DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

Guidance 1163: 2

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Pursuant to Senate Bill 1163 (Chapter 661, Statutes 2010), the California Department of Insurance issues the following guidance regarding compliance. [1] Further guidance may be forthcoming in the future.

Section A: Unreasonable Rate Increases

For all health insurance filings, for the purpose of the actuarial certification required under Insurance Code section 10181.6(b)(2) and review under Insurance Code section 10181.11, the factors the Department will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the following:

1) 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 final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. sections 158.101- 158.232, 75 Fed. Reg. 74921-74928, (December 1, 2010)), incorporated herein by reference.

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

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[1] Senate Bill 1163 provides, at Insurance Code section 10181.2, that Article 4.5 (Insurance Code section 10181 *et seq.*) does not

> apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

Accordingly, the above guidance does not apply to the types of insurance listed in Insurance Code section 10181.2.

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

4) Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the Department 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 does not provide a basis upon which the reasonableness of the rate may be determined.

5) Whether the filed rates result in premium differences between insureds within similar risk categories that:

(A) Are otherwise not permissible under applicable California law; or
(B) Do not reasonably correspond to differences in expected costs.

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

7) The rate of return of the insurance company and the parent corporation/ultimate controlling party of that insurer, 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.

8) The annual compensation of each of the 10 most highly paid officers, executives, and employees of both the insurer submitting the rate filing and the parent corporation/ultimate controlling party of that insurer.

9) 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.

10) Whether the cumulative impact of the filed rate, combined with the previous increases, would cause the rate to be unreasonable.

11) The insurer's surplus condition and dividend history.

12) 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 a policyholder could receive, and how many policyholders will be subject to increases lower and higher than the average.

13) The nature and amount of transactions between the filing insurer and any affiliates over the prior 3 years.

14) For individual policies, whether the proposed rates comply with California Code of Regulations Title 10, section 2222.12.

15) To the extent not otherwise covered by the factors listed above, additional factors the Department will 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 45 Code of Federal Regulations section 154.301.

Section B: Filing and Notice

16) For individual and small group health insurance policies, rate submissions for new products and rate increases for existing products must be filed at least 60 days prior to implementation. (Insurance Code section 10181.3(a), (b)(14).)

17) The filing requirements of Senate Bill 1163 (Insurance Code sections 10181.3, 10181.4, 10181.6, 10181.7) apply to new product rates and rate increases implemented on or after January 1, 2011. With respect to rate filings submitted to the department prior to January 1, 2011 that include rate changes which will be implemented as to any insureds after January 1, 2011, the insurer must provide the 60-day notice described in Insurance Code section 10113.9 or 10199.1 for those changes.

18) The consumer notice required by Insurance Code section 10113.9 or 10199.1 must be delivered concurrently with the submission of the rate filing to the department. The notice required by section 10113.9 must include the date on which the proposed rate increase will be applied to the individual(s) to whom the notice is addressed. 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 Insurance Code sections10113.9 or 10199.1 must be provided reflecting the revised rate.

19) To demonstrate compliance with the notice requirements of Insurance Code sections 10113.9 and 10199.1, insurers shall file the following information for each policy form for which a filing has been submitted pursuant to Insurance Code section 10181.3 for rates effective on or after January 1, 2011:

a) The date the required information was filed with the Department, and
b) The date(s) that notice was provided as required by Insurance Code section 10113.9 or 10119.1, and
c) The date that the rate reflected in the filing was first implemented as to an insured.

This report should be filed through SERFF within 10 days after the date the rate was first implemented, with the notation "Rate Notice Compliance Report" in the "Filing Description" field under the "General Information" tab.

Section C: Actuarial Certification

20) (A) The certification required under Insurance Code section 10181.6 (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 Insurance Code section 10181.6 (b)(2) must include the following information:

(1) 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 Insurance Code section 10181.6 (b)(3).

(2) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate for the 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, the total of projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income is adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

(3) For each contract or insurance policy 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 or policy form included in the filing.

(4) 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 the factors listed in Section A, "Unreasonable Rate Increases," of this Guidance. In addition, statements of opinion regarding individual health insurance shall address whether the benefits provided under the policy are reasonable in relation to the premium charged, as described in California Code of Regulations title 10, chapter 5, section 2222.10, *et seq*.

(5) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(2) and (B)(4) 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.

Section D: Filing Requirements

21) Individual and small group health insurance rate filings for existing products must be accompanied by a "California Rate Filing Form" that discloses the information required by Insurance Code section 10181.3(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 10 of the Rate Filing Form. The "California Rate Filing Form" and the "California Rate Filing Spreadsheet," are on the Department's website; please see the "California Rate Filing Form" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for definitions of certain of the items required.

22) All health insurance rate filings for existing products must be accompanied by the "California Plain-Language Rate Filing Description", submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Plain Language Spreadsheet" (Insurance Code section 10181.7(d)). The form and the spreadsheet are on the Department's website; please see "California Plain-Language Rate Filing Description" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for the form and format of the items required.

23) Initial rate filings for new products for individual and small group health insurance must be accompanied by the "California New Product Rate Filing Form" that discloses the information required by Insurance Code section 10181.3(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, accompanied by a spreadsheet containing the information described in the form. See "California New Product Rate Filing Form" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for definitions of certain of the items required.

24) The aggregate rate filing data report required by Insurance Code section 10181.3(c) need not be submitted with each separate rate filing but must be filed with the Department at least quarterly (no later than 5 calendar days after the end of the calendar quarter). Each such report must summarize the required data for the calendar quarter, as well as for the calendar year to date. The report should be identified in SERFF by placing "Aggregate Rate Filing Date Report" in the "Filing Description" field under the "General Information" tab. A form for this report will be provided in subsequent guidance. The

terms "Segment Type", "Product Type", and "average rate increase" will be defined as they are in the attached "California Rate Filing Form" for items 5, 4, and 13 respectively.

For questions, please contact Bruce Hinze at bruce.hinze@insurance.ca.gov.

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