DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

DRAFT Proposed Amended Regulation 4-2-39

CONCERNING ~~PREMIUM~~ RATE SETTING FOR NON-GRANDFATHERED INDIVIDUAL, SMALL AND LARGE GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-3-1110(1), 10-16-107 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide the necessary guidance to carriers to ensure that health insurance rates comply with Colorado's health benefit plan rating laws.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans; health benefit plans subject to the laws of Colorado; student health insurance coverage; and stand-alone dental plans that provide for pediatric dental as an essential health benefit. This regulation excludes individual short-term health insurance policies, as defined in § 10-16-102(60), C.R.S. This regulation applies to all plans or rates not previously reviewed and approved by the Division.

Section 4 Definitions

A. "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L.111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L 111-152.

B. "Actuarial Value" or "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

C. "Benefits ratio" means, for the purposes of this regulation, the ratio of the value of the actual policy benefits, not including policyholder dividends, to the value of the actual premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage.

D. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

E. "Catastrophic plan" shall have the same meaning as found at § 10-16-102(10), C.R.S.

F. "Colorado Option Standardized Plan" or "Standardized Plan" shall have the same meaning as found at § 10-16-1303(14), C.R.S.

GF. "Coordination of benefits" and "COB" mean, for the purposes of this regulation, a provision establishing an order in which policies pay the claims and permitting secondary policies to reduce the benefits so that the combined benefits of all plans do not exceed the total allowable expenses.

HG. "Covered lives" mean, for the purposes of this regulation, the number of members, subscribers and dependents.

IH. "CMS" means, for the purposes of this regulation, the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

JI. "Dividends" mean, for the purposes of this regulation, both policyholder and stockholder dividends.

KJ. "Effective date" means, for the purposes of this regulation, the specific date that the filed or approved rates can be charged to an individual or group.

LK. "Essential health benefit" and "EHB" shall have the same meaning as found at § 10-16-102(22), C.R.S.

ML. "Essential health benefits package" and "EHB package" shall have the same meaning as found at § 10-16-102(23), C.R.S.

NM. "Excessive rates" mean, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided, or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of any additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

ON. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

PO. "Expanded bronze plan" means, for the purposes of this regulation, a bronze plan that provides coverage for at least one (1) major service, other than preventive services, prior to meeting the deductible, or meets the requirements to qualify as a high deductible health plan under 26 U.S.C 223(c)(2), as established at 45 C.F.R. § 156.140(c) with a bronze actuarial value of 60%.

QP. “Federal Actuarial Value Calculator” or AVC means, for the purposes of this regulation, the AV calculator required pursuant to 45 C.F.R. § 156.135(a).

RQ. “File and Uuse” means, for the purposes of this regulation, a filing procedure that does not require approval by the Commissioner prior that requires rates and rating data to be filed with the Division concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage using the rates until on or after the proposed effective date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed effective date of the rate change.

SR. “Filed rate” means, for the purposes of this regulation, the index rate as adjusted for plan design and the case characteristics of age, geographic location, tobacco use and family size only. The “filed rate” does not include the index rate as further adjusted for any other case characteristic.

TS. “Filing date” means, for the purposes of this regulation, the day the rate filing is received at the Division.

UT. “Geographic area” means, for the purposes of this regulation, the geographic area selected by Colorado and approved by the federal government, to be used by carriers in the state of Colorado.

VU. “Grandfathered health benefit plan” shall have the same meaning as found at § 10-16-102(31), C.R.S.

WV. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

XW. “HHS” means, for the purposes of this regulation, the United States Department of Health and Human Services.

YX. “HIOS” means, for the purposes of this regulation, CMS’ Health Insurance and Oversight System.

ZY. “IBNR” means, for the purposes of this regulation, incurred but not reported.

AAZ. “Inadequate rates” mean, for the purposes of this regulation, rates that are insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the Commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The Commissioner may require the submission of additional relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

ABA. “Index rate” shall have the same meaning as found at § 10-16-102(39), C.R.S.

ACB. “Induced Demand Factor” means, for the purposes of this regulation, the anticipated induced demand associated with the health benefit plan’s cost sharing (metal) level.

ADC. “MHPAEA” shall have the same meaning as found at § 10-16-102(43.5), C.R.S.

AED. “Medical Loss Ratio” or “MLR” shall mean the medical loss ratio as set forth in 42 U.S.C. § 300gg-18(b)(1)(A).

AFE. “New policy form” and “new policy form and/or product” mean, for the purposes of this regulation, a policy form that has substantially different new benefits or unique characteristics associated with risk or costs that are different from existing policy forms or revised policy forms. Examples include but are not limited to the following: A guaranteed issue policy form is different than an underwritten policy form; a managed care policy form is different than a non-managed care policy form; a direct written policy form is different from a policy sold using producers, etc.

AGF. “NGF” means, for the purposes of this regulation, a non-grandfathered health benefit plan.

AHG. “Plan” means, for the purposes of this regulation, the pairing of the health insurance coverage benefits under the product with a particular cost sharing structure, provider network, and service area.

AIH. “Premium” shall have the same meaning as found at § 10-16-102(51), C.R.S.

AJ. “Product(s)” means, for the purposes of this regulation, a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, etc.) within a service area.

AK. “PMPM” means, for the purposes of this regulation, per-member, per-month.

AL. “Qualified actuary” means, for the purposes of this regulation, a member of the American Academy of Actuaries, or a person who has demonstrated to the satisfaction of the Commissioner that the person has sufficient educational background and who has not less than seven (7) years of recent actuarial experience relevant to the area of qualification, as defined in Colorado Insurance Regulation 1-1-1.

AM. “Rate” means, for the purposes of this regulation, the amount of money a carrier charges as a condition of providing health coverage. The rate charged normally reflects such factors as the carrier’s expectation of the insured’s future claim costs; the insured’s share of the carrier’s claim settlement; operational and general expenses; and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract.

AN. “Rate filing” means, for the purposes of this regulation, a filing(s) that contains all of the items required in this regulation, ~~and~~ including the proposed base rates and all rating factors, the underlying rating assumptions, support for new product offerings and all changes in existing rates, factors and assumptions utilized, including the continued use of trend factors.

~~1.~~ ~~For individual products, the proposed base rates and all rating factors. The underlying rating assumptions shall be submitted. Support for all changes in existing rates, factors and assumptions shall be provided, including the continued use of previously filed trend factors. Support for new product offerings shall be provided; and~~

~~2. For group products, proposed base rates, the underlying rating factors and assumptions. Support for all changes in existing rates, factors and assumptions shall be provided, including the continued use of previously filed trend factors. Support for new product offerings shall be provided. Groups shall meet the definition contained in §§ 10-16-214(1) and 10-16-215, C.R.S.~~

AO. “Rate increase” shall have the same meaning as found at § 10-16-102(57), C.R.S., and includes increases in any current rate or factor used to calculate rates for new or existing policyholders, members, or certificate holders.

AP. “Rating period” shall have the same meaning as found at § 10-16-102(58), C.R.S.

AQ. “Renewed" means, for the purposes of this regulation, a plan renewed upon the occurrence of the earliest of: the annual anniversary date of issue; the date on which ~~premium~~ rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan. ~~If the plan specifically allows for a change in premiums or benefits due to changes in state or federal requirements, and a change in the health benefit and standalone pediatric dental plan premiums or benefits that is solely due to changes in state or federal requirements, and is not considered a renewal in the plan, then such a change will not be considered a renewal for the purposes of this regulation.~~

AR. “Retention” means, for the purposes of this regulation, the sum of all non-claim expenses, investment income from reserves, ~~including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses~~, and profit/contingency load~~)~~ as a~~the~~ percentage of total premium.

AS. “Review and Approval” means, for the purposes of this regulation, a filing procedure that requires a rate change be affirmatively approved by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate.

AT. “SERFF” means, for the purposes of this regulation, System for Electronic Rates and Forms Filing.

AU. “Silver plan variation” means, for the purposes of this regulation, the three (3) silver plan variations that shall be submitted to the Division for review to ensure compliance with ~~§~~ 45 C.F.R § 156.420(a).

AV. “Stand-alone dental plan” or “SADP” means, for the purposes of this regulation, a dental plan that covers the pediatric dental benefits required by § 10-16-102(22)(b)(VII) and Colorado Insurance Regulation 4-2-42 Section 5.A.2.

AW. “Student health insurance coverage” shall have the same meaning as found at § 10-16-102(65), C.R.S.

AX. "Substantially different new benefit” means, for the purposes of this regulation, a new benefit which results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost-sharing options (i.e., deductibles and copayments) to what is offered as an existing product does not create a new benefit. Actuarial value is the change in benefit cost as developed when making other benefit relativity adjustments.

AY. “Trend” or “trending” means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing. Trend used solely for restating historical experience from the experience period to the rating period, or which is used to project morbidity, is considered a rating assumption.

AZ. “Trend factor(s)” means, for the purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and which reflect any of the components of medical, pharmacy, or insurance trend assumptions used in pricing. ~~Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and technology. Insurance trend includes the effect of underwriting wear-off, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Rate filings shall be submitted on an annual basis to support the continued use of trend factors. Underwriting wear-off does not apply to guaranteed issue products.~~

BA. "Unfairly discriminatory rates" mean, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or, if after allowing for practical limitations, differences in rates which fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

BB. "Unique Plan Design" means, for the purposes of the regulation, a plan which has benefits that are incompatible with the parameters of the federal Actuarial Value Calculator (AVC) and their materiality.

BC. "Use of the rates" ~~or "using the rates"~~ means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to producers and disclosing premium quotes. Rates shall be filed with the Division and forms, as required by § 10-16-107.2, C.R.S., shall be filed prior to use. It does not include releasing information about the proposed rate change to other government entities or disclosing general information about the rate change to the public.

BD. "WNRAR Project" means, for the purposes of this regulation, the Wakely National Risk Adjustment Reporting project.

Section 5 General Rate Filing Requirements

A. Rate Filings ~~Types~~

1. All Filings except Stand-Alone Dental Plans

a. New Products: All New Product Filings are considered File & Use. Carriers must submit rate filings to the Division prior to usage.

b. Existing Products:

(1) Any existing product without any Colorado policyholder receiving a rate increase is considered File & Use.

(2) If any Colorado policyholder is projected to receive an increase, the filing is considered Review & Approval.

2. Stand-Alone Dental Plan Filings

a. New Products: All New Product Filings are considered File & Use. Carriers must submit rate filings to the Division prior to usage.

b. Existing Products:

(1) Any existing products with all Colorado policyholders receiving a rate increase under five (5) percent are considered File & Use.

(2) If any Colorado policyholder is projected to receive an increase of five (5) percent or more, the filing is considered Review & Approval.

(3) All dental coverage plans must submit an annual dental loss ratio filing to comply with § 10-16-165, C.R.S. beginning in 2024 and due on July 31, with the first filing due July 31, 2024. This submission must include the

Dental Loss Ratio form described in § 10-16-165, C.R.S. and prescribed by the Commissioner.

~~1.~~ ~~Review and Approval: Any proposed increase for health benefit plans or an annual rate increase of 5% or more for dental insurance, which is any increase in any base rate, any rating factor, or the continuation of trend, is subject to review and approval by the Commissioner and shall be filed with the Division.~~

~~To determine if the filing is subject to review and approval, calculations shall reflect both the twelve (12) month cumulative impact of trend and any changes to rating factors or base rates.~~

~~2.~~ ~~File and Use: Any new product, or existing product that does not contain a proposed increase, is not subject to review and approval by the Commissioner and shall be filed with the Division.~~

~~To determine if the filing is subject to file and use, calculations shall reflect both the twelve (12) month cumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates during the filed rating period, then the filing would be considered as file and use.~~

B. Timing and General Rate Filing Requirements

1. Carrier Requirements

a. Carriers shall submit rate filings for R~~r~~eview and A~~a~~pproval to the Commissioner at least sixty (60) days prior to the proposed effective date of the rates.

b. Carriers shall submit File and Use rate filings at least one (1) day prior to the effective date requested. ~~For new products and annual filings that are not experiencing a rate increase, carriers shall submit file and use rate filings at least one day prior to the effective date.~~

c. Filings that are resubmissions of previously withdrawn, rejected or disapproved rate filings shall be considered new filings.

2. Rate Filing Deadlines

a. Rate Review Deadlines

(1) The filing shall be reviewed for completeness and, if found incomplete, the Commissioner may reject or disapprove the filing within the first thirty (30) calendar days of the review period. If the Commissioner has not rejected or disapproved the filing on or before the thirtieth (30) day, the filing shall be considered complete.

(2) For rates subject to File and Use: any deficiencies identified by the Commissioner past 30 days after filing shall be corrected on a prospective basis. Any rate deficiency identified, including but not limited to the requirements of § 10-16-107(3), C.R.S., may be subject to a penalty if the violation is determined to be willful. Violations may include, but are not limited to, rates found to be excessive, inadequate or unfairly discriminatory. ~~If the Commissioner reviews the filing for substantive content, any deficiencies identified shall be corrected on a prospective basis. Any rate deficiency identified, including but not limited to the~~

~~requirements of § 10-16-107(3), C.R.S., may be subject to a penalty if the violation is determined to be willful. Violations may include, but are not limited to, rates that are found to be excessive, inadequate or unfairly discriminatory~~.

(3) For rates subject to Review and Approval~~, if the Commissioner does not approve or disapprove a rate filing within sixty (60) days of the filing date, the carrier may implement and reasonably rely on the rates~~:

(a) If the Commissioner approves the rate filing within sixty (60) calendar days of the filing date, the carrier may utilize the rates for business effective on the effective date requested or later. Under no circumstances shall the carrier use the rates prior to the effective date requested specified in the rate filing.

