirements of KRS 304.17A-0952 and Section 6 of this administrative regulation.

(4)(a) The currently approved loss ratio on file with the department [~~office~~] under a prior approval process or a minimum guaranteed loss ratio shall be deemed a reasonable loss ratio for any amended policy forms or amended minimum guaranteed loss ratios; and

(b) Rate filings requesting a change in the previously approved loss ratio shall require documented evidence to demonstrate increased administrative cost or other evidence that the insurer would not be able to achieve previously approved profitability targets.

(5) If experience is filed by duration pursuant to Section 8(2) of this administrative regulation, a refund shall be calculated in accordance with Section 8(3) of this administrative regulation.

(6) If experience is filed by utilizing a target loss ratio and the actual achieved loss ratio is less than the target loss ratio, a refundable premium shall be determined as follows:

(a) Refundable premium shall be equal to the annual earned premium multiplied by the percentage by which the target loss ratio exceeds the actual achieved loss ratio;

(b)1. If the annual earned premium is equal to or greater than $2,500,000, the minimum re-fundable premium shall be equal to the refundable premium as established in paragraph (a) of this subsection; or

2. If the annual earned premium is less than $2,500,000, the:

a. Minimum refundable premium shall be equal to the refundable premium multiplied by the ratio of the annual earned premium divided by $2,500,000;

b. Refund carryover shall be equal to any amount by which the refundable premium exceeds the minimum refundable premium; and

c. Refundable premium in the subsequent year shall be the sum of the refund carryover plus the calculated refundable premium for the subsequent year;

(c) The refund to be paid to a policyholder pursuant to KRS 304.17A-095(6)(d) shall be calculated by dividing the earned premium for that policyholder by the total earned premium for

the year, and multiplying that percentage of the aggregate refund of the policy form by the aggregate refund; and

(d) The amount of the refund shall include the computation of interest in accordance with KRS 304.17A-095(6)(d) in determining whether payment shall be made to the policyholder or to the Kentucky State Treasurer.

(7) If experience is filed by duration, an audit shall be conducted in accordance with Section 8(4) of this administrative regulation.

(8) If experience is filed by target loss ratio, an audit shall be conducted in accordance with KRS 304.17A-095(6)(b), which shall include the following:

(a) Guaranteed lifetime loss ratio;

(b) Actual loss ratio;

(c) Analysis of prior year estimated items, including uncollected premiums and unpaid claim liabilities;

(d) Earned premium;

(e) State premium tax;

(f) Local premium tax;

(g) Assessments;

(h) Incurred claims;

(i) Preferred provider organization expenses;

(j) Case management and utilization review expenses;

(k) Reinsurance premiums less reinsurance recoveries;

(l) A description of reinsurance and identity of reinsurer;

(m) A statement that incurred claims do not include administrative expenses, late payment charges, punitive damages, legal fees, or any other related administration expenses;

(n) A statement that incurred claims have been reduced for the full amount of all provider discounts, rebates, coordination of benefits savings, subrogation savings, and any other savings;

(o) A statement of refund checks not being issued before approval of the audit;

(p) Calculation of minimum refundable premium, actual refunded premium, and refund carryover;

(q) Calculation of percent of earned premium that is to be refunded;

(r) Method used to calculate a policyholder's actual refund;

(s) Historical experience for the policy form since inception;

(t) An auditor's certification; and

(u) An actuarial certification.

(9) An initial rate filing shall be a formal filing, and a subsequent rate filing may be by actuarial certification.

(10) An initial rate filing shall be required for insurers electing to file under a minimum guar-anteed loss ratio pursuant to KRS 304.17A-095(6).

Section 10. Amendments to Previously Approved Rate Filings. (1) For any change that is not a material change, an insurer shall submit an amendment to a rate filing previously approved by the department [~~office~~], which shall include the following:

(a) Identification of the rate file number assigned and stated in the Order of Approval received by the insurer from the department [~~office~~] for the previously approved rate filing;

(b) Date of approval of the previously approved rate filing;

(c) The proposed effective date of the amendment;

(d) A fifty (50) dollar filing fee;

(e) A copy [~~Two (2) copies~~] of a properly completed HIPMC-F1 form, Face Sheet and Verification Form; and[~~, which is incorporated by reference in 806 KAR 17:005~~]

(f) A copy [~~Two (2) copies~~] of a properly-completed HIPMC-R32 form, Health Benefit Plan Rate Filing Information Form[~~, which is incorporated by reference in 806 KAR 17:005; and~~]

[~~(g) If the filing is for a basic health benefit, Two (2) copies of the completed HIPMC-RF-25 Form, Basic Health Benefit Plan Summary Sheet - Form and Rate Filings, which is incorporated by reference in 806 KAR 17:005~~].

