02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 940: REQUIREMENTS FOR HEALTH INSURANCE RATE FILINGS AND DATA REPORTING

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Section 1. Purpose

A. This rule establishes procedures and guidelines for filing individual and group health insurance rates and health maintenance organization (HMO) rates in this State. The rule is intended to inform those filing health insurance rates of the types of data required to permit the Bureau to appropriately review the filings submitted and to provide meaningful rate information to the public.

B. This rule establishes procedures for annual reporting of medical loss ratios and payment of rebates in accordance with federal and Maine law.

C. Annual data reporting requirements set forth in Appendix A enable the Bureau to monitor the continued viability of Maine's small group and individual health plan markets.

Section 2. Authority

This rule is adopted by the Superintendent pursuant to Title 24 M.R.S.A. § 2321 and Title 24-A M.R.S.A. §§ 212, 405-A(2)(E), 2413, 2736, 2736-C, 2808-B, 2839, 4207, and 4309-A.

Section 3. Applicability and Scope

This rule applies to all individual, group, and blanket health insurance rates and health maintenance organization rates that are subject to Title 24 M.R.S.A. § 2321 and Title 24-A M.R.S.A. §§ 405-A, 2736, 2736-C, 2808-B, 2839, and 4207. To the extent provided in Section ~~14~~ 15, this rule is applicable to multiple-employer welfare arrangements licensed pursuant to Title 24-A M.R.S.A. Chapter 81 and captive insurance companies licensed pursuant to Title 24-A M.R.S.A. Chapter 83. This rule does not apply to rates for credit insurance subject to Title 24-A M.R.S.A. Chapter 37, Medicare supplement insurance subject to Title 24-A M.R.S.A. Chapter 67, or long-term care insurance subject to Title 24-A M.R.S.A. Chapters 68 and 68-A.

Section 4. Definitions

A. "ACA" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts.

B. "Carrier" means any insurance company, nonprofit hospital and medical service organization, or health maintenance organization authorized to issue health coverage in this State.

C. "Community rate" means the rate to be charged for a specific benefit plan, family structure (e.g., individual, couple, one-parent family, family), and group size (in the case of small group rates), prior to any adjustments for age, industry, occupation, geographic area, or tobacco use.

D. "Covered person" means a policyholder, certificate holder, subscriber, member, enrollee, dependent, or other individual entitled to benefits under a health benefit plan.

E. "MLR" means the medical loss ratio as defined by the ACA.

F. "Potentially unreasonable" means a rate filing which exceeds the threshold requiring review pursuant to Section 2794(a)(2) of the federal Public Health Service Act.

~~F. "Premium" means the amount of money charged a policyholder for an insurance policy.~~

G. "Pure loss ratio" means the ratio of incurred claims to earned premiums for a given period, as determined in accordance with accepted actuarial principles and practices, and subject to the following provisions. For the purposes of this calculation, incurred claims do not include any claim adjustment expenses or cost containment expenses. Any savings offset payments, access payments, or reinsurance assessments paid pursuant to Title 24-A M.R.S.A. § 6913, § 6917, or § 3957, and any assessments for transitional reinsurance pursuant to the ACA, are treated as incurred claims. Except in situations where the assuming carrier is responsible for 100% of the ceding carrier's financial risk and administration of the policies, earned premiums and incurred claims must be stated on a direct basis without regard to commercial reinsurance. Reimbursements pursuant to the transitional reinsurance pursuant to the ACA shall be deducted from incurred claims. For individual health plans subject to Title 24-A M.R.S.A. § 2736-C, reinsurance premiums pursuant to Title 24-A M.R.S.A. § 3958 shall be deducted from earned premiums and reimbursements pursuant to Title 24-A M.R.S.A. § 3958 shall be deducted from incurred claims.

H. "Small group" refers to small group health plans as defined by Title 24-A M.R.S.A. § 2808-B.

I. "Transitional coverage" means a non-grandfathered individual or small group policy issued before January 1, 2014 and subject to the federal transitional policy announced in November 2013 and extended in March, 2014 and in February, 2016.

Section 5. General Rate Submission Requirements

A. 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.

B. Filings must be filed electronically, using the System for Electronic Rate and Form Filing (SERFF).

1. Filings must also include a completed "Rate Filing Review Requirements Checklist," available on the Bureau's website.

2. The Superintendent may request additional information as necessary.

3. Group rates are submitted on a "file and use" basis for informational purposes, with the exception of small group rates subject to Title 24-A M.R.S.A. § 2808-B where the anticipated average number of members during the period for which the rates will be in effect does not meet standards for full or partial credibility pursuant to the ACA, in which case the rates must be filed for prior approval.

4. Rates for individual health plans subject to Title 24-A M.R.S.A. § 2736-C are submitted on a "file and use" basis for informational purposes if the carrier has elected the guaranteed loss ratio option pursuant to Subsection 8(H) and rate review is not required pursuant to the ACA.