(b) If the Commissioner does not approve or disapprove a rate filing within sixty (60) days of the filing date, the carrier may implement and reasonably rely on the rates. Any deficiencies identified by the Commissioner past 60 days after filing shall be corrected on a prospective basis.

(4) Withdrawn, Rejected or Disapproved Filings: Rates for withdrawn, rejected or disapproved filings shall not be used or distributed. Use of rates in rate filings that are withdrawn, rejected or disapproved shall constitute a violation of Colorado law.

(5) Rates Not on File

(a) Rates not on file with the Division, including the continued use of trend factors beyond twelve (12) months, are deemed to be unfiled rates, which is a violation of Colorado law. Any rates or rating factors not on file with the Division shall not be used.

(b) Failure to file a compliant rate filing shall render the carrier as using unfiled rates and the Division may take appropriate action as allowed by Colorado law. ~~b.~~

b. The Division will utilize the following, as provided in § 2-4-108, C.R.S.:

(1) To determine the start of the thirty (30) and sixty (60) calendar day period, the day after the filing date will be utilized. For example, if a filing is submitted in SERFF on June 1, the review period will begin on June 2, regardless of the day of the week.

(2) If the thirtieth (30) or sixtieth (60) calendar day falls on a Saturday, Sunday, or legal holiday, the review period will be extended to the next business day which is not a Saturday, Sunday, or legal holiday. For example, if the 60-day expires on July 4, the review period will be extended to July 5, as long as July 5 falls on a business day.

3. Rate Filing Guidelines and Review Guidelines

a. General Rate Filing Requirements

(1) Rates for~~on~~ all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health care coverage, shall be filed with the Division prior to the marketing, issuance or deliverance of coverage.

(2) All carriers shall submit a compliant rate filing whenever the rates to be charged to new policyholders or certificate holders differ from the rates on file with the Division. Included in this requirement are the following changes:

(a) Periodic experience submission ~~recalculation of experience~~;

(b) Change in rate calculation methodology or factor values;

(c) Continuing to use previously filed trend or proposing revised trend; and/or~~Changes in the trend; and/or~~

(d) Other changes in rating assumptions.

(3) All carriers shall submit a compliant rate filing on at least an annual basis to support the continued use of trend factors which change on a pre~~-~~determined basis. Trend factors that~~which~~ change on a predetermined basis can be continued for no more than a period of twelve (12) months. To continue the use of trend factors, ~~that change on a predetermined basis,~~ a filing shall be submitted for that particular form with an effective date within one (1) year of the implementation of the most recent approved rate filings.

(4) All carriers shall submit a compliant rate filing when the rates are changed on an existing product even if the rate change pertains to new business only.

(5) All carriers shall submit a compliant rate filing within sixty (60) calendar days after Commissioner approval of the assumption, acquisition or merger of a block of business.

(6) Each line of business requires a separate rate filing. Rate filings shall not be combined with form filings.

(7) All carriers are expected to review their experience on a regular basis, no less than annually, and file revisions, as appropriate and in a timely manner, to ensure that rates are not excessive, inadequate or unfairly discriminatory and to avoid filing large rate changes.

(8) Carriers shall not represent an existing product to be a new policy form, or product, unless it fits the definition set forth in Section 4.X. of this regulation.

(9) A separate filing shall be submitted for each carrier. A single filing made for more than one carrier, or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/Indemnity/Point of Service plan.

(10) Small group health benefit plan rate filings shall not be combined with either individual or large group health benefit rate filings.

b. General Elements of Rate Filings

(1) All rate filings shall be filed electronically in SERFF using a format made available by the Division, unless exempted by rule for an emergency situation as determined by the Commissioner.

(2) The rate filing shall demonstrate that the proposed rates are not excessive, inadequate, or unfairly discriminatory.

(3) The rate filing shall contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate.

(4) The rate filing shall contain Colorado experience.

(5) If Colorado experience is partially credible, similar coverage and/or nationwide experience shall also be submitted in the rate filing.

(6) For an acquisition or merger, the acquiring or assuming carrier shall provide support for the rating factors, even if there is no change in the rating factors. The new filing shall demonstrate that the rating assumptions are still appropriate.

(7) The Form Schedule tab in SERFF shall be completed for all rate filings. This tab shall list all policies, riders, endorsements, or certificates affected by the rate filing. Actual forms shall not be attached to the rate filing.

(8) The Effective Date Requested field on the General Information tab in SERFF shall be completed with a specific date. Using a notation such as "On Approval" is not a valid response.

(9) The Commissioner may require submission of any relevant information deemed necessary in determining whether to approve or disapprove a rate filing.

c. Rate Filing Disapproval: The Commissioner shall disapprove the rate filing if any of the following apply:

(1) The benefits provided are not reasonable in relation to the premiums charged;

(2) The rate filing contains rates that are excessive, inadequate, unfairly discriminatory;

(3) The data and/or actuarial support do not justify the requested rate increase;

(4) The rate filing is incomplete;

(5) The data in the filing fails to adequately support the proposed rates;

(6) The rate filing fails to demonstrate compliance with MHPAEA as required under Colorado Insurance Regulation 4-2-64; or

(7) The rate filing ~~Otherwise d~~does not comply with the provisions of this regulation.

~~4. Rate Usage Guidelines~~

~~a. Review and Approval~~

~~(1) If the Commissioner approves the rate filing within sixty (60) calendar days, as specified in Section 5.B.2.a. of this regulation, the carrier may utilize the rates for business effective on the effective date or later. Under no circumstances shall the carrier provide insurance coverage using the rates until on or after the proposed effective date specified in the rate filing.~~

~~(2) Carriers are permitted to bill and require payment for new rates prior to the effective date requested; however, carriers shall not use the new rates, bill or require payment from consumers with an effective date prior to the effective date requested.~~

~~b. File and Use: Carriers shall not use the rates sooner than the day after the filing date. Correction of any deficiency shall be on a prospective basis.~~

~~c. Withdrawn, Rejected or Disapproved Filings: Rates for filings that are withdrawn, rejected or disapproved shall not be used or distributed. Use of rates in rate filings that are withdrawn, rejected or disapproved shall constitute a violation of Colorado law.~~

~~d. Rates Not on File~~

~~(1) Any rates or rating factors that are not on file with the Division shall not be used.~~

~~(2) Failure to file a compliant rate filing shall render the carrier as using unfiled rates and the Division will take appropriate action as allowed by Colorado law.~~

~~(3) Rates not on file with the Division, including the continued use of rates beyond one year, are deemed to be unfiled rates, which is a violation of Colorado law under § 10-16-107, C.R.S.~~

4~~5~~. Confidentiality

a. All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S.

b. The Division does not consider the following as confidential; including, but not limited to:

(1) Rates

(2) All base rating factors applied to develop an individual's, a family's, a university's or an employer's rates

(3) All required experience period data, including trend data

(4) Support for general expenses for detailed expense categories as needed to verify expense loads

(5) Required information in the actuarial memorandum.

c. The entire filing, including the actuarial memorandum, shall not~~cannot~~ be held as confidential.

d. There shall be a separate SERFF component for the confidential exhibits, which shall be indicated as such by the confidential icon in SERFF.

e. A "Confidentiality Index" shall be completed if the carrier desires confidential treatment of any information submitted. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected.

5~~6~~. Interest and Penalty Payments:

Any interest, penalties, settlements, or other additional payments as defined in ~~and penalty payments that a carrier makes pursuant to~~ § 10-16-106.5(5), C.R.S., ~~shall not be included in the carrier's experience used for rate setting~~ shall be excluded entirely from the development of rates in any rate filing submission.

Section 6 Individual and Small Group Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: the Colorado Actuarial Memorandum (Narrative) and a 4-2-39 Template (Excel spreadsheet). The narrative, template and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. ~~The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative, and a completed Regulation 4-2-39 Excel Template, supplied by the Division in SERFF. The Excel template is provided in SERFF, labeled "Regulation 4-2-39 Template." Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.~~

1. Colorado Actuarial Memorandum (Narrative): Carriers shall supply all items in this section in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The following items, at a minimum, must be provided in the narrative:

a. Summary: The narrative shall contain a summary that includes, but is not limited to, the following:

(1) Reason(s) for the rate filing: The carriers shall provide a statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new

option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

(2) Requested Rate Action: The overall rate increase or decrease shall be provided. Increases or decreases to the following rate components, at a minimum, shall also be provided:

(a) Base Rate Change

(b) Trend Requested

(c) Benefit Factor Change

(d) Area Factor Change

(e) MHPAEA Compliance

(f) Law and Regulation Changes

(3) Overall Rate Action: Identify the overall, minimum, and maximum rate percentage changes.

(4) Marketing Method(s): Note whether the product is marketed through producers, internet, direct response, or other sources. If product is marketed through other sources, specify the sources.

(5) Premium Classification: Note the factors which apply to the rate. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

(6) Product Descriptions: Describe the benefits provided by the policy, or contract in the narrative. This section shall include Essential Health Benefits (EHBs) and list any substitution of benefits or any additional benefits provided above the required EHB.

(7) Policy or Contract: All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

b. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the narrative shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

c. Coordination of Benefits and/or Subrogation:

The narrative shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

d. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period is one (1) year.

(1) Individual Market: Individual health benefit plan rates shall be filed annually, by a date specified by the Commissioner, with an effective date of January 1. The rating period shall be twelve (12) months and premiums cannot change throughout the year.

(2) Small Group Market: Small group health benefit plan rates shall be filed annually, by a date specified by the Commissioner, with an effective date of January 1. Rating periods shall not be more than twelve (12) months. A carrier shall treat all health benefit plans issued or renewed in the same calendar quarter as having the same rating period. Rates in the annual filing may be trended quarterly. Small group health benefit plan rates shall be filed no more frequently than quarterly.

e. Rate History~~:~~

(1) The narrative shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) filings approved immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

(2) This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

(3) This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

f. Experience:

The narrative shall include a discussion of the experience data used for establishing the proposed rate. All justification and support for the experience data which is not provided as part of the Excel spreadsheet shall be provided in this section of the narrative.

g. Credibility: The narrative shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

(1) Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

(2) The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

(3) The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

(4) The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

(5) The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

h. Federal Medical Loss Ratio (MLR):

Medical carriers shall provide a calculation of the federal medical loss ratio (MLR) for the three (3) most recently completed calendar years and a projected MLR for the current calendar year showing all allowable adjustments in the numerator and denominator.

(1) The carrier shall indicate all adjustments allowed in the minimum MLR calculation that will be used to reach the minimum required MLR.

(2) The minimum MLR requirement is pursuant to 42 U.S.C. § (b)(1)(A)(ii).

(3) Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

(4) For the purpose of determining whether a carrier is meeting the MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

i. Trend:

The narrative shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported.

j. Risk Adjustment:

The narrative shall include a section with a complete explanation as to how the risk adjustment transfer amounts and factors were developed.

k. Complete Explanation as to how the Proposed Rates were Determined:

The narrative shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions,

with detailed support for each assumption. The Division may return a rate filing if support for any rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The narrative shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums, with additional exhibits as necessary to fully demonstrate how the rates were developed.

(1) Rate Development Requirements

(a) Carriers shall develop a single market-wide index rate for the individual and small group single risk pool plans it offers. The index rate for a market segment (individual or small group) shall be based on the total combined EHB claims experience of all enrollees in all single risk pool plans in the respective individual and small group single risk pool.

(b) After setting the Index Rate, the carrier shall make market-wide adjustments for each of the following:

(i) The expected aggregated payments and charges under the federal risk adjustment program;

(ii) The expected reimbursements from the Colorado Reinsurance Program under § 10-16-1105, C.R.S.; and

(iii) The Exchange user fees.

(c) The rate for any given plan shall not vary from the resulting adjusted market-wide Index Rate, except for the following factors:

(i) The actuarial value and cost-sharing structure of the plan;

(ii) The plan's provider network;

(iii) Delivery system characteristics; If the delivery system characteristics factor is not equal to 1, the carrier shall explain what is included in the delivery system characteristics factor within the narrative.

(iv) Utilization management practices;

(v) Plan benefits in addition to EHB; and

(vi) With respect to catastrophic plans - the expected impact of specific eligibility categories for those plans.

(d) The Index Rate, the market-wide adjustment to the Index Rate, and the plan-specific adjustments shall be actuarially justified and implemented transparently, consistent with federal and state rate review processes.

(2) Market Wide Index Rate

(a) Market-wide index rate (average rate) shall be:

(i) Based on EHB claims experience of all enrollees in all health benefit plans in the single risk pool, where carriers shall provide EHBs and essential health care benefit packages,

(ii) Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees; and

(iii) Index rates may be developed separately for supplemental stand-alone benefits, and all such similar benefits are pooled for setting the respective index rate.

(b) Rates on an individual policy issued on or after January 1, 2015, are only guaranteed through December 31 of that year. All members will receive new rates on January 1 of the following year. For example, an individual enrolling on October 1, 2022, would have his or her rates in effect until December 31, 2022, and would then be subject to the new rates effective on January 1, 2023.

(3) Market Wide Index Rate Development

(a) Average Projected Benefit Cost Per-Member-Per-Month

(i) The index rate shall initially be set by determining the average benefit cost of all members in the single risk pool in the state. Carriers are expected to consider all of the usual data adjustments and methods in developing the PMPM cost, from their experience, including the following:

(ii) Credibility: Carriers shall determine the credibility levels of the experience being used and adjust appropriately. Carriers shall always discuss actuarial justification for credibility of the data being used.

(iii) Typical methods to deal with experience deemed to be less than 100% credible would be: supplement the Colorado experience with similar national business; or supplement small employer business with other Colorado experience with similar characteristics (membership, network, plan designs).

(b) Large Claims: Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

(c) Carriers shall support and provide estimates for the IBNR claims portion of total incurred claims.

