

**Maine Bureau of Insurance - Rate Filing Review Requirements Checklist
Individual Health Plans
Subject to [Title 24-A M.R.S.A. § 2736-C](#):
H15I, H16I.005A, H16I.005B, H16I.005C, HOrg02I.005B, HOrg02I.005C
02/2013**

S E C T I O N	REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENT	SPECIFIC LOCATION OF COMPLIANCE IN FILING
A.	<p>General Rate Filing Requirements:</p> <p>Separate Filings:</p>	<p>Rule 940, § 5. A.</p> <p>Rule 940, § 6. D.</p>	<p>A rate filing must be submitted whenever a new policy, rider, or endorsement form that affects benefits is submitted for approval and whenever there is a change in the rates applicable to a previously approved form. The filing must be clearly identified as an individual rate filing.</p> <p>Individual rates must be filed separately from small group or large group rates. Grandfathered plans must be filed separately from non-grandfathered plans. The Superintendent may request additional information as necessary.</p>	
B.	Electronic (SERFF) Filing Requirements:	<p>Title 24-A, 2736, 1.</p> <p>Rule 940, § 5. B.</p>	<p>All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF) and include a completed "Rate Filing Review Requirements Checklist." See http://www.serff.com.</p> <p>If the filing is found to be in compliance with the applicable requirements, the SERFF record will show the rates to be "Filed for Information" or "Approved," and the record will be closed.</p>	
C.	Additional Rate Filing Requirements:	Rule 940, § 5. C.	Every rate submission subject to Title 24-A, § 2736-C must contain the following:	
	1. Carrier Information:	Rule 940, § 5. C. 1.	The name and address of the carrier, HOIS ID, NAIC number and the name, title, email address and direct phone number of the person responsible for the filing, must be provided in the SERFF "Filing Contact Information" section.	Cover Letter & Supplemental Memo, pg 1
	2. Scope and Purpose of Filing:	Rule 940, § 5. C. 2.	Specify whether this is a new form and rate filing, a rate revision, or a justification of an existing rate.	<i>Location, page: Supplemental Memo, page 1</i>
	3. Description of Benefits:	Rule 940, § 5. C. 3.	List all policy form numbers including HIOS Product Codes and Product Names. Indicate if open to new sales. Include a brief description of the benefits provided by each policy form and any attached riders or	<i>Location, page: Supplemental Memo, page 2 &</i>

			endorsements.	<i>Section D</i>
	4. In-Force Business and annualized premium:	Rule 940, § 5. C. 4.	Provide the number of Maine policyholders or certificateholders who will be affected by the proposed rate revision and their annualized premium.	<i>Location, page: Supplemental Memo, page 2</i>
	5. Proposed Effective Date(s):	Rule 940, § 5. C. 5.	State the proposed effective date and method of implementation of the proposed rate (e.g., next anniversary or next premium due date).	<i>Location, page: Supplemental Memo, page 1</i>
	6. Confidentiality:	Title 24-A, 2736, 2.	Rate filings for individual health plans and all supporting information are public records, except: (1) Protected health information required to be kept confidential by state or federal statute must be kept confidential, and (2) Descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3 rd party may be kept confidential. Any confidential information should be clearly identified as described in the <i>confidentiality protocol</i> , available on the Bureau of Insurance website.	<i>Location, page, if applicable: N/A</i>
D.	Submission Requirements, Individual Health Plans:	Rule 940, § 6.A.	All individual health insurance rate filings. *See Title 24-A, §2736-C, 1.C. for definition of “Individual health plan.” Note: Pursuant to Title 24- §2701, 2.C. , Title 24-A, §2736, §2736-A, §2736-B, and §2736-C apply to: (1) Association groups as defined by Title 24-A, §2805-A , except associations of employers; (1-A) Credit union groups as defined by Title 24-A §2807-A ; and (2) Other groups as defined by Title 24-A, §2808 , except employee leasing companies registered pursuant to Title 32, Chapter 125 .	
	1. Rate Filings must Accompany Form Filings:	Rule 940, § 6. B.	Every policy, rider, or endorsement form affecting benefits which is submitted for approval must be accompanied by a rate filing or, if the form does not require a change in the premium, the submission must include a complete explanation of the effect on the anticipated loss ratio. The rate filing must include all rates, rating formulas and revisions. Rates for new forms must be filed with the form rather than separately unless included in a general rate filing for all individual products.	<i>Location, page: Supplemental Memo, page 2 & Part III Memo, page 1</i>
	2. Rate Revisions:	Rule 940, § 6. C.	If the filing is a rate revision, the reason for the revision must be stated.	<i>Location, page: N/A – new filing</i>
	3. 60-day Advance Filing Notice:	Rule 940, § 6. D.	The filing must be received by the Bureau at least 60 days before the implementation date unless the Superintendent waives this requirement pursuant to Title 24-A, §2736, 1.	
	4. Non-compliant	Rule 940, § 6. D.	If the Bureau requests additional information or finds rates not to be in	