C. To assist the Bureau, every rate submission must contain, the information and documents set forth in this subsection to the extent applicable based on the type of filing:. For policies subject to ACA rating requirements, inclusion of the ACA Rate Filing Justification Part I, the unified rate review template, and Part III, the actuarial memorandum, will satisfy paragraphs 1 through 5 below.

1. Carrier Information: Include the name and address of the carrier. The name, title, direct phone number, and email address of the person responsible for the filing must also be noted.

2. Scope and Purpose of Filing: Specify whether this is a new form filing, a rate revision, or a justification of an existing rate.

3. Description of Benefits: Include a copy of the summary of coverage and explanation of benefits provided to consumers in accordance with the ACA, if applicable, for each policy form. Otherwise, include a brief description of the benefits provided by the policy, including any attached riders or endorsements within the scope of the rate submission.

4. In-Force Business: Include pPolicy count and annualized premium of Maine policyholders or certificate holders who will be affected by the proposed rate revision. For group business, include the number of covered persons.

5. Proposed Effective Date: State the proposed effective date and method of the proposed rate revision implementation (e.g., next anniversary or next premium due date).

6. Confidentiality

a. Filings for all individual health insurance and for small group health plans subject to Title 24-A M.R.S.A. § 2808-B and all supporting information are public records except that:

(i) Protected health information required to be kept confidential by state or federal statute must be kept confidential; and

(ii) Descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a provider or other third party may be kept confidential.

Any confidential information should be clearly identified as described in the confidentiality protocol available on the Bureau of Insurance website.

b, Filings for group health insurance other than small group health plans subject to Title 24-A M.R.S.A. § 2808-B may be prepared in a manner that protects the confidentially of information that is confidential under Maine law by following the confidentiality protocol available on the Bureau of Insurance website. Carriers are encouraged to minimize the amount of information for which confidentiality is requested.

Section 6. Requirements for Individual and Small Group Rate Submissions ~~Subject to Prior Approval~~ <u>Other Than ACA Rate Filings</u>

A. In addition to the requirements of Section 5, the following rate filings must meet the requirements of this section, unless the Superintendent determines that the requirement is not appropriate for a particular filing:

1. All individual health insurance rate filings, except ~~when the carrier has elected the guaranteed loss ratio option pursuant to Subsection 8(H) and rate review is not required pursuant to the ACA~~ <u>rate filings for policies subject to the ACA rating requirements</u>;

2. Small group rate filings subject to Title 24-A M.R.S.A. § 2808-B, ~~but only if the carrier's anticipated average number of members in all small group health plans during the period for which the rates will be in effect does not meet standards for full or partial credibility pursuant to the ACA~~ <u>except policies subject to the ACA rating requirements</u>;

3. Association groups as defined by Title 24-A M.R.S.A. § 2805-A and other groups as defined by Title 24-A M.R.S.A. § 2808, except as to any employer subgroups of the association group when:

a. The employer is a member of the group and provides coverage through the group as a *bona fide* employee benefit~~,~~; and

b. Either the employer is a large employer or the employer is a small employer and the carrier's anticipated average number of members in all small group health plans during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the ACA; and

4. Credit union groups as defined by Title 24-A M.R.S.A. § 2807-A.

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 must be filed with the form rather than separately.

C. If the filing is a rate revision, the reason for the revision must be stated.

D. Individual rates must be filed separately from group rates. Small group rates must be filed separately from individual or large group rates. The filing must clearly identify the market to which the filing applies. 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 M.R.S.A. § 2736(1) or § 2808-B(2-A)(A). Every effort will be made to process filings within 30 days. If the Bureau requests additional information or finds rates not to be in compliance, rates approved previously must continue to be used.

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 no less frequently than annually 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.

1. All PDF documents must be submitted in a searchable format, not scanned.

2. All PDF documents must be unlocked so that information can be copied from the document.

3. All spreadsheets must be in Excel format and include formulas. A PDF copy of each spreadsheet must also be included.

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 automatic trend increases may be implemented one year or more after the effective date of the filing unless a new filing is submitted and approved.

G. In addition to the general filing requirements for all filings, rate submissions subject to this section must contain to the extent applicable for the type of filing:

1. Morbidity: Describe the morbidity basis for the form, including the source or sources used. Any substantive adjustments from the source or earlier assumptions must be explained. The morbidity assumed must be adequately justified by supporting data.

2. Mortality: If applicable, ~~the filing must~~state the mortality basis and any substantive adjustments from earlier assumptions must be explained.

3. Issue Age Range: Specify the issue age range of the form and whether premiums are on an issue age, attained age, or other basis.