(d) Risk Adjustment Payments: For single risk pool individual and small employer business, carriers shall consider estimates of risk adjustment payment transfers either to or from HHS. Carriers with risk profiles of members indicating higher than market risks shall consider adjusting the index rate to reflect receiving payments from the risk adjustment program.

(e) In developing the health cost trend, costs shall be projected to the applicable rating period, assuming an actuarially justifiable health cost trend. For individual business, index rates shall not be trended monthly or quarterly through any rating period, and index rates shall be the same for each month during a rating period. For small employer businesses, index rates may increase quarterly to reflect trend.

(f) Adjustments for Demographic Mix, Benefit Mix, and Area: Other projected population changes from the experience period to the rating period shall include considerations of changes to the carrier's mix of demographics, benefits, and geographic area.

(4) Benefit Factor Adjustments to the Index Rate

(a) The adjusted index rate may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs.

(i) Differences in the rates for different benefit plans, for enrollees with the same case characteristics of age, geographic location, family size, and tobacco use shall be attributable to plan design only.

(ii) Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan.

(iii) The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features. Using this method, a carrier's benefit factor for a plan design relative to the benefit factor for a richer (leaner) plan design shall be higher (lower).

(b) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans shall be reflected.

(5) Acceptable Case Characteristic Factor Categories

(a) Carriers will be allowed to adjust premiums only for the following factors: self-only or family enrollment, geographic area, age, and tobacco. These factors apply to products offered both inside and outside the Exchange, and for both individual and small group products.

(b) Rates may vary based on whether a plan covers an individual or a family. 42 U.S.C. § 300gg provides that, with respect to family coverage, the rating variation permitted for age and tobacco use shall be applied based on the portion of the premium attributable to each family member covered under a plan.

(c) The per-member rating methodology under 45 C.F.R. § 147.102(c)(1) shall apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member, and no more than three (3) covered children under the age of 21 whose per-member rates can be taken into account in determining the family premium.

(d) Health status and claims experience shall not be used as case characteristics.

(6) Geographic Factors

A complete explanation as to how the geographic factors were developed shall be provided. Health claims may be used in the process of developing geographic factors. As stated in the ACA, rating factors shall not reflect differences in member health status. Geographic rating factors shall only reflect differences in the costs of delivery and shall not include differences for population morbidity by geographic area. Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories in the following table.

Rating Area	**County**
Rating Area 1	Boulder
Rating Area 2	El Paso, Teller
Rating Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Rating Area 4	Larimer
Rating Area 5	Mesa
Rating Area 6	Weld
Rating Area 7	Pueblo
Rating Area 8 (East)	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
Rating Area 9 (West)	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

For a small employer in Colorado, the applicable area factor for each employee is based on the principal business location of the small employer, rather than the residence of each employee.

For an individual policy, the applicable area factor applied to rates for each member is based on the location of the primary policyholder rather than the residence of each family member.

(7) Age Factors

Carriers are required to follow the federal age bands. Age factors and age bands shall be determined based on an enrollee's age on the date of policy issuance or renewal and shall not exceed the 3:1 age ratio. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

(8) Tobacco Use Rate

(a) Carriers may vary tobacco rating by age (for example, a younger enrollee may be charged a lower tobacco use rate than an older enrollee) provided the tobacco use rate does not exceed the non-tobacco use rate by more than 1.15:1.

(b) Carriers in the individual and small group market may remove the tobacco rating factor (as described in 42 U.S.C. § 300gg) for individuals participating in a wellness program.

(c) "Tobacco use" is defined at 45 C.F.R. § 147.102(a)(1)(iv) as the use of a tobacco product or products four (4) or more times per week within, but no longer than, the past six (6) months by legal users of tobacco products (generally those 21 years and older). It includes all tobacco products and clarifies that the term tobacco use does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use shall be defined by carriers in terms of the time since the individual's last use of a tobacco product.

(9) Morbidity

Other projected population changes from the experience period to the rating period shall include considerations of the projected morbidity of insureds entering or leaving the single risk pool. For any morbidity factor used, a complete explanation of development shall be provided.

(10) Exchange User Fees

The development of the plan cost and index rate shall include market-wide adjustments for Exchange user fees.

Carriers shall make a market-wide adjustment to the index rate for Exchange user fees. This will ensure that Exchange user fees are spread evenly across the market, inside and outside the Exchange, and protecting against adverse selection.

(11) Calculating Actuarial Value

(a) The ACA requires carriers offering health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan meets a distinct level of coverage, or actuarial value (AV), specified in section 1302 of the ACA: bronze, expanded bronze, silver, gold, or platinum (also known as "metal levels"). Carriers may also offer catastrophic-only coverage to certain eligible individuals.

AV standards will help consumers compare health benefit plans by providing information about relative plan generosity. The AV standard of a health benefit plan is determined using the following calculation:

$$\frac{\text{(Total Overall Health Costs – Total Enrollee Cost Sharing)}}{\text{Total Overall Health Costs}}$$

AV shall be calculated based on the provision of EHB to a standard population and is presented as a percentage. Additionally, AV determines a health benefit plan's metal level.

The AVs shall meet the metal level requirements and de minimis ranges specified in the most current "Notice of Benefit and Payment Parameters" published by CMS.

(b) To satisfy actuarial value (AV) requirements, carriers are required to use the federal AVC in accordance with 45 C.F.R. § 156.135. In order to assist with this calculation, the SERFF Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP application, HHS recalculates this value to validate that a carrier's plan designs meet AV requirements.

(c) The AVC will be integrated with SERFF so that the Division can evaluate plans for compliance with AV standards on an automated basis. Carriers will first complete the Plans and Benefits Template and submit the information through SERFF; the Plans and Benefits Template will directly populate the AVC to determine a plan's AV and corresponding metal level. A plan's results from the AVC will be displayed automatically in SERFF.

(d) Carriers will determine AV in accordance with 45 C.F.R. § 156.135. The AVC will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discounts or utilization estimates).

(e) If a carrier determines that a material aspect of its plan design cannot be accommodated by the AVC, 45 C.F.R. § 156.135 allows for alternative calculation methods supported by certification of an actuary.

(12) Calculating the Actuarial Value of Unique Plan Designs.

(a) Although the AVC has been designed to accommodate the vast majority of plan designs, there is the possibility that the AVC will not be able to accommodate a small percentage of plan designs. Under 45 C.F.R. § 156.135(b), carriers with plan designs that are not compatible with the AVC shall use an alternate method to calculate AV, as described below. For example, the following types of plan designs would not be compatible with the AVC.

Example 1: A plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent (10%) coinsurance for the first $1,000 in consumer spending after the deductible, 20 percent (20%) coinsurance for the next $1,000 in consumer spending, and 40 percent (40%) coinsurance up to a $6,350 out-of-pocket maximum. This plan design would not be compatible because the current AVC can accommodate only a single coinsurance rate for each benefit.

Example 2: A plan with a multi-tiered provider or hospital network with substantial amounts of utilization expected in tiers other than the two (2) lowest-priced tiers. This plan design would not be compatible because the current AVC does not take into account utilization beyond the second network tier when computing AV.

Generally, a plan design that includes different cost sharing for services not included in the AVC would be considered compatible with the AVC. For example, advanced imaging is a single cost-sharing entry in the AVC; a plan design would not be considered incompatible because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AVC does not consider quantitative or qualitative limits for any benefit, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

(b) To account for plan designs that are incompatible and ensure that requiring the use of the AVC allows for plan innovation, 45 C.F.R. § 156.135(b) provides two (2) alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AVC.

Carriers issuing such plans shall:

(i) Make adjustments to certain key plan design features to enter a modified plan design that fits into the parameters of the AVC, and have an actuary certify that the plan design appropriately fits into the parameters of the AVC; or

(ii) Use the AVC to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the AVC-generated AV to account for remaining plan features. For example, a carrier with reference pricing for prescription drugs could use the AVC to determine the

AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

Both of the AV calculation methods for evaluating incompatible plans designs shall be certified by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. If a carrier uses either of the two (2) alternate methods for calculating AV just described, the carrier shall submit an actuarial certification.

(13) Induced Demand Factor

Induced Demand Factors (IDF) may be reflected in the development of the AV and Cost Sharing Benefit Design in the URRT. The Induced Demand Factors shall be no greater than the value determined by inputting the actuarial value (AV), as determined by the federal AVC, into the formula below:

$$\text{Induced Demand Factor} = 1.24 - AV + AV^2$$

For plans which include members expected to receive Cost Sharing Reductions through plan variants, the applicable plan-level IDF shall be determined by calculating the applicable IDF for each AV variant, then taking an average of the variant-level IDFs weighted by the distribution of projected enrollees within each variant.

I. Retention:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The narrative shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

(1) Retention Percentage:

The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components to be listed shall be provided by the Division in the "Regulation 4-2-39 Template IND and SG" and shall include (but may not be limited to) at least the following:

(a) General expenses;

(b) Commissions and other acquisition expenses (may be separated);

(c) Taxes;

(d) ACA fees;

(e) Health Insurance Affordability Fee required pursuant to § 10-16-1205, C.R.S.; and Colorado Insurance Regulation 4-2-76;

(i) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.);

(ii) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall use exactly 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.);

(f) Other assessments;

(g) Profit and contingencies: Profit and contingency load -may not vary by metal level;

(h) Exchange fees; and

(i) Quality Improvement.

(2) Retention loads shall be spread out across all rates in the single risk pool using the same rating factor. Retention rating factors shall not vary between on-Exchange and off-Exchange plans. Differences in expenses due to Exchange fees shall be spread out across all single risk pooled plans.

(3) Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

(4) Administrative and Other Fees: Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

(5) The carrier shall comply with the following minimum benefit ratios.

Individual Health Benefit Plans	80%
Small Group Health Benefit Plans	80%

m. Effects of Law Changes:

The narrative shall identify, quantify, and adequately support any changes to the proposed rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable statutory or regulatory changes shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

n. Commissions:

The narrative shall discuss whether there are additional payments beyond commissions, such as bonuses and incentives, made to brokers and provide a high-level summary of the payment structure. For individual market carriers, the carriers shall indicate if the commission rates remain the same during the Special Enrollment Period (SEP) and Open Enrollment Period (OEP). If there are any differences in commission rates between SEP and OEP, the narrative shall explain the differences.

o. Interest and Penalty Payments - The narrative shall include:

(1) A chart showing the total interest, penalties, settlements, or other additional payments as defined in § 10-16-106.5(5), C.R.S. the carrier has paid in the three (3) calendar years prior to the filing date, and the current year to date.

(2) An attestation that any such payments have been excluded entirely from the development of rates: including, but not limited to, excluded from the incurred claims in the carrier's experience period used for rate setting and from the projection of administrative expenses.

p. Actuarial Certification:

(1) An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

2. 4-2-39 Template (Excel spreadsheet): Carriers are required to use the Excel spreadsheet provided by the Division, titled "IND SG 4-2-39 Template.", referred to hereafter as the Excel spreadsheet Carriers shall provide detailed data according to the instructions in the Excel spreadsheet.

a. Experience:

The Excel spreadsheet shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes. Required data shall include, but is not limited to:

(1) Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

(2) Premium and number of policyholders may be combined for medical and pharmacy experience.

(3) National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

(4) If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

(5) Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

(6) Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the end date of the experience period shall be no older than six (6) months prior to the filing date.

(7). The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

b. Federal Medical Loss Ratio (MLR):

Medical carriers shall provide a calculation of the MLR for the three (3) most recently completed calendar years and a projected MLR for the current calendar year showing all allowable adjustments in the numerator and denominator.

(1) The minimum MLR requirement is pursuant to 42 U.S.C. § (b)(1)(A)(ii).

(2) Carriers shall apply all allowable adjustments in the MLR calculation.

c. Trend:

Required data shall include, but is not limited to:

(1) The four (4) most recent years of monthly experience data used to evaluate historical trends.

(a) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(b) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

(2) Pharmacy data shall be shown separately from the medical data.

(3) The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

(4) The provided claims experience shall include the following separate data elements for each month:

(a) Actual medical (non-pharmacy) paid on incurred claims;

(b) Total medical incurred claims (including estimated IBNR claims);

(c) Actual pharmacy paid on incurred claims;

(d) Total pharmacy incurred claims (including estimated IBNR claims);

(e) Average covered lives for medical; and,

(f) Average covered lives for pharmacy.

(5) Data elements shall be aggregated into 12-month annual periods, with yearly, PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall also be identified.

d. Risk Adjustment:

(1) The carrier shall provide a comprehensive exhibit that details the following:

(a) The finalized and/or latest best estimate -historical risk adjustment transfer amounts and factors.

(b) The projected risk adjustment transfer amounts and factors for the rating period.

(2) Regardless of the methodology used to estimate the risk adjustment transfer, the following statewide and carrier elements of the transfer formula must be included: average premium per member per month (PMPM), plan liability risk score, actuarial value, allowable rating factor, induced demand factor, and geographic cost factor. Additionally, historical and projected information from the carrier regarding member months, estimated transfer amounts in rate filings, actual transfer amounts, and Risk Adjustment Data Validation (RADV) results shall be provided.

e. Retention:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. Specifically, carriers shall provide, at a minimum, all retention components listed in Section 6.A.1.l.i.

f. Effects of Law Changes:

The quantifiable rating impact for each law or regulation change shall be provided in the Excel spreadsheet.

g. Commissions:

The carrier shall provide a broker commission schedule for both new and renewing sales of Colorado Option Standardized Plans and non-Colorado Option Standardized Plans in the Excel spreadsheet.

h. Plan Adjustment Factors:

The carrier shall provide detailed breakdowns by plan HIOS ID, geographic rating area, exchange status, and qualified individual status for each rate submission, including but not limited to:

(1) Plan Adjustment Factors: geographic rating factors, actuarial value (AV) and cost-sharing, and provider network and delivery system characteristics

(2) Projected Enrollment: projected number of member months.

j. Out of Network Claims Payment:

The carrier shall provide Out of Network claims data for the experience period. This data shall include Out of Network claims payments, and the difference in Out of Network claims payments and premium due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.