	Filing:		compliance, rates filed previously must continue to be used.	
	5. Completeness and Timeliness of Filing:	Rule 940, § 6. E.	The filing must include sufficient supporting information to demonstrate that the rates are not excessive, inadequate, or unfairly discriminatory. Carriers are required to review their experience <i>no less frequently than annually</i> and to file rate revisions, upward or downward, as appropriate. Upward revisions must be filed in a timely manner to avoid the necessity of large increases.	
	6. Limitation on the application of approved trend factor(s):	Rule 940, § 6. F.	If any rates will be automatically adjusted subsequent to the effective date of the filing based on a trend factor or other factor, this must be clearly disclosed in the filing. Automatic trend increases must be limited to one year from the effective date. No further automatic trend increases may be implemented unless a new filing is submitted and approved.	<i>Location, page, if applicable: Supplemental Memo, page 3</i>
	7. Morbidity:	Rule 940, § 6. G. 1.	Describe and explain the morbidity basis for the rates. Any substantive adjustments from the source or earlier assumptions must be explained. The morbidity assumed must be adequately justified by supporting data.	<i>Location, page: Supplemental Memo, page 2</i>
	8. Mortality:	Rule 940, § 6. G. 2.	If applicable, the filing must state the mortality basis for the rates, and any substantive adjustments from earlier assumptions must be explained.	<i>Location, page, if applicable: Supplemental Memo, page 2</i>
	9. Issue Age Range:	Rule 940, § 6. G. 3.	Specify the issue age range of the forms and whether premiums are on an issue age, attained age, or other basis.	<i>Location, page: Supplemental Memo, page 3</i>
	10. Average Premium and Pre- and Post- Rate Change Monthly Premiums:	Rule 940, § 6. G. 4.	Display the average annual premium per individual policy for both Maine and all states in which the forms are or were sold. If a rate adjustment is proposed, <i>the filing must disclose the average percentage increase a policyholder will experience as well as the largest percentage increase that any in-force policy will receive.</i> The average increase must be determined by comparing the aggregate premium before and after the increase (assuming no lapses) for all policies affected by the rate adjustment. The maximum increase is the largest increase for an in-force policy, including changes due to trend, aging, and changes in demographic, area, and/or tobacco rating factors, but not including changes due to the policyholder's aging or moving to a different area.	<i>Location, page: Supplemental Memo, page 2</i>
	11. Medical Trend Assumptions:	Rule 940, § 6. G. 5.	Provide the medical trend used <i>and the assumptions used to calculate the trend.</i>	<i>Location, page: Section A & Supplemental Memo, page 3</i>
	12. Maine Experience (Past and Future Anticipated):	Rule 940, § 6. G. 6.	Carriers shall consider experience solely within the State of Maine in developing rates using the single risk pool for all non-grandfathered plans as required by the federal Affordable Care Act (ACA). However, if there is	<i>Location, page: Section A & Supplemental</i>