4. Average Premium: Display the average annual premium per individual policy or group certificate for both Maine and all states in which the form is or was sold. If a rate adjustment is proposed, 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. The average increase must be determined by comparing the aggregate premium before and after the increase (assuming no lapses) for all policies renewing during the period during which the rates are intended to be in effect. The maximum increase is the largest increase for an in-force policy, including changes due to trend, aging, and changes in demographic, area, industry rating factors, but excluding changes in the covered population under a group policy.

5. Medical Trend Assumptions: Provide the medical trend and any other trends used and the assumptions used to calculate the trend(s).

6. Maine Experience on the Form (Past and Future Anticipated): ~~Carriers shall c~~Consider experience solely within the State of Maine in developing rates. However, if there is insufficient experience within Maine upon which a rate can be based, the carrier may use nationwide experience. In considering experience outside the State of Maine, as much weight as possible must be given to Maine experience. 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, except that for small group business only the past three years must be displayed, including the following information :

   (1) Year
   (2) Collected premium
   (3) Earned premium
   (4) Paid claims
   (5) Paid pure loss ratio
   (6) Change in claim liability and reserve
   (7) Incurred claims
   (8) Incurred pure loss ratio
   (9) Expected incurred claims
   (10) Actual-to-expected claims
   (11) Active Life Reserves

   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). Past experience must be presented on both an actual basis and a constant premium rate basis.

7. National Experience: Provide the ~~S~~same data as for paragraph 6 for all states in which the form is or was sold.

8. History of Rate Adjustments: List the approval dates and average percentage rate adjustments for the form both nationwide and in Maine since inception of the policy form, except that for small group business only data for the past three years need be listed.

9. Renewability Clause: Identify the renewability classification of the form.

10. Loss Ratios: 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.

11. Premium Classes: State all the attributes upon which the premium rates vary. If the form is area-rated, a complete table of area factors for all states must be included.

12. Marketing Method: Provide a brief description of the market and the marketing method. Specify whether the form is still being sold and whether the filing applies only to new business, only to in-force business, or both, and the reasons therefor.

13. Medical Underwriting: Provide a description of the extent to which this product will be medically underwritten, if any, and the expected impact by duration and in total, on claim costs.

14. Active Life Reserves: If applicable, the filing must state whether the policy includes active life reserves and describe the basis for these reserves.

15. Actuarial Certification: Provide ~~C~~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.

Section 7. Individual Rate Filings Subject to Pure Loss Ratio Standards

A. Applicability: This section applies to all individual policies except (a) rate filings for individual health plans subject to the ACA rating requirements and (b) rate filings for which ~~when~~ the carrier has elected the guaranteed loss ratio option pursuant to Subsection 8(H) and rate review is not required pursuant to the ACA. For purposes of this section, the group policies specified in Paragraphs 6(A)(3) and (4) are treated as individual policies.

B. Minimum pure loss ratios for individual policies

1. This subsection does not apply to rates for individual policies issued on or after December 1, 1993~~,~~ and subject to Title 24-A M.R.S.A. § 2736-C.

2. Definitions: For the purposes of this subsection, the following definitions apply:

a. Average Annual Premium Per Policy, $X: The average annual premium per individual policy or group certificate shall include all charges for riders and endorsements and shall be estimated by the carrier based on an anticipated distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., but assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated pure loss ratio calculation).

The value of X shall be determined for each calendar year of issue. It is calculated based on the pricing assumptions applicable to that calendar year of issue.

b. Consumer Price Index Factor, I: The factor, I, is used to adjust the test for low and high average premiums to account for inflation. It is indexed to a value of 1.00 for 2010 and is defined as:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, 2009}} = \frac{\text{CPI-U, Year (N-1)}}{215.969}$$

where:

(i) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

(ii) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, with 1982–84=100, as determined by the U.S. Department of Labor, Bureau of Labor Statistics; and

(iii) The CPI-U for any year (N-1) is taken as the value for September. For 2009, this value was 215.969, setting the value of I equal to 1 for 2010.

c. Renewal Clauses

OR - Optionally Renewable: Renewal is at the option of the insurance company.

CR - Conditionally Renewable: Renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health.

GR - Guaranteed Renewable: Renewal cannot be declined by the insurance company for any reason, at least until the age of 65 or until eligibility for Medicare, but the insurance company can revise rates on a class basis.

NC - Non-Cancelable: Renewal cannot be declined, at least until the age of 65 or until eligibility for Medicare, nor can rates be revised by the insurance company.

NR - Nonrenewable: This includes short-term nonrenewable policies with a maximum duration of one year and no contractual renewal provision.