~~1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:~~

~~a. Reason(s) for the rate filing: A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated. This information shall be included in the narrative.~~

~~b. Requested Rate Action: The overall rate increase or decrease shall be provided. Increases or decreases to the following rate components, at a minimum, shall also be provided: overall rate increase or decrease shall be. Identify the rate increase or decrease amount for all appropriate items. This shall include at a minimum of the following:~~

~~(1) Base Rate Change~~

~~(2) Trend Requested~~

~~(3) Benefit Factor Change~~

~~(4) Area Factor Change~~

~~(5) MHPAEA Compliance~~

~~(6) Law and Regulation Changes~~

This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

c. Overall Rate Action: Identify the overall, minimum, and maximum rate percentage changes. This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

d. Marketing Method(s): Select all marketing methods used for the filed form. This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

e. Market Type(s): This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

(1) Select the appropriate market type(s). Identify if the product will be sold to associations, trusts, etc., this shall be noted in the narrative.

(2) Small Groups shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or his or her dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

f. Premium Classification: Select all attributes upon which the premium rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas. This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

g. Product Descriptions: Describe the benefits provided by the policy, or contract in the narrative. This section shall include Essential Health Benefits (EHBs) and list any substitution of benefits or any additional benefits provided above the required EHB. This information shall be included in the narrative.

h. Policy or Contract: All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis: Select the appropriate age basis used for the forms. This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

j. Renewability Provision: All health benefit plans are guaranteed renewable. Carriers shall select "guaranteed renewable." This information shall be included in the "Regulation 4-2-39 Template" spreadsheet.

k. Rate Change Distribution: Complete the Rate Distribution table. This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) approvals immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage:

The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components to be listed shall be provided by the Division in the "Regulation 4-2-39 Template IND and SG" and shall include (but may not be limited to) at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Health Insurance Affordability Fee required pursuant to § 10-16-1205, C.R.S.; and Colorado Insurance Regulation 4-2-76.

i) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.)

ii) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall use exactly 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.)

(6) Other assessments;

(7) Profit and contingencies Standardized Plans Standardized;

(8) Exchange fees; and

(9) Quality Improvement

b. Retention loads shall be spread out across all rates in the NGF pool using the same rating factor. Retention rating factors shall not vary between on-Exchange and off-Exchange plans. Differences in expenses due to Exchange fees shall be spread out across all NGF pooled plans.

c. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

d. Administrative and Other Fees: Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

e. The carrier shall comply with the following minimum benefit ratio guidelines.

Individual Health Benefit Plans	80%
Small Group Health Benefit Plans	80%

This information shall be provided in both the narrative and the "Regulation 4-2-39 Template" spreadsheet.

4. Federal Medical Loss Ratio

This information shall be provided in both the narrative and in the "Regulation 4-2-39 Template" spreadsheet.

a. Medical carriers shall provide a calculation of the federal medical loss ratio (MLR) for the two (2) most recently completed calendar years and a projected MLR for the current calendar year showing all allowable adjustments in the numerator and denominator.

b. The carrier shall indicate all adjustments allowed in the minimum MLR calculation that will be used to reach the minimum required MLR.

c. Pursuant to 42 U.S.C. § (b)(1)(A)(ii), the federal minimum MLR requirement is 80% for Individual and Small Group markets.

d. Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

e. For the purposes of determining whether a carrier is meeting the MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

5. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. This information shall be provided in the narrative. In addition, the following information shall be providedincluded in the Regulation 4-2-39 Templateshall:

a. The "Regulation 4-2-39 Template" contains a tab for a summary of trend assumptions. Medical trend assumptions shall be listed separately, and are defined as:

(1) Medical provider price increases;

(2) Utilization changes;

(3) Medical cost shifting;

(4) New medical procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. Pharmaceutical trend assumptions shall be listed separately, and are defined as:

(1) Pharmaceutical price increases;

(2) Pharmacy utilization changes;

(3) Effect of cost shifting;

(4) Introduction of new drugs; and

(5) Other pharmaceutical trend, which means, for the purposes of this section, the combined effect of any other items impacting pharmacy trend that are not captured in items (1) – (4), including the effect of pharmaceutical deductible leveraging. The components of the pharmacy trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other pharmaceutical trend. Other pharmaceutical trend shall be fully justified in the rate filing, and described in the narrative.

c. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the "Regulation 4-2-39 Template".

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

d. Pharmacy data shall be shown separately from the medical data.

e. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

f. The provided claims experience shall include the following separate data elements for each month:

(1) Actual medical (non-pharmacy) paid on incurred claims;

(2) Total medical incurred claims (including estimated IBNR claims);

(3) Actual pharmacy paid on incurred claims;

(4) Total pharmacy incurred claims (including estimated IBNR claims);

(5) Average covered lives for medical; and,

(6) Average covered lives for pharmacy.

g. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified in the "Regulation 4-2-39 Template" spreadsheet.

6. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

7. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes. the

a. Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

b. Premium and number of policyholders may be combined for medical and pharmacy experience.

c. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

d. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

e. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

f. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the experience period shall include consecutive data no older than six (6) months prior to the filing date.

g. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined.

Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

8. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the HIOS Plan ID number; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change. If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

9. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

10. Out of Network Claims Payment

For the experience period, the carrier shall provide the following Out of Network claims data:

a. Total number of claims;

b. Aggregate amount of billed charges;

c. Aggregate amount of that would have been paid in the absence of §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

d. Aggregate amount that was paid due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

e. Premium impact of the difference between (c) and (d) for the projection period.

This information shall be provided in the "Regulation 4-2-39 Template" spreadsheet.

11. Effect of Law Changes:

The actuarial memorandum shall identify, quantify, and adequately support any changes to the proposed rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s) in the previous 12 months. All applicable

statutory or regulatory changesrequirements shall be listed, including those with no rating impact. Theis quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The quantifiable rating impact for each law or regulation charge shall be provided in the "Regulation 4-2-39 Template" spreadsheet according to the instructions in that template, and shall be supported in the narrative.

12. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

13. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period is one (1) year.

a. Individual Market: Individual health benefit plan rates shall be filed annually, by a date specified by the Commissioner, with an effective date of January 1. The rating period shall be twelve (12) months and premiums cannot change through the year.

b. Small Group Market: Small group health benefit plan rates shall be filed annually, by a date specified by the Commissioner, with an effective date of January 1. Rating periods shall not be more than twelve (12) months. A carrier shall treat all health benefit plans issued or renewed in the same calendar quarter as having the same rating period. Rates in the annual filing may be trended quarterly. Small group health benefit plan rates shall be filed no more frequently than quarterly.

This information shall be included in the narrative.

14. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

15. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

~~This explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums. This information shall be included in the narrative, with additional exhibits as necessary to fully demonstrate how the rates were developed.~~

~~a. Rate Development Requirements~~

~~(1) Carriers shall develop a single market-wide index rate for the individual and small group NGF plans it offers. The index rate for a market segment (individual or small group) shall be based on the total combined EHB claims experience of all enrollees in all NGF plans in the respective individual and small group single risk pool.~~

~~(2) After setting the Index Rate, the carrier shall make market-wide adjustments for each of the following:~~

~~(a) The expected aggregated payments and charges under the federal risk adjustment program;~~

~~(b) The expected reimbursements from the Colorado Reinsurance Program under § 10-16-1105, C.R.S.; and~~

~~(c) The Exchange user fees.~~

~~(3) The premium rate for any given plan shall not vary from the resulting adjusted market-wide Index Rate, except for the following factors:~~

~~(a) The actuarial value and cost-sharing structure of the plan;~~

~~(b) The plan's provider network;~~

~~(c) Delivery system characteristics;~~

~~(d) Utilization management practices;~~

~~(e) Plan benefits in addition to EHB; and~~

~~(f) With respect to catastrophic plans - the expected impact of specific eligibility categories for those plans.~~

~~(4) The Index Rate, the market-wide adjustment to the Index Rate, and the plan-specific adjustments shall be actuarially justified and implemented transparently, consistent with federal and state rate review processes.~~

~~b. Market Wide Index Rate~~

~~(1) Market-wide index rate (average rate) shall be:~~

~~(a) Based on EHB claims experience of all enrollees in all NGF health benefit plans in the risk pool, where carriers shall provide EHBs and essential health care benefit packages,~~

~~(b) Adjusted for risk adjustment/reinsurance payments and charges, and Exchange user fees; and~~

(c) Index rates may be developed separately for supplemental stand-alone benefits, and all such similar benefits are pooled for setting the respective index rate.

(2) Rates on an individual policy issued on or after January 1, 2015, are only guaranteed through December 31 of that year. All members will receive new rates on January 1 of the following year. For example, an individual enrolling on October 1, 2022 would have his or her rates in effect until December 31, 2022, and would then be subject to the new rates effective on January 1, 2023.

c. Market Wide Index Rate Development

(1) Average Projected Benefit Cost Per Member Per Month

(a) The index rate shall initially be set by determining the average benefit cost of all NGF members in the pool in the state. Carriers are expected to consider all of the usual data adjustments and methods in developing the PMPM cost, from their experience, including the following:

(b) Credibility: Carriers shall determine the credibility levels of the experience being used and adjust appropriately. Carriers shall always discuss actuarial justification for credibility of the data being used.

(c) Typical methods to deal with experience deemed to be less than 100% credible would be:

(i) Supplement the Colorado experience with similar national business; or

(ii) Supplement small employer business with other Colorado experience with similar characteristics (membership, network, plan designs).

(2) Large Claims: Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

(3) Carriers shall support and provide estimates for the IBNR claims portion of total incurred claims.

(4) Risk Adjustment Payments: For NGF individual and small employer business, carriers shall consider estimates of risk adjustment payment transfers either to or from HHS. Carriers with risk profiles of members indicating higher than market risks shall consider adjusting the index rate to reflect receiving payments from the risk adjustment program.

(5) In developing the health cost trend, costs shall be projected to the applicable rating period, assuming an actuarially justifiable health cost trend. For individual business, index rates shall not be trended monthly or quarterly through any rating period, and index rates shall be the same for each month during a rating period. For small employer business, index rates may increase quarterly to reflect trend.

(6) Adjustments for Demographic Mix, Benefit Mix, and Area: Other projected population changes from the experience period to the rating period shall include considerations of newly uninsured policyholders entering the market and grandfathered members moving into NGF products.

(7) Adjustments for underwriting wear-off may be made due to members who were previously underwritten.

d. Benefit Factor Adjustments to the Index Rate

(1) The adjusted index rate as developed from the process in Section 6.N.1. may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs.

(a) Differences in the rates for different benefit plans, for enrollees with the same case characteristics of age, geographic location, family size, and tobacco use shall be attributable to plan design only.

(b) Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan.

(c) The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features. Using this method, a carrier's benefit factor for a plan design relative to the benefit factor for a richer (leaner) plan design shall be higher (lower).

(2) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans shall be reflected.

e. Acceptable Case Characteristic Factor Categories

(1) Carriers will be allowed to adjust premiums only for the following factors: self-only or family enrollment, geographic area, age, and tobacco. These factors apply to products offered both inside and outside the Exchange, and for both individual and small group products.

(2) Rates may vary based on whether a plan covers an individual or a family. 42 U.S.C. § 300gg provides that, with respect to family coverage, the rating variation permitted for age and tobacco use shall be applied based on the portion of the premium attributable to each family member covered under a plan.

(3) The per-member rating methodology under 45 C.F.R. § 147.102(c)(1) shall apply. Per-member rating requires that the age and tobacco use factors be apportioned to each family member, and no more than three (3) covered children under the age of 21 whose per-member rates can be taken into account in determining the family premium.

(4) Health status and claims experience shall not be used as case characteristics

f. Individual Plan Design

The actuarial value of each plan shall be calculated at the individual level in accordance with 45 C.F.R. § 156.135. Carriers shall not calculate the AV at the family level.

g. Geographic Factors

A complete explanation as to how the geographic factors were developed shall be provided. Health claims may be used in the process of developing geographic factors. As stated in the ACA, rating factors shall not reflect differences in member health status. Geographic rating factors shall only reflect differences in the costs of delivery and shall not include differences for population morbidity by geographic area. Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

If a carrier uses geographic location to calculate rates, then it shall use the nine (9) mandatory categories in the following table.

Rating Area	**County**
Rating Area 1	Boulder
Rating Area 2	El Paso, Teller
Rating Area 3	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
Rating Area 4	Larimer
Rating Area 5	Mesa
Rating Area 6	Weld
Rating Area 7	Pueblo
Rating Area 8 (East)	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
Rating Area 9 (West)	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

For a small employer in Colorado, the applicable area factor for each employee is based on the principal business location of the small employer, rather than the residence of each employee.

For an individual policy, the applicable area factor applied to rates for each member is based on the location of the primary policyholder rather than the residence of each family member.

h. Age Factors

Carriers are required to follow the federal age bands. Age factors and age bands shall be determined based on an enrollee's age on the date of policy issuance or

renewal and shall not exceed the 3:1 age ratio. For individuals who are added to the plan or coverage on a date other than the date of policy issuance or renewal, the enrollee's age is determined as of the date such individuals are added or enrolled in the coverage.

Children: A single age band covering children 0 through 14 years of age, where all premium rates are the same.

Children and Adults: One-year age bands starting at age 15 and ending at age 63.

Older adults: A single age band covering individuals 64 years of age and older, where all premium rates are the same.