			<p>insufficient experience within Maine upon which a rate can be based, the carrier may use nationwide experience using the single risk pool as required by the ACA. In considering experience outside the State of Maine, as much weight as possible must be given to Maine experience to the extent it is credible. If nationwide experience is used, premiums must be adjusted to the Maine rate level and, where appropriate, claims must be adjusted to Maine utilization and price levels. If premiums incorporate area factors that adjust for variations in utilization and price levels such that adjusting experience to Maine levels would result in the same percentage adjustment to both premiums and claims, then neither adjustment need be made. The carrier in its rate filing shall expressly show what geographic experience it is using. Experience from inception for each calendar year and, where appropriate, each policy year must be displayed, including the following information:</p> <ol style="list-style-type: none"> (1) Year (2) Collected premium (3) Earned premium (4) Paid claims (5) Paid loss ratio (6) Change in claim liability and reserve (7) Incurred claims (8) Incurred loss ratio (9) Expected incurred claims (10) Actual-to-expected claims (11) Active Life Reserves <p>For future years, columns (3), (7), and (8) must be displayed. For periods where the actual claim runoff is complete, that data must be displayed to replace (6).</p> <p>Past experience must be presented on both an actual basis and a constant premium rate basis.</p>	<i>Memo, page 4</i>
	13. National Experience:	Rule 940, § 6. G. 7.	If national experience is considered in developing the rates, provide the same data as for “D. 13,” above, for all states in which the forms are or were sold.	<i>Location, page: Supplemental Memo, page 4</i>
	14. History of Rate Adjustments:	Rule 940, § 6. G. 8.	List the implementation dates and average percentage rate adjustments for all forms both nationwide and in Maine since inception of the policy form.	<i>Location, page: Supplemental Memo, page 4</i>
	15. Renewability Clause:	Rule 940, § 6. G. 9.	Individual health plans are guaranteed issue and guaranteed renewal, pursuant to Title 24-A, §2850-B, 3.	<i>Location, page: Supplemental Memo, page 4</i>

	16. Minimum Pure Loss Ratio:	Rule 940, § 6. G. 10. & Rule 940, § 8. A.; See Title 24-A, § 2736-C. 5.	State the minimum pure loss ratio determined according to Section 7, 8 or 9 as applicable and the anticipated future and lifetime pure loss ratios. Policies issued before December 1, 1993, are subject to the loss ratio standards of Rule 940, § 7. A. & B.	<i>Location, page: Supplemental Memo, page 5</i>
	17. Rating Attributes:	Rule 940, § 6. G. 11.	State all the attributes upon which the premium rates vary. If the forms are area-rated, a complete table of area factors for all states must be included. See Title 24-A, §2736-C, 2. A.-F. Discuss the impact of any changes in geographic factors within Maine.	<i>Location, page: Supplemental Memo, page 4 & Section C</i>
	18. Marketing Method:	Rule 940, § 6. G. 12.	Provide a brief description of the market and the marketing method. Specify which plans will be sold on and off the Exchange.	<i>Location, page: Supplemental Memo, page 1</i>
	19. Medical Underwriting and other Rating Practices:	Title 24-A, §2736-C, 2.B., 2.C, & 2.D.	Prohibited: A carrier may not medically underwrite and/or vary the premium rate due to the gender, health status, claims experience, or policy duration of the individual. Please include statement of compliance with this requirement in the actuarial memorandum. See § D.27, below.	<i>Location, page: Supplemental Memo, page 4</i>
	20. Active Life Reserves	Rule 940, § 6. G. 14.	If applicable, the filing must state whether the policy includes active life reserves and describe the basis for these reserves.	<i>Location, page: N/A</i>
	21. Actuarial Certification, non-HMO Rate Filings:	Rule 940, § 6. G. 15.	Include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the entire rate filing is in compliance with the applicable laws of the State of Maine and with the rules of the Bureau of Insurance. "Qualified actuary," as used herein, means a member in good standing of the American Academy of Actuaries.	<i>Location, page:(non-HMO filings): N/A</i>
	22. Actuarial Certification, HMO Rate Filings:	Rule 940, § 10.	HMO rate filings must include a certification by a qualified actuary that the rates are not excessive, inadequate, or unfairly discriminatory, along with adequate supporting information. "Qualified actuary," as used herein, means a member in good standing of the American Academy of Actuaries.	<i>Location, page:(HMO filings): Supplemental Memo, page 7 and Part III Memo</i>
	23. Rate Revisions, Combination of Forms:	Rule 940, § 7. C. 2.	When a block of business in force under a grandfathered form no longer being sold has declined to a size such that the number of actual claims nationally in a twelve month period is less than two hundred, then the business under such form must be combined with other grandfathered or non-grandfathered blocks of business in the same class, which are on a consistent rate basis, for purposes of rating and monitoring the grandfathered plan. The Superintendent may approve exceptions to this requirement if the enrollees are permitted to change to a new form and the superintendent determines that the change would be in the best interest of the enrollees.	Not Applicable