3. With respect to a form under which the average annual premium, $X, is expected to be at least as large as I × $550 but not more than I × $3,300, the filing must demonstrate that the anticipated *pure loss ratio* is at least as great as shown in the following table:

Type of Coverage	**Renewal Clause**				
	OR	CR	GR	NR	NC
Medical Expense	60%	55%	55%	50%	50%
Loss of Income and Other	60%	55%	50%	45%	45%

4. Low Average Premium Forms: For a policy form under which the expected average annual premium, $X, is less than I × $550, the appropriate ratio from the table in paragraph 1 may be adjusted downward by the following formula:

$$R' = R \times \frac{(I \times 1{,}100) + X}{(I \times 1{,}650)}$$

where: R is the table ratio;
R' is the resulting guideline ratio;
I is the consumer price index factor as defined in ~~A~~§7(B)(2)(b) above; and
X is the average annual premium defined in ~~A~~§7(B)(2)(a) above up to a maximum of I × $550.

In no event, however, shall R' be less than 45%.

5. High Average Premium Forms: For a policy form under which the expected average annual premium, $X, is greater than I × $3,300, the appropriate ratio from the table above must be adjusted upward by the following formula:

$$R' = R \times \frac{(I \times 8{,}800) + X}{(I \times 12{,}100)}$$

where: R is the table ratio
R' is the resulting guideline ratio
I is the consumer price index factor as defined in ~~A~~§7(B)(2)(b) above
X is an average annual premium as defined in ~~A~~§7(B)(2)(a) above exceeding I × $3,300

In no event, however, shall R' exceed 65%.

C. Rate Revisions

1. If the form is no longer actively marketed, a statement must be included as to whether a similar form is actively marketed and, if so, a discussion of equity between the two forms, including a comparison of the benefits and premium rates, must also be included. Except as provided in Sections 8 and 9, rates for individual policy forms for closed blocks should not significantly exceed rates for an open block unless the difference is justified by differences in benefits or other conditions, or unless the fact that renewal rates would exceed new business rates was disclosed at issue. The Superintendent may approve exceptions to this requirement if the enrollees are permitted to change to the new form and the Superintendent determines that the change would be in the best interest of the enrollees.

2. Combination of Forms: When a block of business in force under a 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 blocks of business in the same class, which are on a consistent rate basis, for rating and monitoring purposes. 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.

3. Filings of revised premiums must demonstrate that both the following loss ratios meet minimum standards as set forth in ~~subsection~~ Subsection B of this Section, in Title 24-A M.R.S.A. § 2736-C(5), or in Title 24-A M.R.S.A. § 2808-B(2-B)(A), whichever is applicable:

a. An anticipated pure loss ratio calculated over the future lifetime of the form;

b. An anticipated pure loss ratio derived by dividing (i) by (ii) where

(i) is the sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and

(ii) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums.

The Superintendent may accept alternative demonstrations where appropriate, particularly for small blocks with no credible experience.

Section 8. Individual Health Plans Subject to Title 24-A M.R.S.A. § 2736-C

In addition to the applicable requirements of Section 5, Section 6, Subsection 7(C), ~~and~~ Section 12, and Section 13, rate filings subject to Title 24-A M.R.S.A. § 2736-C, which include rate filings for certain group polices specified in Title 24-A M.R.S.A. § 2701(2)(C), must meet the following requirements:

A. Minimum Required Loss Ratio: As applicable, state the minimum required loss ratio for the form as defined in Title 24-A M.R.S.A. § 2736-C. Policies issued before December 1, 1993~~,~~ are subject to the loss ratio standards of Section 7. This subsection does not apply when the carrier has elected the guaranteed loss ratio option pursuant to Subsection H and rate review is not required pursuant to the ACA.

B. Rate Differentials between Plans: 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:

1. 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.

2. 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.

This subsection does not apply to policies subject to the ACA rating requirements.

C. Modified Community Rating: The filing must include the community rate and any formulas or factors used to adjust that rate.

1. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience, or policy duration of the individual.

2, A carrier may vary the premium rate due to family membership to the extent permitted by the ACA.

3. For rates effective before July 1, 2012, any variations based on age and/or tobacco use must result in rates that are no less than 80% and no more than 120% of the community rate.

4. Rates for policies, contracts, or certificates that are executed, delivered, issued for delivery, continued, or renewed effective on or after July 1, 2012, are subject to the following rating restrictions:

a. Except as provided in Subsection D, variations based on age must not exceed the limits set forth in Title 24-A M.R.S.A. § 2736-C(2), paragraph D, subparagraphs 5 through 7.

b. Pursuant to the ACA, on or after January 1, 2014, age variations are limited to a ratio of 3 to 1 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

c. Variations based on geographic area are limited to a ratio of 1.5 to 1.

d. Variations based on tobacco use are limited to a ratio of 1.5 to 1.