The following are the federal age band requirements:

AGE	PREMIUM RATIO	AGE	PREMIUM RATIO	AGE	PREMIUM RATIO
0-14	0.765	31	1.159	48	1.635
15	0.833	32	1.183	49	1.706
16	0.859	33	1.198	50	1.786
17	0.885	34	1.214	51	1.865
18	0.913	35	1.222	52	1.952
19	0.941	36	1.230	53	2.040
20	0.970	37	1.238	54	2.135
21	1.000	38	1.246	55	2.230
22	1.000	39	1.262	56	2.333
23	1.000	40	1.278	57	2.437
24	1.000	41	1.302	58	2.548
25	1.004	42	1.325	59	2.603
26	1.024	43	1.357	60	2.714
27	1.048	44	1.397	61	2.810
28	1.087	45	1.444	62	2.873
29	1.119	46	1.500	63	2.952
30	1.135	47	1.563	64 and Older	3.000

i. Tobacco Use Rate

(1) Carriers may vary tobacco rating by age (for example, a younger enrollee may be charged a lower tobacco use rate than an older enrollee) provided the tobacco use rate does not exceed the non-tobacco use rate by more than 1.15:1.

(2) Carriers in the individual and small group market may remove the tobacco rating factor (as described in 42 U.S.C. § 300gg) for individuals participating in a wellness program.

(3) "Tobacco use" is defined at 45 C.F.R. § 147.102(a)(1)(iv) as the use of a tobacco product or products four (4) or more times per week within, but no longer than, the past six (6) months by legal users of tobacco products (generally those 21 years and older). It includes all tobacco products and clarifies that the term tobacco use does not include religious or ceremonial uses of tobacco (for example, by American Indians and Alaska Natives). Tobacco use shall be defined by carriers in terms of the time since the individual's last use of a tobacco product.

j. Family Size Categories

(1) All adults can be rated based on their age.

(2) Up to 3 children (oldest), under the age of 21 can be rated. This includes child only coverage.

k. Morbidity

Other projected population changes from the experience period to the rating period shall include considerations of projected newly insureds entering the market and grandfathered members moving into NGF products. For any morbidity factor used, a complete explanation of development shall be provided.

l. Exchange User Fees

The development of the plan cost and index rate shall include market-wide adjustments for Exchange user fees.

Carriers shall make a market-wide adjustment to the index rate for Exchange user fees. This will ensure that Exchange user fees are spread evenly across the market, inside and outside the Exchange, and protecting against adverse selection.

m. Calculating Actuarial Value

The ACA requires carriers offering NGF health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered plan meets a distinct level of coverage, or actuarial value (AV), specified in section 1302 of the ACA: bronze, expanded bronze, silver, gold, or platinum (also known as "metal tiers"). Carriers may also offer catastrophic-only coverage to certain eligible individuals.

AV standards will help consumers compare health benefit plans by providing information about relative plan generosity. The AV standard of a health benefit plan is determined using the following calculation:

$$\frac{\text{(Total Overall Health Costs – Total Enrollee Cost Sharing)}}{\text{Total Overall Health Costs}}$$

AV shall be calculated based on the provision of EHB to a standard population and is presented as a percentage. Additionally, AV determines a health benefit

plan's metal level tier. The ACA directs that NGF individual and small group plans inside and outside the Exchanges meet specific AV targets (or be a catastrophic plan):

Bronze = 60% AV

Silver = 70% AV

Gold = 80% AV

Platinum = 90% AV

These targets allow for a de minimis range of -4% / +2% points

On-Exchange individual silver plans are allowed a de minimis range of -2% / +2%

An acceptable de minimis range of -4% / +5% points is allowed for an expanded bronze plan.

An acceptable de minimis range of -1%/+1% points is allowed for a silver plan variation.

n. Calculating the Actuarial Value

(1) To satisfy actuarial value (AV) requirements, carriers are required to use the federal AVC in accordance with 45 C.F.R. § 156.135. In order to assist with this calculation, the SERFF Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP application, HHS recalculates this value to validate that a carrier's plan designs meet AV requirements.

(2) The AVC will be integrated with SERFF so that the Division can evaluate plans for compliance with AV standards on an automated basis. Carriers will first complete the Plans and Benefits Template and submit the information through SERFF; the Plans and Benefits Template will directly populate the AVC to determine a plan's AV and corresponding metal tier. A plan's results from the AVC will be displayed automatically in SERFF.

(3) Carriers will determine AV in accordance with 45 C.F.R. § 156.135. The AVC will guarantee plans with the same cost sharing structure will have the same actuarial value (regardless of plan discounts or utilization estimates).

(4) If a carrier determines that a material aspect of its plan design cannot be accommodated by the AVC, 45 C.F.R. § 156.135allows for alternative calculation methods supported by certification of an actuary.

o. Calculating the Actuarial Value of Unique Plan Designs.

(1) Although the AVC has been designed to accommodate the vast majority of plan designs, there is the possibility that the AVC will not be able to accommodate a small percentage of plan designs. Under 45 C.F.R. § 156.135(b), carriers with plan designs that are not compatible with the AVC shall use an alternate method to calculate AV, as described below.

For example, the following types of plan designs would not be compatible with the AVC.

Example 1: A plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10 percent (10%) coinsurance for the first $1,000 in consumer spending after the deductible, 20 percent (20%) coinsurance for the next $1,000 in consumer spending, and 40 percent (40%) coinsurance up to a $6,350 out-of-pocket maximum. This plan design would not be compatible because the current AVC can accommodate only a single coinsurance rate for each benefit.

Example 2: A plan with a multi-tiered provider or hospital network with substantial amounts of utilization expected in tiers other than the two (2) lowest-priced tiers. This plan design would not be compatible because the current AVC does not take into account utilization beyond the second network tier when computing AV.

Generally, a plan design that includes different cost sharing for services not included in the AVC would be considered compatible with the AVC. For example, advanced imaging is a single cost-sharing entry in the AVC; a plan design would not be considered incompatible because it assigns different copayment amounts to different types of imaging (e.g., MRI versus CT). Similarly, because the AVC does not consider quantitative or qualitative limits for any benefit, the application of limits to a particular benefit would generally not necessitate one of the alternative methods for AV calculation.

(2) To account for plan designs that are incompatible and ensure that requiring the use of the AVC allows for plan innovation, 45 C.F.R. § 156.135(b) provides two (2) alternative methods of calculating AV for plans that cannot meaningfully fit within the parameters of the AVC.

Carriers issuing such plans shall:

(a) Make adjustments to certain key plan design features to enter a modified plan design that fits into the parameters of the AVC, and have an actuary certify that the plan design appropriately fits into the parameters of the AVC; or

(b) Use the AVC to determine the AV for plan provisions that do fit within its parameters, and then have an actuary calculate appropriate adjustments to the AVC-generated AV to account for remaining plan features. For example, a carrier with reference pricing for prescription drugs could use the AVC to determine the AV for the medical benefits in its plan and then make adjustments to reflect its prescription drug benefits.

Both of the AV calculation methods for evaluating incompatible plans designs shall be certified by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. If a carrier uses either of the two (2) alternate methods for calculating AV just described, the carrier shall submit an actuarial certification.

p. Induced Demand Factor

Induced Demand Factors (IDF) may be reflected in the development of the AV and Cost Sharing Benefit Design in the URRT. The Induced Demand Factors shall be no greater than the value determined by inputting the actuarial value (AV), as determined by the federal AVC, into the formula below:

$$\text{Induced Demand Factor} = 1.24 - AV + AV^2$$

q. Small Group Composite Rating

(1) Small group carriers may offer small group rates calculated using a four-tier family rate and, in addition or in the alternative, may offer small groups individual rates calculated for each employee pursuant to Section 6 N. of this regulation. If a small group carrier offers composite rating, the carrier shall offer the small group the choice of both individually-rated employees and composite rates, at initial application and each renewal.

(2) If a small group carrier offers both rating methodologies for a plan, the small group carrier shall ensure that:

(a) Both methods are offered to every small group, with differences between methodologies clearly explained in writing; or

(b) Every small group shall be given a written option to indicate in check-off form, or other similar form, in the application or renewal application, that:

(i) Both rating methods need to be presented;

(ii) Only rates for individual employees need to be presented; or

(iii) Only the composite rate needs to be presented.

(3) Small group carriers may offer small groups four-tier composite rates as an alternative to rates calculated individually for each employee. If the small group carrier offers composite rating, the carrier shall make the same offer for all plans.

(4) Calculating Composite Rates

(a) The total premium charged to the small group shall be calculated using the per-member methodology in Section 6 of this regulation. Age, geographic area and tobacco use (if applicable) are determined at the time coverage is issued to the group. The small group's total premium is equal to the sum of the premiums for each covered employee and his/her covered spouse and/or dependents.

(b) Once the small group's total premium has been calculated, it shall be allocated to covered employees based on the tier factor applicable to each employee's family composition. All carriers will use the following standard tier definitions and factors:

~~(i) Employee Only = 1.00~~

~~(ii) Employee and Spouse = 2.00~~

~~(iii) Employee and Child(ren) = 1.85~~

~~(iv) Employee, Spouse, and Child(ren) = 2.85~~

~~(c) Any allowable tobacco use factor shall be allocated separately to the corresponding individual employee or dependent, so the average Employee Only premium does not include any tobacco factor.~~

~~(5) A small group's total composite premium shall equal the sum of the per-member premiums for all covered employees and dependents. In addition, once the composite premiums are computed at the beginning of the plan year, they shall not vary during the plan year, regardless of any census changes within the group.~~

~~(6) If the small group carrier offers composite rating, the Colorado alternative tiered composite premium methodology will be required to be offered to all small groups without regard to size.~~

~~(7) Small group carriers may decide which plans will offer composite premiums and which plans will not.~~

~~(8) Small group carriers offering plans on the Exchange's Small Employer Health Options Program (SHOP) are not required to include the option of composite rating for those small group plans offered on the SHOP, unless and until the Exchange implements the ability for small group carriers to utilize composite rating~~

~~16. Actuarial Certification:~~

~~An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.~~

B. Rating Manual Requirements:

A rating manual shall be submitted to the Division for all products. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided ~~as~~in Excel,~~an Excel~~ in a template which shall be supplied by the Division ~~in SERFF a spreadsheet, separate from the Division "Regulation 4-2-39 Template"~~.

C. Risk Adjustment Support Requirements:

1. To support risk adjustment assumptions included in the filing, if a carrier participates in the WNRAR Project, the carrier shall submit the most recent WNRAR risk adjustment estimates in the spreadsheet format provided to the carrier at the time of the rate filing submission. If a carrier does not participate in the WNRAR Project, the carrier shall submit a detailed exhibit that demonstrates the analysis to arrive at the carrier's risk adjustment assumptions. The Division will hold this information confidential.

2. The Division may request the most up-to-date WNRAR risk adjustment estimates in spreadsheet format at any time. The Division will hold this information confidential.

D~~C~~. Other Rate Filing Requirements:

1. Format: All required reports and documentation shall be submitted through SERFF in a searchable PDF format~~.~~ or, where noted within this regulation, an Excel spreadsheet.~~.~~

2. Submission Requirements for Rate Filings: ~~Carriers shall complete and submit~~ The following information shall be provided in SERFF~~: in order for a rate filing submission to be considered complete~~:

   a. Carriers shall complete all SERFF required data fields.

   b. Carriers shall list all forms associated with the rate filing under the Form Schedule Tab.

      (1) Carriers shall complete all data fields (Form Name, Form Number, Form Type, Action, Readability Score) under this tab.

      (2) Carriers shall attach ~~copies of~~ the actual form documents as part of a rate filing.

   c. Carriers shall attach ~~a copy of~~ the Rate ~~Tables/~~Manual spreadsheet under the Rate/Rule Schedule Tab.

   d. Carriers shall attach ~~attach copies of~~ the following documents under the appropriate tabs~~Supporting Documentation Tab~~ in the Filing (Non-Binder) section in SERFF:

      (1) If a carrier uses a third party to submit a rate and/or form filings on their behalf, a Letter of Authority~~, which shall be attached under the Supporting Documentation Tab in SERFF~~.

      (2) A copy of the Colorado Actuarial Memorandum, which includes all elements contained in Section 6 of this regulation.

      (3) The following documents required by CMS, in accordance with 45 C.F.R. § 154.215:

         (a) Part I – Unified Rate Review Template;

         (b) Part II – Consumer Justification Narrative shall be completed ~~for all rate increases~~if any renewing plan within a product has a rate increase of 15% or more.~~, but is optional for new plans;~~

         (c) Part III – Actuarial Memorandum.

(4) Any applicable justification or attestations forms specified by the Division.

~~e~~. ~~Carriers shall attach copies of the following documents required by CMS under the Supporting Documentation Tab in the Plan Management (Binder) section of SERFF~~

~~(1) Part I - the Unified Rate Review Template; and~~

~~(2) Part II - Consumer Justification Narrative, which shall be completed for all rate increases, but optional for new plans.~~

~~3. The Supplemental Template shall be completed for all Individual and Small Group rate filings. The Supplemental template will be available in SERFF and will be labeled "Supplemental Template." Carriers are required to use the version in SERFF at the time of submission.~~

34. Colorado Option Plans

a. Carriers shall use the Division's Colorado Option Standardized Plans Actuarial Value Certification document, which includes AV screenshots from the current federal AVC and a discussion of the methodology used to determine the final AVs. Carriers shall submit the AV Certification document in the rate filing to demonstrate this reliance.

b. Profit and contingency load may vary between Colorado Option Standardized plans and non-Colorado Option Standardized plans;

c. The profit and contingency load percentage for Colorado Option Standardized plans is limited to no more than two percent ~~15~~(2.0%) of premium.

4. For Individual Plan Design - The actuarial value of each plan shall be calculated at the individual level in accordance with 45 C.F.R. § 156.135. Carriers shall not calculate the AV at the family level.

