State Of California
California Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE

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GUIDANCE RELATED TO PREMIUM RATE FILINGS

The purpose of this letter is to provide health care service plans (health plans) with guidance concerning SB 1163 (Leno -- Stats. 2010, ch. 661), and SB 546 (Leno -- Stats. 2015, ch. 801).

Background

Under Senate Bill 1163 (Leno -- Stats. 2010, ch. 661), health plans must file specified premium rate information with the Department of Managed Health Care (DMHC), provide certain actuarial certifications, and meet specified website and consumer notice requirements.

SB 1163 also authorizes the DMHC to review premium rates including unreasonable rate increases as defined by the Patient Protection and Affordable Care Act. Thus, the DMHC will look to federal rules and guidance to help in its review process.

Pursuant to SB 1163, the Director of the DMHC may issue guidance to health plans, effective until the DMHC formally adopts regulations. Accordingly, the DMHC developed the following guidance in consultation with the CDI.

The DMHC may provide additional guidance as necessary to ensure consistent and appropriate implementation of SB 1163, and the guidance may be revised to conform with federal rules or guidance, or as otherwise necessary.

Under Senate Bill 546 (Leno -- Stats. 2015, ch. 801), health plans must file additional specified rate information with the DMHC, and meet additional

consumer notice requirements.

SB 546 also authorizes the DMHC to conduct a public meeting annually regarding large group rate changes after the DMHC has completed a review of the large group rate information required to be submitted by the plan or insurer, as specified.

The DMHC may provide additional guidance as necessary to ensure consistent and appropriate implementation of SB 546 and the guidance may be revised to conform with federal rules or guidance, or as otherwise necessary.

Individual and Small Group Health Contracts

Filing and Notice

1) For individual and small group health contracts, rate submissions for new products and rate increases for existing products must be filed at least 60 days prior to the effective date of the new product rate or the rate increase. (Health and Safety Code section 1385.03 (a), (b)(14).) At this time, health plans are not required to file rate submissions for new products or rate increases for existing products for large group contracts with the DMHC.

2) The notice to enrollees or subscribers required by Health and Safety Code section 1374.21 and 1389.25 must include the date on which the proposed rate increase will be applied to the individual(s) to whom the notice is addressed.

3) For the purposes of Health and Safety Code section 1385.03(a), the concurrent filing requirement is satisfied if the health plan files its rate submission with the DMHC prior to or on the same date that it delivers its notice to the enrollees or subscribers. Consumers must receive notice consistent with Health and Safety Code sections 1374.21 and 1389.25. If a rate filing is revised after its initial submission so as to change the rates, an additional 30-day notice meeting the requirements of Health and Safety Code section 1374.21 and 1389.25 must be provided reflecting the revised rate.

4) If the implementation of a rate increase for which notice has been provided to enrollees or subscribers is delayed or the amount of the increase is reduced before the effective date of the increase, the health plan shall provide the enrollees or subscribers with a written explanation for the delay or decrease. Such explanation may be included with the first billing statement associated with the delayed or decreased rate increase.

Unreasonable Rate Increases

5) For individual and small group health plan rate filings, for the purpose of the actuarial certification required under Health and Safety Code section

1385.06(b)(2) and review under Health and Safety Code section 1385.11, the factors the DMHC will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors expressly referenced in 45 C.F.R. 154.205:

i) The relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law. (See interim federal rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. section 158.101-158.232, 75 Fed. Reg. 74921-74928, (December 1, 2010), incorporated herein by reference.

ii) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

iii) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

iv) Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the DMHC in connection with the filed rate increase, are incomplete, inadequate, fail to provide sufficient clarity and detail such that a qualified health actuary could not make an objective appraisal of the reasonableness of the rate, or which otherwise do not provide a basis upon which the reasonableness of the rate may be determined.

v) Whether the filed rates result in premium differences between enrollees within similar risk categories that are otherwise not permitted under California law or that do not reasonably correspond to differences in expected costs.

In addition, the DMHC may consider other factors specified in the California Department of Insurance (CDI) guidance dated April 5, 2011, (or as amended thereafter) including, but not limited to, the following:

vi) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible historical emerging experience data, including comparisons of experience data to projections submitted as support for prior rate filings.

vii) The annual compensation of each of the ten most highly paid officers, executives, and employees of both the health plan submitting the filing, and the parent corporation/ultimate controlling party of the health plan.

viii) The rate of return of the health plan and the parent corporation/ultimate

controlling party of the health plan, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

ix) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

x) Whether the cumulative impact of the filed rate increase, combined with previous increases over the 12 months immediately preceding the effective date of the proposed filed rate increase, would cause the rate increase to be unreasonable.

xi) The health plan's surplus condition, which may include dividend history.

xii) Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of the proposed rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group, including consideration of the minimum and maximum rate increases an enrollee could receive, and how many enrollees will be subject to increases lower or higher than the average.

xiii) The nature and amount of transactions between the health plan and any affiliates.

xiv) To the extent not otherwise covered by the factors listed above, additional factors that the DMHC may consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors set forth in the most current version of federal regulations, including 45 C.F.R, section 154.301.