(2) Each amendment filing shall contain documentation to demonstrate the necessity of the amendment, which shall include the following:

(a) An itemized list of the information to be amended and the reason for the amendment;

(b) A statement identifying the impact of the amendment in relation to benefits and costs on current and future policyholders; and

(c) A statement identifying the impact of the amendment on the insurer.

(3) One (1) copy of the amendment filing and written material relating to the filing shall be submitted to the Kentucky Attorney General's department [~~office~~] by the insurer at the same time as the submission to the department [~~office~~].

(4) The amendment to a previously approved rate filing shall not be deemed received until the department [~~office~~] confirms that the information and fifty (50) dollar filing fee required under this section have been received.

(5) Within sixty (60) days of confirmation of receipt of the required information and fee, the department [~~office~~] shall notify the insurer in writing of the acceptance or rejection of the amendment.

(6) The sixty (60) day confirmation time shall not begin until the department [~~office~~] confirms that the required information and fee have been received.

Section 11. Material Incorporated by Reference: (1) The following material is incorporated by reference:

(a) Actuarial Standard of Practice No. 8, "Regulatory Filings for Rates and Financial projections for Health Plans, originally adopted 1990, newly adopted 03/2014 [~~(Doc. No. 010, 1990 Edition)~~]", American Academy of Actuaries;

(b) Actuarial Standard of Practice No. 26, "Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans, originally adopted 10/1997, revised and effective 05/2011 [~~(Doc. No. 052, adopted October, 1996)~~]", American Academy of Actuaries;

[~~(c) Actuarial Standard of Practice No. 31, "Documentation in Health Benefit Plan Ratemaking (Doc. No. 060, adopted October, 1997)", American Academy of Actuaries;~~]

(c) [~~(d)~~] Actuarial Standard of Practice No. 41, "Actuarial Communication, originally adopted 03/2002, revised and effective 05/2011 (~~Doc. No. 086, adopted March, 2002~~)", American Academy of Actuaries.

(d) HIPMC-R32 Form, Health Benefit Plan Rate Filing Information Form, 04/2021

(e) HIPMC-F1 Form, Face Sheet and Verification Form, 07/2020

(f) HIPMC-R33, Health Benefit Plan Regions, 04/2021

(g) Certification Form HIPMC-R34, Certification Form, 04/2021

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department [~~office~~] of Insurance, The Mayo-Underwood Building, 500 Mero Street [~~215 West Main Street~~], Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on the Department of Insurance[~~office's~~] internet Web site at http://www.insurance.ky.gov [~~http://doi.ppr.ky.gov~~].

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READ AND APPROVED:

Date

Sharon P. Clark
Commissioner, Department of Insurance

Date

Kerry B. Harvey
Secretary, Public Protection Cabinet

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall be held at 9:00 AM July 23rd, 2021at 500 Mero Street, Frankfort, KY 40602. Individuals interested in being heard at this hearing shall notify this agency in writing by five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through 11:59 PM July 30th, 2021. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

Contact Person: Abigail Gall
Title: Executive Administrative Secretary
Address: 500 Mero Street, Frankfort, KY 40601
Phone: +1 (502) 564-6026
Fax: +1 (502) 564-1453
Email: abigail.gall@ky.gov

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Regulation: 806 KAR 17:150
Contact Person: Abigail Gall
Phone: +1 (502) 564-6026
Email: abigail.gall@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes procedures for filing health benefit plan rates so the Commissioner will have relevant information to approve or disapprove a rate filing.

(b) The necessity of this administrative regulation: KRS 304.17A-095 authorizes the Commissioner to promulgate an administrative regulation to obtain relevant information for health benefit plan rate filings and set forth the format for the filings. This administrative regulation is needed to ensure that health benefit plans provide the required information necessary for the commissioner to approve or disapprove rate filings.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 304.2-110(1) authorizes the commissioner to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code, as defined by KRS 304.1-010. KRS 304.17A-095(7) authorizes the commissioner to promulgate an administrative regulation to obtain relevant information for health benefit plan rate filings and to set forth the format of the filings. This administrative regulation establishes procedures for filing health benefit plan rates so the commissioner will have relevant information to approve or disapprove the rate filing.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will enable the commissioner to receive the information required to approve or disapprove a health benefit plan rate filing as required by KRS 304.17A-095.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendments filed in this administrative regulation include amending outdated language to meet the statutory requirements on Chapter 13A. Other amendments include incorporating previous materials into the regulation, update market segments, establishing a requirement for forms to be submitted electronically using SERFF system. The amendments also reflec the new adoption dates of the materials incorporated by reference.