5. For Small Group Plan Design

a. Family Size Categories

(1) All adults can be rated based on their age.

(2) Up to 3 children (oldest), under the age of 21 can be rated. This includes child only coverage.

b. Small Group Composite Rating

(1) Small group carriers may offer small group rates calculated using a four-tier family rate and, in addition or in the alternative, may offer small groups individual rates calculated for each employee pursuant to Section 6 N. of this regulation. If a small group carrier offers composite rating, the carrier shall offer the small group the choice of both individually-rated employees and composite rates, at initial application and each renewal.

(2) If a small group carrier offers both rating methodologies for a plan, the small group carrier shall ensure that:

(a) Both methods are offered to every small group, with differences between methodologies clearly explained in writing: or

(b) Every small group shall be given a written option to indicate in check-off form, or other similar form, in the application or renewal application, that:

(i) Both rating methods need to be presented;

(ii) Only rates for individual employees need to be presented; or

(iii) Only the composite rate needs to be presented.

(3) Small group carriers may offer small groups four-tier composite rates as an alternative to rates calculated individually for each employee. If the small group carrier offers composite rating, the carrier shall make the same offer for all plans.

(4) Calculating Composite Rates

(a) The total premium charged to the small group shall be calculated using the per-member methodology in Section 6 of this regulation. Age, geographic area and tobacco use (if applicable) are determined at the time coverage is issued to the group. The small group's total premium is equal to the sum of the premiums for each covered employee and his/her covered spouse and/or dependents.

(b) Once the small group's total premium has been calculated, it shall be allocated to covered employees based on the tier factor applicable to each employee's family composition. All carriers will use the following standard tier definitions and factors:

(i) Employee Only = 1.00

(ii) Employee and Spouse = 2.00

(iii) Employee and Child(ren) = 1.85

(iv) Employee, Spouse, and Child(ren) = 2.85

(c) Any allowable tobacco use factor shall be allocated separately to the corresponding individual employee or dependent, so the average Employee Only premium does not include any tobacco factor.

(5) A small group's total composite premium shall equal the sum of the per-member premiums for all covered employees and dependents. In addition, once the composite premiums are computed at the beginning of the plan year, they shall not vary during the plan year, regardless of any census changes within the group.

(6) If the small group carrier offers composite rating, the Colorado alternative tiered-composite premium methodology will be required to be offered to all small groups without regard to size.

(7) Small group carriers may decide which plans will offer composite premiums and which plans will not.

(8) Small group carriers offering plans on the Exchange's Small Employer Health Options Program (SHOP) are not required to include the option of composite rating for those small group plans offered on the SHOP, unless and until the Exchange implements the ability for small group carriers to utilize composite rating.

c. Small Groups shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or his or her dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

d. Groups shall meet the definition contained in §§ 10-16-214(1) and 10-16-215, C.R.S.

Section 7 Large Group Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and a completed ~~Regulation~~ 4-2-39 Template (Excel spreadsheet)~~Template~~, supplied by the Division in SERFF. The Excel spreadsheet ~~template~~ is provided in SERFF, labeled "LG and Student~~Regulation~~ 4-2-39 Template." Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

a. Reason(s) for the rate filing:

A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

This information shall be included in the narrative.

b. Requested Rate Action:

Identify the rate increase or decrease amount for all appropriate items.

This shall include at a minimum ~~of~~ the following items:

(1) Base Rate Change

(2) Trend Requested – Trend factors that directly affect the rates (i.e. rating factors that are applied throughout the rating period) are part of the requested increase.

(3) Trend factors of this type shall be reflected anywhere that a requested change is reported.

(4) Benefit Factor Change

(5) Area Factor Change

(6) MHPAEA Compliance

(7) Law and Regulation Changes

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

c. Overall Rate Action:

Identify the overall, minimum, and maximum rate percentage changes.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

d. Marketing Method(s):

Select all marketing methods used for the filed form.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

e. Market Type(s):

Select the appropriate market type(s). Identify if the product will be sold to associations, trusts, etc.; ~~,~~ this shall be noted in the narrative.

Large groups shall not use any health status-related factor in determining the premium or contribution for any enrolled individual and/or his or her dependent. However, the prohibition in this subsection shall not be construed to prevent the carrier from establishing premium discounts or rebates or modifying otherwise applicable copayments, coinsurance, or deductibles in return for adherence to programs of health promotion or disease prevention if otherwise allowed by state or federal law.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

f. Premium Classification:

Select all attributes upon which the ~~premium~~ rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

g. Product Descriptions:

Describe the benefits provided by the policy~~,~~ or contract in the narrative. This description shall include major categories of the policy to include but not limited to office visits, inpatient hospital stays, radiology, and pathology.

This information shall be included in the narrative.

h. Policy or Contract:

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis:

Select the appropriate age basis used for the forms.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

j. Renewability Provision:

All health benefit plans are guaranteed renewable. Carriers shall select "guaranteed renewable".

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

k. Rate Change Distribution:

Complete the Rate Change Distribution table.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) filings approved~~als~~ immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage: The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carries shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Health Insurance Affordability Fee pursuant to § 10-16-1205, C.R.S.; and Colorado Insurance Regulation 4-2-76.

(a~~i~~) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.)

(b~~ii~~) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall exactly use 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.)

(6) Other assessments; and

(7) Profit and contingencies

b. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

c. The carrier shall comply with the following minimum benefit ratios ~~guidelines~~. The only components permitted to decrease the benefit ratio are ACA fees and the Health Insurance Affordability Fee required pursuant to § 10-16-1205, C.R.S.

Large Group Health Benefit Plans	85%
Expatriate Health Plans	75%

This information shall be provided in both the narrative and in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

4. Federal Medical Loss Ratio (MLR)

a. For the purpose~~s~~ of determining whether a carrier is meeting the federal MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

b. Medical carriers shall provide a calculation of the MLR for the three~~two~~ (3~~2~~) most recently completed calendar years and a projected MLR for the current calendar year, showing all allowable adjustments in the numerator and denominator.

c. The carrier shall indicate all adjustments allowed in the MLR calculation that will be used to reach the minimum required MLR.

d. The federal minimum MLR requirement is p~~P~~ursuant to 42 U.S.C. § 300gg-18(b)(1)(A)(i)., ~~the federal minimum MLR requirement is 85% for Large Group markets.~~

e. Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

This information shall be provided in both the narrative and in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

5. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. Trend factors shall not automatically renew. Continued use of trend factors shall be filed and adequately supported annually. This information shall be provided in the narrative. In addition, the following information shall be included in the Division-provided ~~Regulation 4-2-39 Template~~Excel spreadsheet:

a. The ~~"Regulation 4-2-39 Template"~~Excel spreadsheet contains a tab for a summary of trend assumptions. Medical trend assumptions shall be listed separately, and are defined as:

(1) ~~Medical provider price increases~~Changes in unit costs of medical services or procedures, medical provider price changes;

(2) Utilization changes;

(3) Medical cost shifting;

(4) New medical procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. Pharmaceutical trend assumptions shall be listed separately, and are defined as:

(1) Pharmaceutical price increases;

(2) Pharmacy utilization changes;

(3) Effect of cost shifting;

(4) Introduction of new drugs; and

(5) Other pharmaceutical trend, which means, for the purposes of this section, the combined effect of any other items impacting pharmacy trend that are not captured in items (1) – (4), including the effect of pharmaceutical deductible leveraging. The components of the pharmacy trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other pharmaceutical trend. Other pharmaceutical trend shall be fully justified in the rate filing, and described in the narrative.

c. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the Excel spreadsheet~~"Regulation 4-2-39 Template"~~.

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

d. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

e. The provided claims experience shall include the following separate data elements for each month:

(1) Actual medical (non-pharmacy) paid on incurred claims;

(2) Total medical incurred claims (including estimated IBNR claims);

(3) Actual pharmacy paid on incurred claims;

(4) Total pharmacy incurred claims (including estimated IBNR claims);

(5) Average covered lives for medical; and,

(6) Average covered lives for pharmacy.

f. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified.

6. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

7. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

b. Premium and number of policyholders may be combined for medical and pharmacy experience.

c. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

d. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

e. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

f. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the end date of the experience period shall be ~~include consecutive data~~ no older than six (6) months prior to the filing date.

g. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

8. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the plan name, number or description; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

9. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

10. Out-of-Network Claims Payment

For the experience period, the carrier shall provide the following Out-of-Network claims data:

a. Total number of claims;

b. Aggregate amount of billed charges;

c. Aggregate amount of that would have been paid in the absence of §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

d. Aggregate amount that was paid due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

e. Premium impact of the difference between (c) and (d) for the projection period.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

11. Effects of Law Changes:

The memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The rating impact for each law change shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

12. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

13. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period for products using trend is one (1) year.

This information shall be included in the narrative.

14. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

15. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for ~~each~~ any rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

a. Base Rate Development

A complete explanation as to how the base rate was developed shall be provided. Carriers may utilize actual claims experience in developing the base rate. The base rate shall be actuarially justified and implemented transparently, consistent with state rate review processes.

The memorandum's narrative shall clearly reference all other rating factors and definitions used, including but not limited to the area factors, age factors, gender factors, etc. Carriers shall provide support for the use of each of these factors in the rate filing. The same level of support~~s~~ for changes to any of these factors shall be included in all renewal rate filings. In addition, each carrier shall review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing.

This information shall be included in the narrative.

b. Geographic Factors

A complete explanation as to how the geographic factors were developed shall be provided. Health claims may be used in the process of developing geographic factors. Carriers shall identify counties and zip codes, if zip codes are utilized, of each service area if a state-wide network is not used.

The following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:

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

(a) The following zip codes in Elbert County: 80101, 80106, 80107, 80117;

(b) The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136;

(c) The following zip codes in El Paso County: 80132, 80133;

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

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

(a) The following zip codes in Jefferson County; 80401 – 80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465; and

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

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

If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory.

The use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss is prohibited. Areas of the state with like expectations of loss shall be treated in a similar manner. Also, policyholders utilizing the same provider groups shall be rated in a like manner. The use of zip codes in determining rating factors can result in inequities.

Carriers shall review the appropriateness of area factors at least every five (5) years and provide detailed support for the continued use of the factors in rating filings and upon request.

Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

c. Age

Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve are prohibited. However, this

requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating.

d. Benefit Factors

The base rate may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs. Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan. The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features.

A complete explanation as to how the benefit factors were developed shall be provided.

e. Morbidity

Other projected population changes from the experience period to the rating period shall include consideration of newly insured policyholders entering the market and grandfathered members moving into NGF products. For any morbidity factor used, a complete explanation of development shall be provided.

f. Large Claims

Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

g. Network Factor Adjustments

The rate may be modified to reflect cost differences between different provider networks. Network factors shall not be developed to reflect health status or claims experience of members included in the different networks. Factors shall be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience shall not be directly used as the basis for setting a network factor. Network factors shall reflect the following estimated cost differences between networks:

(1) Differences in reimbursement levels and discounts between providers;

(2) Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc.; and

(3) Other delivery system characteristics of a network.

h. Determining Minimum Value

(1) A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%.

(2) An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.

(3) A group health plan may determine if it provides MV using the following methods:

(a) The Minimum Value Calculator pursuant to 45 C.F.R. § 156.145(a)(1); or

(b) A safe harbor established by HHS and the Internal Revenue Service pursuant to 45 C.F.R. § 156.145(1)(2); or

(c) Certification by an actuary if neither is suitable.

This information shall be included in the narrative.

16. Interest and Penalty Payments - The narrative shall include:

a. A chart showing the total interest, penalties, settlements, or other additional payments as defined in § 10-16-106.5(5), C.R.S. the carrier has paid in the three (3) calendar years prior to the filing date, and the current year to date.

b. An attestation that any such payments have been excluded entirely from the development of rates: including, but not limited to, excluded from the incurred claims in the carrier's experience period used for rate setting and from the projection of administrative expenses.

17~~6~~. Actuarial Certification

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

B. Transition Credits

1. Carriers are required to comply with § 10-3-1104(1)(g) C.R.S. regarding transition payments. In particular:

a. The carrier shall include any transition payment in the contract signed by an employer group.

(1) Carriers should provide the amount of transition credits awarded during the experience period of the rate filing in both dollar amounts and as a percent of premium,

(2) Carriers should estimate the amount of transition credits anticipated during the rating period of the rate filing,

(3) Carriers may be asked to provide additional justification for transition credits in a rate filing, and

(4) Carriers should show where the transition credits are allocated within the classification of expenses (i.e. general expenses, commissions).

C. Rating Manual Requirement:

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as an Excel spreadsheet, separate from the Division "~~Regulation~~ LG and Student 4-2-39 Template".

D. Record Retention:

Large group health benefit plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing shall contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing shall contain an example of how rates are calculated. While the final rate charged to the large group may differ from the initial quote, all rating variables shall be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier shall retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate shall be identified in the detailed material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the Commissioner upon request.

The rates for subgroups shall be determined in an actuarially sound manner using credible data. The methodology for determining these rates shall be on file with the Division and any changes in the methodology shall be filed with the Division.

E. Prohibited Rating Practice

The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income.

Section 8 Student Health Insurance Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and a completed ~~Regulation~~ 4-2-39 Template (Excel spreadsheet)~~Template~~, supplied by the Division in SERFF. The Excel spreadsheet~~template~~ is provided in SERFF, labeled "~~Regulation~~ LG and Student 4-2-39 Template." Carriers are required to use the version in SERFF at the time of submission. Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The actuarial memorandum and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be

accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

   a. Reason(s) for the rate filing:

      A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

      This information shall be included in the narrative.

   b. Requested Rate Action:

      Identify the rate increase or decrease amount for all appropriate items.