Actuarial Certification

6) (A) The certification required under Health and Safety Code section 1385.06 (b)(2) is a "Statement of Actuarial Opinion," as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a "Health Filing," as defined in Actuarial Standard of Practice No. 8, promulgated by the Actuarial Standards Board, and it is also an "Actuarial Communication," as defined in Actuarial Standard of Practice No. 41, promulgated by the Actuarial Standards Board.

(B) The certification required under Health and Safety Code section 1385.06 (b)(2) must include the following information:

i) A statement of the qualifications of the actuary issuing the certification. The

actuary's qualifications must meet the standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Health and Safety Code section 1385.06 (b) (3).

ii) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate for the particular market segment (i.e., small group or individual). Premium rates are actuarially sound if, for business in California and for the period covered by the certification, projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital reserves required by the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing at Health and Safety Code section 1340, et seq.

iii) For each contract included in the filing, a complete description of the data, assumptions, rating factors and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract form included in the filing.

iv) A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall address, at a minimum, the first five factors listed in "Unreasonable Rate Increases" in this Guidance. In addition, statements of opinion shall discuss the criteria promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. sections 154.200 and 154.205.

v) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(ii) and (B)(iv) above, including any independent rating models and rating factors utilized.

(C) All of the information required in (B), above, must be contained within the actuarial certification.

Filing Requirements

7) Individual and small group health plan rate filings for existing products must be accompanied by the "California Rate Filing Form" that discloses the information required by Health and Safety Code section 1385.03(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Rate Filing Spreadsheet," as well as a separate spreadsheet containing rate information in response to question ten of the Rate Filing Form. The "California Rate Filing Form" and the "California Rate Filing Spreadsheet," can be found on the DMHC website and include definitions of certain required items.

8) Individual and small group health plan rate filings for existing products must be accompanied by the "California Plain Language Website Filing Form," submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Plain Language Spreadsheet" (Health and Safety Code section 1385.07(d)). The form and the spreadsheet can be found on the DMHC website.

9) Initial rate filings for new products for individual and small group health plan filings must be accompanied by the "California New Product Rate Filing Form" that discloses the information required by Health and Safety Code section 1385.03(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, accompanied by a spreadsheet containing the information described in the form which can be found on the Department's website and include definitions of certain required items.

10) The aggregate rate filing data report required by Health and Safety Code section 1385.03(c) need not be submitted with each separate rate filing but must be filed with the DMHC annually, due on or before February 15. Each such report must summarize the required data for the calendar year. The report should be identified in SERFF by placing "Aggregate Rate Filing Data Report" in the "Filing Description" under the "General Information" tab. A template form entitled "California Annual Aggregate Rate Data Report Form" may be used to meet this requirement. The terms "Segment Type," "Product Type," and "average rate increase" are defined as they are in the attached "California Rate Filing Form" for items 5, 4, and 13, respectively.

Large Group Health Contracts

Filing and Notice

1) For large group health contracts, each health plan shall file the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year, and additional aggregate rate information with the DMHC on or before October 1, 2016, and annually thereafter.

2) No change in premium rates or changes in coverage stated in a group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

3) Renewal notices delivered by plans shall include a statement comparing the proposed rate change stated in a group health plan service contract to the average rate increases negotiated by CalPERS and by Covered California. The statement must include information on:

   i) Whether the rate proposed to be in effect is greater than, less than or equal to the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

   ii) Whether the rate proposed to be in effect is greater than, less than or equal to the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year in which the rates are final.

   iii) Whether the rate change includes any portion of the excise tax paid by the health plan; however, the Department has confirmed this is not applicable in 2016 through 2019 and accordingly need not be included in the notice.

   iv) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

Filing Requirements

For large group health care service plan contracts, each health plan shall file with the DMHC annually the "California Large Group Annual Aggregate Rate Data Report" that discloses the information required by Health and Safety Code section 1385.045. A template form of the report including definitions of certain required items can be found on the Department's website.

The aggregate rate data report should be filed in SERFF on or before October 1, 2016, and annually thereafter. The report should be submitted as a PDF document identified in SERFF by entering "Large Group Aggregate Rate Data Report" in the "Filing Description" under the "General Information" tab.

If you have any questions concerning the guidance issued in this letter, please

contact the Office of Legal Services at (916) 322-6727.

Shelley Rouillard, Director

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