D. Closed Blocks: A carrier that offered individual health plans before July 1, 2012, may close its individual book of business sold before that date and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after that date, subject to the following:

1. Rates are subject to the following rating restrictions:

   a. Variations based on age must not exceed the limits set forth in Title 24-A M.R.S.A. § 2736-C(2)(I), subparagraphs 1 through 5.

   b. Pursuant to the ACA, on or after January 1, 2014, age variations are limited to a ratio of 3 to 1 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

   c. Variations based on geographic area are limited to a ratio of 1.5 to 1.

   d. Variations based on tobacco use are limited to a ratio of 1.5 to 1.

2. Pursuant to the ACA, except for enrollees in grandfathered health plans as defined under the ACA, beginning January 1, 2014, a carrier shall consider all enrollees in all individual health plans offered by the carrier to be members of a single risk pool. Therefore, after that date, the separate community rate for the closed block will only apply to grandfathered health plans and to transitional coverage as defined in Subsection 4(I).

~~E. The filing must include a full explanation of how rates were modified, and the amount of the modifications, to reflect:~~

~~1. Reinsurance provided pursuant to Title 24-A M.R.S.A. Chapter 54-A;~~

~~2. Risk adjustment under the ACA; and~~

~~3. For rates that will be in effect during the years 2014 through 2016, reinsurance and risk corridors under the ACA.~~

~~This subsection does not apply when the carrier has elected the guaranteed loss ratio option pursuant to Subsection H and rate review is not required pursuant to the ACA.~~

F. Annual ~~data collection~~ Data Collection: The information described in Appendix A must be submitted annually. This data must be filed separately from any rate filing and must be in an electronic format prescribed by the Superintendent.

G. Notice to Policyholders: 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 M.R.S.A. § 2735-A, and the date on which the notices were sent. If they 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.

H. Guaranteed Loss Ratio Option

1. Each filing must specify whether or not the carrier elects the guaranteed loss ratio option with respect to the filing. If the guaranteed loss ratio option is elected, the election may be changed in subsequent filings. However, if the guaranteed loss ratio option is elected and the election is later changed and the effective date of the rate filing changing the election is other than January 1, then the carrier must guarantee the loss ratio through the end of the calendar year.

2. The guaranteed loss ratio option is available only if the Superintendent determines that the carrier's anticipated average number of members in all individual health plans during the period for which the

rates will be in effect meets standards for full or partial credibility pursuant to the ACA. The rate 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.

3. If the guaranteed loss ratio option is elected, the calculation of the rebates paid pursuant to Section 13 must be based on a minimum MLR of 80%, even if the applicable federal minimum for the individual market in Maine is lower.

4. Rates filed pursuant to the guaranteed loss ratio option do not require prior approval unless rate review is required pursuant to the ACA. Rates subject to ACA review must be filed for prior approval. Rates not subject to ACA review must be filed for informational purposes at least 60 days before implementation unless the Superintendent waives this requirement. Informational filings will be reviewed for compliance with subsections A through D and with the requirements of Title 24-A M.R.S.A. § 2736-C. Any deficiencies will be brought to the attention of the carrier. If the rates have already been implemented and do not meet statutory requirements, corrective action may be required. Every effort will be made to process filings within 30 days.

5. If the filing does not require prior approval, it must include the following in addition to the items required by Section 5 and Subsections B(2), C, and G of this section:

   ~~a. The average annual premium per policy;~~

   ~~b. If a rate adjustment is proposed, the average percentage change. The average increase or decrease must be determined by comparing the aggregate premium before and after the increase (assuming no lapses and ignoring changes in age) for all policies renewing during the period during which the rates are intended to be in effect;~~

   ~~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 Subsection B.

Section 9. Small Group Health Plans Subject to Title 24-A M.R.S.A. § 2808-B

In addition to the requirements of Section 5 and, if applicable, Sections 6 and 12, small group rate filings subject to Title 24-A M.R.S.A. § 2808-B, which include rate filings applicable to subgroups as defined in Title 24-A M.R.S.A. § 2808-B(1)(H), must meet the following requirements:

A. Small group rates must be filed separately from large group rates or individual rates. The carrier must clearly identify the filing as a small group rate filing.

B. In addition to the general requirements for all filings, small group health rate submissions must contain:

   1. Rate Factors: The filing must include the community rate and any formulas or factors used to adjust that rate.

      a. A carrier may not vary the premium rate due to the gender or health status of any covered individual, or due to claims experience or policy duration.

b. A carrier may vary the premium rate due to family membership to the extent permitted by the ACA.

c. Except as provided in paragraph 3, variations based on age must not exceed the limits set forth in set forth in Title 24-A M.R.S.A. § 2808-B(2)(D), subparagraphs 4 through 8.

d. Pursuant to the ACA, age variations are limited to a ratio of 3 to 1 on or after January 1, 2014 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

e. Pursuant to the ACA, variations by industry or occupation will not be permitted on or after January 1, 2014 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

f. Variations based on geographic area are limited to a ratio of 1.5 to 1.

g. Variations based on tobacco use are limited to a ratio of 1.5 to 1.