      This shall include at a minimum ~~of~~ the following items:

      (1) Base Rate Change

      (2) Trend Requested

      (3) Benefit Factor Change

      (4) Area Factor Change

      (5) MHPAEA Compliance

      (6) Law and Regulation Changes

      This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

   c. Overall Rate Action:

      Identify the overall, minimum, and maximum rate percentage changes.

      This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

   d. Marketing Method(s):

      Select all marketing methods used for the filed form.

      This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

   e. Market Type(s):

      Select the appropriate market type(s).

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

f. Premium Classification:

Select all attributes upon which the ~~premium~~ rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

g. Product Descriptions:

Describe the benefits provided by the ~~policy, or~~policy or contract in the narrative. This description shall include major categories of the policy to include but not limited to office visits, inpatient hospital stays, radiology, and pathology.

This information shall be included in the narrative.

h. Policy or Contract:

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis:

Select the appropriate age basis used for the forms.

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

j. Renewability Provision:

All health benefit plans are guaranteed renewable. Carriers shall select "guaranteed renewable."

This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

k. Rate Change Distribution:

Complete the Rate Change Distribution table.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) filings approved~~als~~ immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage:

The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Health Insurance Affordability Fee pursuant to§ 10-16-1205, C.R.S., and Colorado Insurance Regulation 4-2-76.

(a~~i~~) Two and one-tenth percentage of premiums collected by for-profit carriers. For-profit carriers shall use exactly 2.10% (§ 10-16-1205(1)(a)(I)(B), C.R.S.)

(b~~ii~~) One and fifteen hundredths percentage of premiums collected by non-profit carriers. Non-profit carriers shall exactly use 1.15% (§ 10-16-1205(1)(a)(I)(A), C.R.S.)

(6) Other assessments; and

(7) Profit and contingencies.

b. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

c. The carrier shall comply with the following minimum benefit ratio ~~guidelines~~. The only components permitted to decrease the benefit ratio are ACA fees and the Health Insurance Affordability Fee required pursuant to § 10-16-1205, C.R.S.

Student Health Insurance Coverage	80%

This information shall be provided in both the narrative and in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

4. Federal Medical Loss Ratio (MLR)

a. For the purpose~~s~~ of determining whether a carrier is meeting the federal MLR requirements, a carrier shall provide a list of other plans under its legal entity that will be pooled with the plan in the rate filing for purposes of determining whether the federal minimum MLR will be met.

b. Medical carriers shall provide a calculation of the MLR for the three ~~two~~ (3~~2~~) most recently completed calendar years and a projected MLR for the current calendar year, showing all allowable adjustments in the numerator and denominator.

c. The carrier shall indicate all adjustments allowed in the MLR calculation that will be used to reach the minimum required MLR.

d. The federal minimum MLR requirement is p~~P~~ursuant to 42 U.S.C. § 300gg-18(b)(1)(A)(ii)., ~~the federal minimum MLR requirement is 80% for Student Health.~~

e. Carriers shall apply all allowable adjustments in the MLR calculation. Note that meeting the federal MLR minimum level does NOT satisfy rating requirements in the State of Colorado. The Division reviews the federal MLR as part of effective rate review to assist CMS with monitoring and enforcement of rebate calculations.

This information shall be provided in both the narrative and in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

5. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. This information shall be provided in the narrative. In addition, the following information shall be included in the Division-provided Excel spreadsheet ~~"Regulation 4-2-39 Template"~~:

a. The ~~"Regulation 4-2-39 Template"~~ Excel spreadsheet contains a tab for a summary of trend assumptions. Medical trend assumptions shall be listed separately, and are defined as:

(1) Changes in unit costs of medical services or procedures, medical provider price changes;~~Medical provider price increases~~;

(2) Utilization changes;

(3) Medical cost shifting;

(4) New medical procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting medical trend that are not captured in items (1) – (4), including the effect of deductible leveraging, anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the medical trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. Pharmaceutical trend assumptions shall be listed separately, and are defined as:

(1) Pharmaceutical price increases;

(2) Pharmacy utilization changes;

(3) Effect of cost shifting;

(4) Introduction of new drugs; and

(5) Other pharmaceutical trend, which means, for the purposes of this section, the combined effect of any other items impacting pharmacy trend that are not captured in items (1) – (4), including the effect of pharmaceutical deductible leveraging. The components of the pharmacy trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other pharmaceutical trend. Other pharmaceutical trend shall be fully justified in the rate filing, and described in the narrative.

c. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the Excel spreadsheet~~"Regulation 4-2-39 Template"~~.

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

d. Pharmacy data shall be shown separately from the medical data.

e. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

f. The provided claims experience shall include the following separate data elements for each month:

(1) Actual medical (non-pharmacy) paid on incurred claims;

(2) Total medical incurred claims (including estimated IBNR claims);

(3) Actual pharmacy paid on incurred claims;

(4) Total pharmacy incurred claims (including estimated IBNR claims);

(5) Average covered lives for medical; and,

(6) Average covered lives for pharmacy.

g. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends listed separately for medical and pharmacy. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified.

6. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

7. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. Medical and pharmacy experience shall be provided separately for incurred claims and number of claims.

b. Premium and number of policyholders may be combined for medical and pharmacy experience.

c. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

d. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

e. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

f. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the end date of the experience period shall be ~~include consecutive data~~ no older than six (6) months prior to the filing date.

g. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

8. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the plan name, number or description; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

9. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

10. Out-of-Network Claims Payment

For the experience period, the carrier shall provide the following Out-of-Network claims data:

a. Total number of claims;

b. Aggregate amount of billed charges;

c. Aggregate amount of that would have been paid in the absence of §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

d. Aggregate amount that was paid due to §§ 10-16-704(3)(d)(I) and (5.5)(b)(I), C.R.S.;

e. Premium impact of the difference between (c) and (d) for the projection period

This information shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

11. Effects of Law Changes:

The memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The rating impact for each law change shall be provided in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

12. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or

merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

13. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period for products using trend is one (1) year.

This information shall be included in the narrative.

14. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

15. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for any~~each~~ rating assumption is found to be inadequate.

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a. Base Rate Development

A complete explanation as to how the base rate was developed shall be provided. Carriers may utilize actual claims experience in developing the base rate. The base rate shall be actuarially justified and implemented transparently, consistent with state rate review processes.

The memorandum's narrative shall clearly reference all other rating factors and definitions used, including but not limited to the area factors, age factors, gender factors, etc. Carriers shall provide support for the use of each of these factors in the rate filing. The same level of support~~s~~ for changes to any of these factors shall be included in all renewal rate filings. In addition, each carrier shall review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing.

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factors. Carriers shall identify counties and zip codes, if zip codes are utilized, of each service area if a state-wide network is not used.

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(a) The following zip codes in Elbert County: 80101, 80106, 80107, 80117;

(b) The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136;

(c) The following zip codes in El Paso County: 80132, 80133;

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

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

(a) The following zip codes in Jefferson County; 80401 – 80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465; and

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The use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss is prohibited. Areas of the state with like expectations of loss shall be treated in a similar manner. Also, policyholders utilizing the same provider groups shall be rated in a like manner. The use of zip codes in determining rating factors can result in inequities.

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Geographic factors shall be actuarially justified and verified to have been set based upon the above criteria.

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Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve are prohibited. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating.

d. Benefit Factors

The base rate may be modified for each plan design by reflecting benefit cost adjustments due to the different benefit plan designs. Benefit factors shall not reflect the health status of members assumed to be enrolled in any particular plan, and shall not reflect claims experience of members in a particular plan. The benefit cost relativity between plans shall only reflect the true benefit differences due to different member cost sharing levels and plan design features.

A complete explanation as to how the benefit factors were developed shall be provided.

e. Morbidity

Other projected population changes from the experience period to the rating period shall include consideration of ~~newly insured policyholders entering the market and grandfathered members moving into NGF products~~the morbidity of insureds entering or leaving the pool. For any morbidity factor used, a complete explanation of development shall be provided.

f. Large Claims

Complete explanation of how large claims impact the line of business. Discuss the methods for adjusting data by pooling large claims above a threshold and apply pooling charges.

g. Network Factor Adjustments

The rate may be modified to reflect cost differences between different provider networks. Network factors shall not be developed to reflect health status or claims experience of members included in the different networks. Factors shall be set assuming each network has the same average member risk profile and levels of member health. Therefore, claims experience shall not be directly used as the basis for setting a network factor. Network factors shall reflect the following estimated cost differences between networks:

(1) Differences in reimbursement levels and discounts between providers;

(2) Differences in the utilization management of members, including tighter control of referrals, stricter managed care, disease management and wellness programs, etc.; and

(3) Other delivery system characteristics of a network.

h. Determining Minimum Value

(1) A group health plan provides minimum value (MV) if the total allowed costs of benefits paid by the plan is no less than 60%.

(2) An individual eligible for coverage in an employer-sponsored plan that provides MV is not eligible for premium tax credits.

(3) A group health plan may determine if it provides MV using the following methods:

(a) The Minimum Value Calculator pursuant to 45 C.F.R. § 156.145(a)(1); or

(b) A safe harbor established by HHS and the Internal Revenue Service pursuant to 45 C.F.R. § 156.145(a)(2); or

(c) Certification by an actuary if neither is suitable.

This information shall be included in the narrative.

16. Interest and Penalty Payments - The narrative shall include:

a. A chart showing the total interest, penalties, settlements, or other additional payments as defined in § 10-16-106.5(5), C.R.S. the carrier has paid in the three (3) calendar years prior to the filing date, and the current year to date.

b An attestation that any such payments have been excluded entirely from the development of rates: including, but not limited to, excluded from the incurred claims in the carrier's experience period used for rate setting and from the projection of administrative expenses.

176. Actuarial Certification

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory

B. Transition Credits

1. Carriers are required to comply with § 10-3-1104(1)(g) C.R.S. regarding transition payments. In particular:

a. The carrier shall include any transition payment in the contract signed by a college, university, or other institution of higher education.

(1) Carriers should provide the amount of transition credits awarded during the experience period of the rate filing in both dollar amounts and as a percent of premium,

(2) Carriers should estimate the amount of transition credits anticipated during the rating period of the rate filing,

(3) Carriers may be asked to provide additional justification for transition credits in a rate filing, and

(4) Carriers should show where the transition credits are allocated within the classification of expenses (i.e. general expenses, commissions).

C. Rating Manual Requirement:

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as an Excel spreadsheet, separate from the Division "~~Regulation~~LG and Student 4-2-39 Template".

D. Record Retention:

Student health insurance contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each student health insurance rate filing shall contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing shall contain an example of how the rates are calculated. While the final rate charged to the college, university, or other institution of higher education may differ from the initial quote, all rating variables shall be on file with the Division.

Carriers shall submit final rates for each college, university, or other institution of higher education that have been negotiated at least 60 days prior to implementation of those rates. Carriers shall retain detailed records for each college, university, or other institution of higher education policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each college, university, or other institution of higher education policy insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate shall be identified in the detailed material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the Commissioner upon request.

The rates for subgroups shall be determined in an actuarially sound manner using credible data. The methodology for determining these rates shall be on file with the Division and any changes in the methodology shall be filed with the Division.

E. Prohibited Rating Practice

The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income.

F. Timing and General Rate Filing Requirements

1. Student health filings shall be submitted on or before April 1 preceding the school year in which coverage is to be provided.

2. Student health insurance carriers shall not use the rates until the Division has closed the rate filing as approved.

Section 9 Stand-Alone Dental Rate Filing Requirements

A. Actuarial Memorandum Requirements

The rate filing shall contain a compliant actuarial memorandum, which is comprised of two (2) parts: a narrative and a completed ~~Regulation~~ 4-2-39 ~~Excel~~ Template (Excel spreadsheet)~~,~~ ~~supplied by the Division in SERFF. The Excel template is provided in SERFF, labeled "Regulation 4-2-39 Template SADP.".~~ Carriers are required to use the ~~version in SERFF at the time of submission~~ Excel spreadsheet provided by the Division, titled "SADP 4-2-39 Template". Carriers shall supply all items that require a narrative as a separate document in PDF format. The narrative shall contain complete support for any calculated item or provide adequate details. The narrative, template,~~actuarial memorandum~~ and all supporting documents or exhibits shall be attached to the Supporting Documents tab in SERFF, and shall be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Only the rate manual shall be attached to the Rate/Rule tab in SERFF.

1. Summary: The memorandum shall contain a summary that includes, but is not limited to, the following:

   a. Reason(s) for the rate filing:

      A statement as to whether this is a new product offering; a rate revision to an existing product, which includes rates applicable to new business only; or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision shall be clearly stated.

      This information shall be included in the narrative.

   b. Requested Rate Action:

      Identify the rate increase or decrease amount for all appropriate items.

      This shall include at a minimum ~~of~~ the following items:

      (1) Base Rate Change

      (2) Trend Requested

      (3) Benefit Factor Change

      (4) Area Factor Change

      (5) Law and Regulation Changes

         This information shall be included in the Excel ~~"Regulation 4-2-39 Template"~~ spreadsheet.

   c. Overall Rate Action:

Identify the overall, minimum, and maximum rate percentage changes.

This information shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

d. Marketing Method(s):

Select all marketing methods used for the filed form.

This information shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

e. Market Type(s):

Select the appropriate market type(s). Identify if the product will be sold to associations, trusts, etc., this shall be noted in the narrative.

This information shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

f. Premium Classification:

Select all attributes upon which the ~~premium~~ rates vary. This section shall comply with all rating reforms including, but not limited to, the age and tobacco ratios, family composition, and geographic areas.

This information shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

g. Product Descriptions:

Describe the EHB benefit provided by the policy or contract in the narrative. For non-grandfathered individual and small group stand-alone dental plans, this section shall also list any additional benefits provided.

