# Rate Filing Disclosure

The following three sections apply to those premium increases that meet the “unreasonable” test under Section 2794 of the Public Health Service Act. Health insurance issuers are required to submit the information required under these three sections and a complete rate filing which includes a justification for the premium increase to the Secretary and the relevant state prior to the implementation of the increase.

## Section 1 — Overview of the Rate Filing

### A. Issuer Information and Type of Plan

1. **Health Insurance Issuer**
   - Insurance company submitting the rate change request.

2. **NAIC Company Code**
   - Unique identifier assigned to the insurance company.

3. **State**
   - State where rate filing is required to be filed.

4. **Type of Plan**
   - Select one
   - **Individual**
   - **Small Group**
   - **Large Group**
   - **Conversion**

5. **SERFF Tracking Number**
   - Unique identifier assigned by the SERFF system to identify the filing.

6. **State Tracking Number**
   - Unique identifier assigned by the state to identify the filing.

7. **Policy Form Number(s)**
   - Unique identifier related to the policy forms associated with the rate filing.

8. **Plan Name(s)**
   - Name given to the plan by the insurer

9. **Product Type**
   - Select all that apply
   - **HMO** - Health Maintenance Organization
   - **PPO** - Preferred Provider Organization
   - **POS** - Point of Service
   - **HSA** - Health Savings Account
   - **HDHP** - High Deductible Health Plan
   - **FFS** - Fee-For-Service
   - **EPO** - Exclusive Provider Organization
   - **Other**

10. **Description of Deductible, Copayment and Coinsurance**

11. **Block of Business Status**
    - Select one
    - **Open**
    - **Closed**

### B. Rate Request

1. **Proposed Effective Date**

2. **Number of Covered Persons in this State**

3. **Number of Covered Persons under the Plans Nationwide**

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B. Rate Request (cont.)

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Proposed Average Rate Increase/(Decrease)$</td>
<td>%</td>
<td>$</td>
</tr>
<tr>
<td>5. Minimum Increase/(Decrease) for any Individual</td>
<td>%</td>
<td>$</td>
</tr>
<tr>
<td>6. Maximum Increase/(Decrease) for any Individual</td>
<td>%</td>
<td>$</td>
</tr>
</tbody>
</table>

$ The average rate does not mean that the premium will increase/(decrease) by this amount. Premiums are affected by many factors, including ages of the people covered, whether family members are covered and the date the policy renews. The "Minimum/Maximum Rate Increase for any Individual" is to capture the minimum/maximum premium increase for any individual within this block of business.

C. Components of the Average Rate Increase/(Decrease) and Basis for Rate Request

Break down the “Proposed Average Rate Increase/(Decrease)” into the following components of rate changes (in percentage):

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>% CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical** Utilization Changes</td>
<td>%</td>
</tr>
<tr>
<td>2. Medical** Price Changes</td>
<td>%</td>
</tr>
<tr>
<td>3. Medical** Benefit Changes Required by Law</td>
<td>%</td>
</tr>
<tr>
<td>4. Medical** Benefit Changes Not Required by Law</td>
<td>%</td>
</tr>
<tr>
<td>5. Changes to Administration Costs</td>
<td>%</td>
</tr>
<tr>
<td>6. Insufficiency of Prior Rates</td>
<td>%</td>
</tr>
<tr>
<td>Continuing losses that need to be covered by additional rate – not a recovery of previous losses, but a projection of continued shortfall from target.</td>
<td></td>
</tr>
<tr>
<td>7. Other Reasons for the Rate Request</td>
<td>%</td>
</tr>
<tr>
<td>8. Overall Average Rate Increase/(Decrease)</td>
<td>%</td>
</tr>
</tbody>
</table>

Provide a Simple Calculation of how the Average Rate Increase/(Decrease) is derived based on the above components of rate changes.

**Medical includes Prescription Drug

D. Earned Premiums, Incurred Claims, and Underwriting Gain/Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing and for Nationwide if the plans are available in other states

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (a) Reported 12-Month Period</td>
<td>From: This State</td>
<td>To: Nationwide</td>
</tr>
<tr>
<td>(b) Member Months</td>
<td>___________________</td>
<td>___________________</td>
</tr>
<tr>
<td>2. Earned Premiums Excluding Federal and State Taxes and Licensing or Regulatory Fees</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3. Reimbursement for Clinical Services Provided to Enrollees</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4. Activities That Improve Health Care Quality</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. Federal and State Taxes and Licensing or Regulatory Fees</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
D. Earned Premiums, Claims Costs, and Underwriting Gain/Loss Per Member Per Month (PMPM) for the 12-Month Experience Period for the Plans Included in this filing and for Nationwide if the plans are available in other states (cont.)