2. Group Size Rate Variation: If rates vary by group size, the filing must disclose those factors and provide support based on expected differences by group size. Pursuant to the ACA, variations by group size will not be permitted on or after January 1, 2014 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

3. Closed Block: A carrier that offered small group health plans before October 1, 2011 may close its small group book of business sold before that date and may establish a separate community rate for eligible groups applying for coverage under a small group health plan on or after that date, subject to the following:

a. Rates are subject to the following rating restrictions:

(i) Variations based on age must not exceed the limits set forth in Title 24-A M.R.S.A. § 2808-B(2)(H), subparagraphs 1 through 5.

(ii) Pursuant to the ACA, on or after January 1, 2014, age variations are limited to a ratio of 3 to 1 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

(iii) Pursuant to the ACA, variations by industry or occupation will not be permitted on or after January 1, 2014 for plans other than grandfathered health plans as defined under the ACA and for transitional coverage as defined in Subsection 4(I).

(iv) Variations based on geographic area are limited to a ratio of 1.5 to 1.

(v) Variations based on tobacco use are limited to a ratio of 1.5 to 1.

b. Pursuant to the ACA, except for enrollees in grandfathered health plans as defined under the ACA, beginning January 1, 2014, a carrier shall consider all enrollees in all small group health plans offered by the carrier to be members of a single risk pool. Therefore, after that date, the separate community rate for the closed block will only apply to grandfathered health plans and to transitional coverage as defined in Subsection 4(I).

4. Disclosure of Percentage Increases: If a rate adjustment is proposed, the filing must disclose the average percentage increase an employer will experience as well as the largest percentage increase that any employer will receive. The average increase must be determined by comparing the aggregate premium before and after the increase (assuming no lapses) for all policies renewing during the period during which the rates are intended to be in effect. The maximum increase is the largest increase for an employer under a currently in-force policy, including changes due to trend, aging, and changes in demographic, area, industry rating factors, but excluding changes in the covered population.

5. Size of Block: The rate filing must state the carrier's anticipated average number of members in all small group health plans during the period for which the rates will be in effect and the basis for the estimate.

6. Association and Trustee Groups: Rates applicable to small employers in association or trustee groups that differ from rates applicable to other small employers are subject to the following:

a. Different community rates may not be used for an association or trustee group, unless authorized by the Superintendent pursuant to Title 24-A M.R.S.A. § 2808-B(2)(E).

~~b. The rate filing must state the percentage by which the rates for the association or trustee group differ from the rates for other small employers. If the difference is not a flat percentage, the filing must state the range of percentage differences and the average percentage.~~

c. Pursuant to the ACA, ~~except for enrollees in grandfathered health plans as defined under the ACA,~~ beginning January 1, 2014, a carrier shall consider all enrollees in all small group health plans offered by the carrier to be members of a single risk pool, except for enrollees in grandfathered health plans as defined under the ACA. Therefore, after that date, the separate community rate for the association or trustee group will only apply to grandfathered, unless the association is deemed to be a single large employer under the ACA.

7. Actuarial Certification: 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.

8. Notice to Policyholders: 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 M.R.S.A. § 2839-A(1), and the date on which the notices were sent. If they 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.

C. Annual data collection: The information described in Appendix A must be submitted annually. This data must be filed separately from any rate filing and must be in an electronic format prescribed by the Superintendent.

D. Credible Blocks

1. A block of small group health plans is considered credible if the carrier's anticipated average number of members in all small group health plans during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the ACA. If the Superintendent determines that the number of members is likely to meet that standard, the filing is subject this subsection. Otherwise it is subject to Subsection E.

2. Filings subject to ACA review must contain the items required by Section 12. Filings not subject to ACA review must include a demonstration that the rate revision is not subject to review pursuant to the ACA.

3. Rates filed pursuant to this subsection do not require prior approval. They must be filed for informational purposes at least 60 days prior to implementation unless the Superintendent waives this requirement pursuant to Title 24-A M.R.S.A. § 2808-B(2-A)(A). Filings will be reviewed for compliance with subsections A through C and with the requirements of the small group law. Any deficiencies will be brought to the attention of the carrier. If the rates have already been implemented and do not meet statutory requirements, corrective action may be required. Every effort will be made to process filings within 30 days.

E. Non-credible Blocks: A block of small group health plans is considered non-credible if the carrier's anticipated average number of members in all small group health plans during the period for which the rates will be in effect does not meet standards for full or partial credibility pursuant to the ACA. Rates for non-credible blocks require prior approval and are subject to the following:

1. Minimum Required Loss Ratio: The minimum anticipated pure loss ratio for the period the rates will be in effect must meet the minimum requirements of Title 24-A M.R.S.A. § 2808-B(2-B)(A).