(b) The necessity of the amendment to this administrative regulation:

(c) How the amendment conforms to the content of the authorizing statutes: KRS 304.2-110(1) authorizes the commissioner to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code, as defined by KRS 304.1-010. KRS 304.17A-095(7) authorizes the commissioner to promulgate an administrative regulation to obtain relevant information for health benefit plan rate filings and to set forth the format of the filings. This administrative regulation establishes procedures for filing health benefit plan rates so the commissioner will have relevant information to approve or disapprove the rate filing.

(d) How the amendment will assist in the effective administration of the statutes: this administrative regulation will continue to enable the commissioner to receive the information required to approve or disapprove a health benefit plan rate filing as required by KRS 304.17A-095

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This will affect licensed insurers writing health insurance in Kentucky.

(4) Provide an analysis of how the entities identified in the previous question will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions each of the regulated entities have to take to comply with this regulation or amendment: Insurers will be required to file information in conformity with current law regarding health insurance rates needed by the commissioner to determine whether the rates should be approved or disapproved. The insurers will be responsible for copying and delivery costs. Because insurers are currently required to file information under 806 KAR 17:150, the costs to the insurers for filing under this amendment should not increase significantly, if at all.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities: The insurer is responsible for the applicable filing fee. Copying and delivery costs.

(c) As a result of compliance, what benefits will accrue to the entities: If the insurer writing the plan meets formatting requirement set in this administrative regulation as well as specified statutes the commissioner shall approve the filing. If the requirements set forth are not met, the commissioner may disapprove the filing.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: Implementation of this amendment is not anticipated to have an initial cost on the Department of Insurance.

(b) On a continuing basis: Implementation of this amendment is not anticipated to have an on-going cost on the Department of Insurance.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department will use funds from its current operational budget to perform the tasks necessary.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment:

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees:

(9) TIERING: Is tiering applied? Explain why or why not. Tiering is not applied because this administrative regulation applied to all insurers licensed to issue, deliver, or renew health benefit plans in Kentucky.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation: 806 KAR 17:150
Contact Person: Abigail Gall
Phone: +1 (502) 564-6026
Email: abigail.gall@ky.gov

(1) What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department of Insurance as the implementer.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 304.2-110(1), 304.17A-095(7)

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue is expected to be generated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? No revenue is expected to be generated.

(c) How much will it cost to administer this program for the first year? No cost is expected.

(d) How much will it cost to administer this program for subsequent years? No cost is expected.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

(4) Revenues (+/-): Neutral

(5) Expenditures (+/-): Neutral

(6) Other Explanation:

SUMMARY OF MATERIALS INCORPORATED

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(a) Actuarial Standard of Practice No. 8, "Regulatory Filings for Rates and Financial projections for Health Plans", American Academy of Actuaries; The purpose of this standard of practice is to set forth the recommended practices for actuaries involved in the preparation and or review of required health rate filings.

(b) Actuarial Standard of Practice No. 26, "Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans", American Academy of Actuaries; The purpose of this standard of practice is to guide the preparer of a required certification of compliance (with regard to rate filings) by identifying the issues to be addressed and the required documentation regarding the relevant regulatory requirements.

(c) Actuarial Standard of Practice No. 41, "Actuarial Communication", American Academy of Actuaries. The purpose of this standard of practice is to provide guidance to actuaries with respect to written, electronic, or oral actuarial communications.

(d) HIPMC-R32 form, Health Benefit Plan Rate Filing Information Form, 02/21. This form requires basic information regarding health insurance rate filings. The form requires information such as the type of filing, the type of policy, the market segment, classes of business, premiums, and the number of policyholders. HIPMC-R32 also requires certification by a company representative that the form is complete and accurate. This is a newly incorporated form to this administrative regulation.

(e) HIPMC-F1 form, Face Sheet and Verification Form, 07/20. This form is required to accompany all rate and form filings for health insurance pursuant to 806 KAR 14:007. The form

requires the filing company's name and address, the company's NAIC Code, form number, description of filing, and a statement as to whether or not the filing is being made by certification. The form also sets forth the amount of the filing fee. HIPMC-F1 is a one-page sheet which assists the Division of Health Insurance Policy and Managed Care in forwarding the filing to the proper person for review. This is a newly incorporated form to this administrative regulation.

(f) HIPMC-R33, Health Benefit Plan Regions, 12/00. This form identifies the counties in each region for the geographical areas in the rate filing. This is a newly incorporated form to this administrative regulation. This is a newly incorporated form to this administrative regulation.

(g) Certification Form HIPMC-R34, Certification Form, 07/08. By signing this form, an actuary certifies that the filing is prepared in accordance with the applicable sections of KRS 304.17A-0952 and KRS 304.17A-0954. This is a newly incorporated form to this administrative regulation.