	24. Minimum Required Loss Ratio	Rule 940, § 8. A.	As applicable, state the minimum required loss ratio for the forms as defined in Section 2736-C. Policies issued before 12/1/93 are subject to the loss ratio standards of Rule 940, Section 7.	<i>Location, page, if applicable: N/A – not subject to rate review & not a credible block of business.</i>
	25. Rate/Benefit Relationships:	Rule 940, § 8. B.	<p>Unless the Superintendent grants an exception in accordance with this subsection, rates for different benefit plans that vary based on benefit differences may not exceed the maximum possible difference in benefits. For example, the difference in annual premium between a plan with a \$250 deductible and an otherwise identical plan with a \$500 deductible may not exceed \$250 unless an exception is granted. The Superintendent will grant exceptions based on the following criteria and conditions:</p> <p>A. The rate differential between plans must be justified based on actual or reasonably anticipated differences in utilization that are independent of differences in health status or demographics. Generally, some of the difference in utilization between richer and leaner benefit plans is due to self-selection (based on health status or demographics) by those choosing one plan over the other, while some of the difference is due to the incentives associated with different cost-sharing levels. While it may not be possible to definitively determine how much of the difference in utilization is related to health status and demographics, the carrier must make a good faith effort to make this distinction.</p> <p>B. In cases where approved rate differences do exceed the maximum possible differences in benefits, it must be clearly disclosed to prospective policyholders and renewing policyholders. A copy of the disclosure to be used and a description of when and how it will be distributed must accompany the proposed rate filing.</p>	<i>Location, page, if applicable: Supplemental Memo, page 5</i>
	26. Index Rate, Formulas, and Factors:	Rule 940, § 8. C. & Title 24-A 2736-C, 2. A.	The filing must include the index rate for non-grandfathered plans and any formulas or factors used to adjust that rate, including actuarial value and cost sharing, provider networks, benefits in addition to the Essential Health Benefits (EHB), and with respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans. Index rate adjustments for any benefits in addition to EHB must be consistent for all products with same additional benefits. Please include a statement of compliance with this requirement in the actuarial memorandum.	<i>Location, page: Section E</i>
	27. Modification of Rates	Rule 940, § 8. E. 45 CFR 156.80(d)	Provide a full explanation of how rates were modified to reflect the reinsurance pursuant to 24-A MRSA Chapter 54-A and/or the ACA, risk adjustment under the ACA and risk corridors under the ACA.	<i>Location, page: Section B and Section E, Part III Memorandum</i>