2. Filings of rates applicable to small employers in association or trustee groups that differ from rates applicable to other small employers must include justification for the difference in rates.

3. The filing must include a full explanation of how rates were modified, and the amount of the modifications, to reflect:

a. Risk adjustment under the ACA; and

b. For rates that will be in effect during the years 2014 through 2016, risk corridors under the ACA.

Section 10. Health Maintenance Organization (HMO) Rate Filings

In addition to the requirements of Section 5 and, to the extent applicable, Sections 6, 7, 8, 9, ~~and~~ 12, and 13, 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.

Section 11. Expenses and Investment Income

In addition to the requirements of Section 5 and, to the extent applicable, Sections 6, 7, 8, 9, ~~and~~ 12, and 13, a rate filing or a group of related rate filings for individual or small group policies or contracts that are subject to prior approval, and that cover or are expected to cover more than 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.

For filings covering fewer than 2,000 Maine residents, this information must be provided if requested by the Superintendent.

Section 12. Review Pursuant to the ACA

A. All rate filings that have been identified as "potentially unreasonable" in accordance with the ACA and are subject to Section 13 of this Rule must include Part II of the ACA Preliminary Justification~~, Part I rate increase summary and Part II written explanation of~~ for the rate increase, in addition to Parts I and III required by Section 13. Part II is a simple and brief narrative for any product(s) within the single risk pool which have rate increases subject to review. Part II should describe the data provided in Part I including the assumptions used to develop the rate increase and should provide an explanation of the most significant factors causing the rate increase.

A-1. All rate filings that have been identified as "potentially unreasonable" in accordance with the ACA and which relate to transitional coverage as defined in Section 4 must include the ACA Preliminary Justification, Part I rate increase summary (a form that summarizes the data used to determine the rate increase) and Part II (the written explanation of the rate increase described in Subsection A).

B. A rate increase will be determined to be unreasonable if it is excessive or unfairly discriminatory, or if the carrier provides data or documentation that is incomplete, inadequate, or otherwise does not provide a basis to determine whether the increase is reasonable, and fails to correct the deficiency within a reasonable time in response to a request by the Bureau.

C. Small group rates for credible blocks filed pursuant to Subsection 9(D) may be implemented regardless of whether they are determined to result in an unreasonable rate increase.

1. A carrier may request a preliminary determination of reasonableness and may modify the filing to avoid implementing an unreasonable rate increase.

2. A carrier requesting such a preliminary determination should specify the date by which the determination is needed and should submit the filing at least 60 days before the preliminary determination is needed. The Bureau may or may not be able to honor requests for a determination in less than 60 days.

Section 13. Policies Subject to the ACA Rating Requirements

A. This section applies to individual and small group health plans that were issued or renewed on or after January 1, 2014, other than grandfathered plans and transitional coverage.

B. In addition to the requirements of other sections of this Rule, rate filings for policies subject to the ACA rating requirements are subject the following requirements:

1. All such filings must include the ACA Rate Filing Justification, Part I, the unified rate review template. This template is a form that summarizes the data used to determine rate increases for the entire single risk pool.

2. If required by Section 12, such filings must include the ACA Rate Filing Justification, Part II, the description justifying the rate increase.

3. All such filings must include the ACA Rate Filing Justification, Part III, the actuarial memorandum and must comply with applicable federal guidance. Part III includes rate filing documentation that

states and CMS uses to understand the actuarial assumptions, justifications, and methodologies used to comply with the market rating rules and to complete the Part I template.

Section ~~13~~ 14. Rebates and Medical Loss Ratio Reporting

A. All reporting forms relating to MLR and rebates under the ACA that are required to be filed with the U.S. Department of Health and Human Services must be submitted to the Superintendent on or before the earlier of the date the forms are filed with the U.S. Department of Health and Human Services or the date they are required to be filed under the ACA, as modified by any extension of time granted by the U.S. Department of Health and Human Services or by the Superintendent.

B. Except as provided in Subsection C, rebates must be paid in the large group, small group, and individual markets to the extent required by the ACA and Title 24-A M.R.S.A. § 4319.

C. In the individual market, if the carrier has elected the guaranteed loss ratio option under Subsection 8(H) and the minimum MLR pursuant to the ACA is less than 80%, then the carrier must also provide a modified reporting form based on an 80% minimum MLR. If the modified calculation indicates that rebates must be paid, the carrier must pay those rebate amounts rather than the rebate amounts, if any, indicated by the federal reporting form. Such rebates must be paid in the same manner as is required for rebates pursuant to the ACA.

Section ~~14~~ 15. MEWAs and Captives

A. For purposes of this section, the following definitions apply:

1. "Captive" means a captive insurance company licensed pursuant to Title 24-A M.R.S.A. Chapter 83.