This information shall be included in the narrative.

h. Policy or Contract:

All policy or contract forms impacted shall be listed on the Form Schedule tab in SERFF.

i. Age Basis:

Select the appropriate age basis used for the forms.

This information shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

j. Renewability Provision:

Select all renewability provisions used for the forms.

This information shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

k. Rate Change Distribution:

Complete the Rate Change Distribution table.

This information shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

2. Rate History:

The memorandum shall include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) filings approved~~als~~ immediately prior to the filing date, including the effective date of each rate change. Rate changes shall include the impact of trend.

a. This chart shall contain the following information: the filing number (SERFF tracking number), the effective date of each rate change, the average increase or decrease in rate, the minimum and maximum increase, and the cumulative rate change for the past twelve (12) months.

b. This chart shall contain the cumulative effect of all renewal rates on all rate filings submitted in the prior year.

c. The rate history shall be provided on both a Colorado basis, as well as an average nationwide basis, if applicable.

This information shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

3. Retention Schedule:

Carriers shall include all retention from expenses, fees and profits that will be loaded into rates. The memorandum shall adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period.

a. Retention Percentage: The actuarial memorandum shall list and adequately support each specific component of the retention percentage. Carriers shall provide actuarial justification for the retention levels, including a comparison to actual expenses in the most recent financial statements, with an explanation for any variations between retention loads used and actual experience for each component. Carriers shall provide justification if any component has changed since the carrier's previous rate filing. Specific retention components shall include at least the following:

(1) General expenses;

(2) Commissions and other acquisition expenses (may be separated);

(3) Taxes;

(4) ACA fees;

(5) Other assessments;

(6) Exchange fees; and

(7) Profit and contingencies

b. Retention loads shall be spread out across all rates in the ~~NGF~~ pool using the same rating factor. Retention rating factors shall not vary between on-Exchange and off-Exchange plans. Differences in expenses due to Exchange fees shall be spread out across all ~~NGF~~ pooled plans.

c. Carriers shall indicate pre-tax and post-tax levels and shall indicate how investment income has been accounted for in the setting of profit margins. Material investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses shall be considered in the ratemaking process. Detailed support shall be provided for any proposed load.

d. Administrative and Other Fees:

Separate administrative, processing, renewal, enrollment, and other special charges are prohibited. Reasonable late payment penalties may be imposed by a small group carrier if the policy discloses the carrier's right to, the amount of, and circumstances under which late payment penalties will be imposed.

e. The carrier shall comply with the following minimum benefit ratio ~~guidelines~~. The only components permitted to decrease the benefit ratio are ACA fees and the Health Insurance Affordability Fee required pursuant to § 10-16-1205, C.R.S.

Stand-Alone Dental (SADP)	65%

This information shall be provided in both the narrative and in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

4. Trend:

The memorandum shall describe the trend factor assumptions used in pricing. These trend factor assumptions shall each be separately discussed, adequately supported, and be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported. This information shall be provided in the narrative. In addition, the following information shall be included in the ~~Regulation 4-2-39 Template~~Excel spreadsheet:

a. The ~~"Regulation 4-2-39 Template"~~Excel spreadsheet contains a tab for a summary of dental trend assumptions. Dental trend assumptions shall be listed separately, and are defined as:

(1) Changes in unit costs of dental services or procedures, dental provider price changes;~~Dental provider price increases;~~

(2) Utilization changes;

(3) Dental cost shifting;

(4) New dental procedures and technology; and

(5) Other insurance trend, which means, for the purposes of this section, the combined effect of any other items impacting dental trend that are not captured in items (1) – (4), including the effect of deductible leveraging,

anti-selection resulting from rate increases and discontinuance of new sales, and the impact on trend due to anticipated demographic changes. The components of the dental trend noted as (1) – (4) shall be determined or assumed before determining the impacts of the other insurance trend. Other insurance trend shall be fully justified in the rate filing, and described in the narrative.

b. The four (4) most recent years of monthly experience data used to evaluate historical trends shall be included in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet if available.

(1) This experience may include data from the plan being rated or may include data from other Colorado or national business for similar lines of insurance, product design, or benefit configuration.

(2) Provided loss data shall be on an incurred basis, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date.

c. The carrier shall indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

d. The provided claims experience shall include the following separate data elements for each month:

(1) Actual dental paid on incurred claims;

(2) Total dental incurred claims (including estimated IBNR claims); and,

(3) Average covered lives for dental.

e. Data elements shall be aggregated into 12-month annual periods, with yearly PMPM data, and year-over-year PMPM trends. Annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends shall be identified.

5. Credibility:

The memorandum shall discuss the credibility of the Colorado data; the Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards shall be met within a maximum of three (3) years if the proposed rates are based on claims experience. If the carrier's Colorado data is not fully credible, partial credibility shall be used, with the following guidelines:

a. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period.

b. The formula for determining the amount of partial credibility to assign to the data is the square root of (number of life years/full credibility standard) or the square root of (number of claims/full credibility standard).

c. The proposed rates shall be based upon as much Colorado data as possible. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard.

d. The partially-credible Colorado data and collateral data used to support partially-credible data shall be provided. Justification of the use of such data, including published data sources (including affiliated companies), shall be provided.

e. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing which bases its conclusions on partially credible data shall include a discussion as to how the rating methodology was modified for the partially credible data.

This information shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet. If the full credibility standard is not met, explanations of the use of partially-credible or aggregated data and resulting changes to rating methodology shall be provided in the narrative.

6. Experience:

The memorandum shall include earned premium, loss experience, average covered lives and number of claims data that has been submitted on a Colorado-only basis for at least three (3) years. Experience shall be provided for the specific company filing prior to being combined with another company for credibility purposes.

a. National or other relevant experience shall be provided in order to support the rates if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to changes in rates, rating factors, rating methodology, trend, new benefit options, or new plan designs for an existing product.

b. If the purpose of the filing is to introduce a new product in Colorado, the product shall be substantially different from an existing product. Nationwide experience for this product shall be provided. If no experience from the new product is available, experience from a comparable product shall be provided, including experience data from other carriers that have been used to support the rates.

c. Support for new policy forms shall be provided. If the new policy form is based on an existing policy form, the existing policy form experience shall be used to support the new policy form, with an explanation as to the differences and relativities between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles and copayments) does not change an existing form into a "new product," as defined in this regulation.

d. Rates shall be supported by the most recent experience available, with as much weight as possible placed upon the Colorado experience. Data used to support rates shall be included in the filing. For both renewal filings and new business filings, the end date of the experience period shall be~~include consecutive data~~ no older than six (6) months prior to the filing date.

e. The loss experience shall be presented on an incurred basis, including the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Capitation payments shall be considered as claim or loss payments. The carrier shall also provide information on how the number of claims was calculated.

This information shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

7. Side-by-side Comparison:

Each memorandum shall include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison shall include five (5) columns: the first containing the category; the second containing the plan name, number, or description; the third containing the current rate, rating factor, or rating variable; the fourth containing all proposed rates, rating factors, or rating variables that are changing; and the fifth containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum shall specifically state this and provide detailed support for each of the rating factors.

This information shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

8. Benefits Ratio Projections:

The memorandum shall contain a section projecting the benefits ratio over the rating period, both with and without the requested rate changes. The comparison shall be shown in chart form, listing projected premiums, projected incurred claims, and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations shall be included.

If the filing is for a new product, the expected projected premiums and projected incurred claims shall be provided.

This information shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

9. Effects of Law Changes:

The memorandum shall identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable mandates shall be listed, including those with no rating impact. This quantification shall include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

This information shall be included in the narrative.

The rating impact for each law change shall be provided in the ~~"Regulation 4-2-39 Template"~~Excel spreadsheet.

10. Assumption, Acquisition or Merger:

Identify whether the products included in the rate filing are part of an assumption, acquisition, or merger of policies from/with another carrier. If so, the memorandum shall include the full name of the carrier(s) from which the policies were assumed, acquired or merged, and the date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption, acquisition or merger rate filing. Commissioner approval of the assumption, acquisition or merger of a block of business is required. See Section 5.B.3.b.6 for assumption, acquisition or merger rate filing requirements.

This information shall be included in the narrative.

11. Rating Period:

Identify the period for which the rates will be effective, including both the Effective and End Date. The date shall concur with the Effective Date Requested field in SERFF. The maximum rating period is one (1) year.

a. Individual Market: Individual rates shall be filed no more frequently than annually. The rating period shall be twelve (12) months and premiums cannot change throughout the year.

b. Small Group Market: Small group rates shall be filed no more frequently than quarterly. An annual rate filing, with an effective date of January 1, shall be made each year by a date specified by the Commissioner. Rating periods shall not be more than twelve (12) months. A carrier shall treat all health benefit plans issued or renewed in the same calendar quarter as having the same rating period. Rates in the annual filing may be trended quarterly.

This information shall be included in the narrative.

12. Coordination of Benefits and/or Subrogation:

The memorandum shall reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

This information shall be included in the narrative.

13. Complete Explanation as to how the Proposed Rates were Determined:

The memorandum shall contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for any~~each~~ rating assumption is found to be inadequate.

The explanation may be on an aggregate expected loss basis or a PMPM basis, but it shall completely explain how the proposed rates were determined. The memorandum shall adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

a. Base Rate Development

A complete explanation as to how the base rate was developed shall be provided. Carriers may utilize actual claims experience in developing the base rate. The base rate shall be actuarially justified and implemented transparently, consistent with state rate review processes.

b. Rating Factors

The memorandum's narrative shall clearly reference all rating factors and definitions used. Carriers shall provide support for the use of each of the rating factors in the rate filing. The same level of support for changes to any of these factors shall be included in all renewal rate filings. In addition, each carrier shall review each of these rating factors every five (5) years, at minimum, and provide detailed support for the continued use of each of these factors in a rate filing. Rates shall not vary by gender.

This information shall be included in the narrative.

14. Interest and Penalty Payments - The narrative shall include:

a. A chart showing the total interest, penalties, settlements, or other additional payments as defined in § 10-16-106.5(5), C.R.S. the carrier has paid in the three (3) calendar years prior to the filing date, and the current year to date.

b. An attestation that any such payments have been excluded entirely from the development of rates: including, but not limited to, excluded from the incurred claims in the carrier's experience period used for rate setting and from the projection of administrative expenses.

154. Actuarial Certification:

An actuarial certification shall be submitted with all filings. An actuarial certification is a signed and dated statement within the sixty (60) days prior to the submission of the filing made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

B. Stand-alone Dental Plan Requirements

1. QHPs in an Exchange may omit the pediatric dental EHB if an SADP on the Exchange offers pediatric dental EHB coverage.

2. SADP offering pediatric dental EHB coverage shall provide coverage up to age 19.

3. The standardized rating regions that apply to the medical QHPs do not apply to SADPs. Each dental carrier can determine its area adjustment factors and how to vary such factors by geographic locations. If zip codes are used to establish the area adjustment factors, no zip code smaller than a three (3) digit zip code shall be used when establishing an area.

4. The standard rating tiers and child factors applicable to the medical QHP do not apply to SADP. The dental carrier can develop a rating structure that conforms to federal and state laws.

5. The pediatric dental EHB coverage offered by a SADP shall be offered without annual and lifetime limits. Such limits may be used for benefits offered in addition to pediatric dental essential health benefits as well as for adult dental benefits.

6. The AV calculation for all SADPs shall include a summary statement and certification signed and dated by a qualified actuary.

7. SADPs offering pediatric dental coverage as an EHB on-the-exchange shall be exchange certified stand-alone dental plans. Stand-alone dental plans offered off-the-exchange shall be approved by the Division.

8. New filings shall be submitted in accordance with the ACA rate filing requirements for Colorado.

C. Rating Manual Requirements:

A rating manual shall be submitted to the Division for each new product. All changes to the rating manual shall be filed with the Division in an appropriate rate filing. Rate pages and rate manual shall be attached to the Rate/Rule Schedule tab in SERFF.

Premium rounding and truncation rules shall be provided in the rate manual for all rate filings.

Rating factors shall be calculated and displayed to four (4) decimal points.

This information shall be provided as an Excel spreadsheet, separate from the Division "SADP~~Regulation~~ 4-2-39 Template".

D. Prohibited Rating Practice

The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income.

Section 10 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 11 Incorporated Materials

45 C.F.R. § 147.102 shall mean 45 C.F.R. § 147.102 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.102. A copy of 45 C.F.R. § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.102 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 156.135 shall mean 45 C.F.R. § 156.135 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.135. A copy of 45 C.F.R. § 156.135 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.135 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 147.145 shall mean 45 C.F.R. § 147.145 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.145. A copy of 45 C.F.R. § 147.145 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.145 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 154.215 shall mean 45 C.F.R. § 154.215 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 154.215. A copy of 45 C.F.R. § 154.215 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 154.215 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 154.220 shall mean 45 C.F.R. § 154.220 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 154.220. A copy of 45 C.F.R. § 154.220 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R.

§ 154.220 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

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45 C.F.R. § 156.420 shall mean 45 C.F.R. § 156.420 as published by the Government Printing Office on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.420. A copy of 45 C.F.R. § 156.420 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.420 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 12 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 13 Effective Date

This amended regulation shall become effective on ~~May 30, 2023.~~ Month, Day, Year.

Section 14 History

Regulation effective October 1, 2013.
Amended regulation effective April 15, 2014.
Amended regulation effective August 15, 2014.
Amended regulation effective January 1, 2016.
Emergency regulation effective August 1, 2017.
Amended regulation effective December 1, 2017.
Emergency regulation effective June 13, 2018.
Amended regulation effective October 15, 2018.
Repealed and Repromulgated regulation effective May 15, 2021.
Amended regulation effective May 30, 2023
Amended regulation effective Month, Day, Year