	28. Savings Offset or Access Payments:	Title 24-A, § 6917	For purposes of loss ratio calculations, any savings offset payments or access payments paid or anticipated to be paid pursuant to Title 24-A. §6913 or §6917 must be treated as incurred claims.	<i>None</i>
	29. Notice to Policyholders:	Rule 940, § 8. G.	The filing must include a copy of the form letter to be used to notify policyholders of a rate increase, as required by Title 24-A, § 2735-A, 1. & 1. A. , and the date on which the notices were sent. If the letters have not yet been sent, state the date they are intended to be sent and provide written confirmation to the Bureau when the notices have been sent. Except as otherwise provided in 24-A MRSA, section 2736-C, subsection 2-B, the notice must also inform policyholders of their right to request a hearing when required pursuant to Title 24-A, § 229 . The notice must show the proposed rate, and unless otherwise provided in 24-A MRSA, section 2736-C, subsection 2-B, state when the rate is subject to regulatory approval. See Bulletin 311 for suggested language.	<i>Location, page:N/A – CMS-required standard letters utilized.</i>
E.	1. Guaranteed Loss Ratio Option	Rule 940, § 8. H.	Specify if the carrier has elected the guaranteed loss ratio option and if so include the additional items required by Section 5 and Subsection B(2), C and G of the rule. The filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate.	<i>Location, page:Not selected at this time – N/A</i>
	2. Prior Approval	Rule 940, § 8. H. 5.	If the filing does not require prior approval, it must include the following in addition to the items required by Rule 940, Section 5 and Section 8, Subsections B(2), C and G: a. The average annual premium per policy; b. If a rate adjustment is proposed, the average percentage changes. c. If a rate adjustment is proposed, the largest percentage increase, meaning the largest increase for an in-force policy, including changes due to trend and changes in rating factors, but ignoring changes in the policyholder's age; d. A demonstration that the rate revision is not subject to review pursuant to the ACA; and e. A demonstration of compliance with Rule 940, Section 8, Subsection B.	<i>Location, page: N/A – prior approval required</i>
	3. Special Requirements for Large Blocks:	Rule 940, § 11.	In addition to the requirements of Rule 940, § 5 , and, to the extent applicable, § 6, § 7, and § 8 , a rate filing or a group of related rate filings for individual policies or contracts covering or expected to cover more than two thousand (2,000) Maine residents is subject to the following: A. Expenses: Include a description of any expense assumptions used, including, for example, per policy and percentage of premium expense for acquisition, maintenance and commissions. B. Investment income: Include an estimate of investment income attributable to the affected policies and how it is reflected in the rates.	<i>Location, page, if applicable: Supplemental Memo, page 4</i>

	4. Review Pursuant to the ACA	Rule 940, § 12.	All rate filings that would result in a rate increase must include the Federal Part I Unified Rate Review Template and Federal Part III Actuarial Memorandum. Filings that have been identified as “potentially unreasonable” in accordance with the ACA must also include Federal Part II written description of the rate increase.	<i>Location, page: Section E</i>
	5. Actuarial Value of Plans	ACA 1302(d)- plans must provide benefits with AVs of 60, 70, 80, or 90 percent.	All rate filings should include the calculated numerical output of the AV calculator, the metal level designation, and the AV inputs used and the document and pages numbers where these can be found in the form filing. If the plan design does not fit into the AV Calculator, carriers must submit an actuarial certification, a detailed description of the alternative methodology used, the calculated actuarial value, and the metal level designation.	<i>Location, page: Section D & Supplemental Memo, page 6</i>
	6. Actuarially Equivalent Substitutions	Proposed 45 CFR 156.115(b)- Substitution of benefits	Certify substantially similar to the required EHB benefits.	<i>Location, page: N/A</i>
	7. Plans In the Single Risk Pool	Rule 940, § 12. Pursuant to section 1312(c) of the ACA	Please list all the plans used as experience in the single risk pool.	<i>Location, page: Section E, Part III Memorandum</i>
	Completed by:	J. Schneider / G. Morales	Date: 09/07/16	Rev. 2/14/2013