2. "MEWA" means a multiple-employer welfare arrangement licensed pursuant to Title 24-A M.R.S.A. Chapter 81.

B. When a rate increase has been identified as "potentially unreasonable" in accordance with the ACA, the following provisions of this Rule apply to MEWAs and captives:

1. Section 5, General Rate Submission Requirements, applies.

2. Section 9, Small Group Health Plans, applies with respect to coverage of small employers, except that Subsection E does not apply and Subsection D applies regardless of whether the average number of members covered meets credibility standards pursuant to the ACA.

3. Section 12, Review Pursuant to the ACA, applies.

3-A. Section 13, Policies Subject to the ACA Rating Requirements, applies.

4. Notwithstanding the requirement for separate large group and small group filings in Sections 5 and 9, a MEWA or captive may make a combined large and small group rate filing if the rates do not differ between large and small groups. However, separate ACA Preliminary Justifications must be included for small groups and, if required, for large groups.

C. When a rate increase is subject to the ACA and has not been identified as "potentially unreasonable" in accordance with the ACA, the MEWA or captive shall provide an informational filing at least 60 days before

the effective date of the rate increase explaining why the increase is not "potentially unreasonable" as defined under the ACA.

D. Section 1~~3~~4, Rebates and Medical Loss Ratio Reporting, applies to MEWAs and captives to the extent required by the ACA.

E. Notwithstanding Paragraph 5(C)(6), MEWAs and captives may prepare filings in a manner that protects the confidentiality of information that is confidential under Maine law, including in the case of captives any information that is protected by Title 24-A M.R.S.A. § 6715, by following the confidentiality protocol available on the Bureau of Insurance web site.

F. No other provisions of this rule apply to MEWAs and captives, except that the general provisions set forth in Sections 1 through 4 and Section 15 apply to the extent relevant.

Section ~~15~~ 16. Effective Date

The provisions of this rule are effective March 1, 2000. The 2001 amendments are effective February 26, 2002. The 2004 amendments are effective May 3, 2004. The 2006 amendments are effective March 12, 2006. The 2012 amendments are effective April 10, 2012. The 2016 amendments are effective April 19, 2016.

APPENDIX A. Annual Data Collection

To enable the Bureau to monitor the impact of small group and individual health insurance reform laws on the~~e~~ose markets, all carriers in the~~e~~ose markets must submit the following information (unless otherwise specified) annually on or before April 30. This information must be filed in an electronic format prescribed by the Superintendent.

~~I. Individual.~~

All carriers offering or renewing individual health plans subject to Title 24-A § 2736-C and carriers offering small group health plans subject to Title 24-A M.R.S.A. §2808-B must provide the following data:

A. Demographic information: For on-exchange and off-exchange separately for each type of ~~coverage (indemnity, PPO, or HMO*)~~metal level plan ((Catastrophic, Bronze, Silver (including 73, 87 and 94% cost sharing reduction plans and no cost sharing reduction plans), Gold and Platinum)) including grandfathered and transitional coverage, report the number of Maine covered persons by age as of the ~~prior year-end~~ current year to reflect open enrollment results. ~~using the following format:~~

~~Age Bands (use 5 year age bands when possible)~~	~~Male~~	~~Female~~	~~Total~~
~~Children (M/F)~~			
~~Total~~			

~~* HMO includes point-of-service (POS) plans.~~

B. Experience data for individual and small group separately: For all plans combined, provide earned premium and incurred claims for the prior calendar year.

~~II. Small Group~~

~~All carriers offering small group health plans subject to Title 24-A § 2808-B must provide the following data for their small group business:~~

~~A. Demographic information:~~

~~1. For each type of coverage (indemnity, PPO, or HMO*), report the number of Maine **employees** insured as of the prior year-end using the following format. Use 5-year age bands when possible and fill out only those tiers that apply:~~

~~Age Bands~~	~~Male~~					~~Female~~				
	~~EE~~	~~EE + Spouse~~	~~EE + Children~~	~~EE + Family~~	~~Total~~	~~EE~~	~~EE + Spouse~~	~~EE + Children~~	~~EE + Family~~	~~Total~~

~~Total~~										

~~* HMO includes point-of-service (POS) plans.~~

~~2. For each type of coverage (indemnity, PPO or HMO), report the number of Maine **lives** covered as of the prior year-end using the format below. If you cannot provide exact counts for dependents, please estimate the number of dependents for each age band and describe your method of estimation.~~

~~Age Bands (use 5 year increments when possible~~	~~Male~~		~~Female~~		~~Total~~
	~~Employee~~	~~Dependent~~	~~Employee~~	~~Dependent~~	
~~Total~~					

~~B. Experience data: For all plans combined, provide earned premium and incurred claims for the prior calendar year.~~