6. Administrative Costs Allocated or Assigned to the Plans
   Reported in this Filing, Excluding Items 4 and 5 Above and
   by the Following Categories:

   a) Total annual compensation of the ten highest paid
      officers or employees .................................................. $  ___________  $  ___________
   b) Total annual compensation for staff other than ten
      highest paid officers or employees  ............................. $  ___________  $  ___________
   c) Agents or brokers fees and commissions  .................. $  ___________  $  ___________
   d) Other General and Administrative Expenses ............... $  ___________  $  ___________
   e) Total = a + b + c + d .................................................. $  ___________  $  ___________

7. Underwriting Gain/(Loss) (Line 2 – (Lines 3 + 4 + 6))  $  ___________  $  ___________

E. Projected Results of the Proposed Rates

1. Reimbursement for Clinical Services Provided to Enrollees
   as a Percentage of Premiums
   % calculated in Section 1.D  Proposed %

2. Activities That Improve Health Care Quality as a Percentage
   of Premiums
   %  ___________  %  ___________  %  ___________  %  ___________

3. Federal and State Taxes and Licensing or Regulatory Fees
   as a Percentage of Premiums
   %  ___________  %  ___________  %  ___________  %  ___________

4. Administrative Costs as a Percentage of Premiums
   %  ___________  %  ___________  %  ___________  %  ___________

5. Underwriting Gain/Loss as a Percentage of Premiums
   %  ___________  %  ___________  %  ___________  %  ___________

   For purposes of calculations in Section 1.E, premiums mean earned premiums excluding federal and state taxes and licensing or regulatory fees.

F. Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

   Calendar Year  Requested This State  Implemented This State  Implemented Nationwide

1. Past Year  %  ___________  %  ___________  %  ___________

2. Past Year  %  ___________  %  ___________  %  ___________

3. Past Year  %  ___________  %  ___________  %  ___________

SECTION 2 — DETAILED DESCRIPTION OF THE RATE FILING

A. Issuer Information and Type of Plan
   Provide a description of the issuer and type of plan.

B. Rate Request
   Provide a brief description of the carrier's rate-making methodology, including identification of the data used and
   the kinds of the assumptions and projections made, and the rating requirements specifically required by this State.
   If this State's data is not credible, describe how a larger set of data is used and how the credibility factors are
   applied in order to derive the rate projection. List the average number of covered persons during the experience

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provide the description of the calculation for the average rate increase/decrease and the minimum/maximum rate change for any individual, including built-in trend factors, duration factors, age, geography, family size, industry, health status and other rating factors used to calculate the average rate increase/decrease or the minimum/maximum rate change. Include a detailed description of how the average rate increase/decrease and the minimum/maximum rate change are translated into the increase/decrease per member per month (PMPM). Provide an illustrative example if necessary. List the rating requirements (such as adjusted community rating) and citations of the rating requirements specifically required by this state.

C. Components of the Average Rate Change and Basis for Rate Request
Provide a detailed description of each component of rate changes listed in Section 1.C and the calculation of the overall average rate increase/decrease derived from these components. List benefits changes required by law, and not required by law, including changes to deductible, copayment, coinsurance and essential health benefits defined under Section 1302(b) of the Patient Protection and Affordable Care Act. Provide reasons for any benefits changes not required by law.

D. Earned Premiums, Claims Costs, and Underwriting Gain Loss
Provide each item listed in Section 1.D for the 12-month experience period from this state and nationwide. List and explain in detail all adjustments in earned premiums, such as state assessments, collections or receipts for risk adjustment and risk corridors, and payments of reinsurance. List all activities that improve health care quality.

E. Projected Results of the Proposed Rates
Include detailed calculations of each item listed in Section 1.E. Provide all justifications of any adjustments used to calculate these projected results.

F. Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years
Provide an explanation of how these calendar-year rate changes in Section 1.F were translated from past rate filings.

G. Additional Comments
Provide additional comments from an officer on the reasons for the proposed rate change, including the following topics:
1. Whether certain benefits have been reduced or enhanced in order to steer members towards more effective and more cost-effective services.
2. Any efforts toward cost containment and quality improvement, especially those inaugurated since the insurer’s last rate filing.
3. Description of how rate changes can vary depending on rating factors, including examples.
4. Incurred claims for clinical services provided to enrollees as referenced in Section 2718 of the Public Health Service Act for the plans included in this rate filing for each month of the experience period and the prior two (12-month) periods, and breakdown by the following categories:
   a) Inpatient Hospital,
   b) Outpatient Hospital,
   c) Physician,
   d) Pharmacy,
   e) Laboratory,
   f) Imaging,
   g) Emergency Room, and
   h) Others

5. A breakdown of the health insurance issuer’s expenses allocated or assigned to the plans included in this rate filing for the experience period and the prior two (12-month) periods at least as detailed as the categories listed below. Provide the documentation and justification of the assignment or allocation of the expense to the plans included in this rate filing.
   a) Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act,
   b) Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act,
   c) Total annual compensation of the ten highest paid officers or employees,
   d) Total annual compensation for staff other than ten highest paid officers or employees,
   e) Agents and brokers fees and commissions, and
   f) Other General and Administrative Expenses.

6. A detailed calculation and documentation of the proposed rate change including but not limited to the following:
   a) Earned premiums for the experience period, premiums adjusted to the current rate level, and the projected earned premiums.
   b) Incurred claims for the experience period, and the projected claims.
   c) Trend factors and detailed development.
   d) Impacts on claims due to benefit changes.
   e) Projected breakdown of the expenses as a dollar amount and as a percentage of projected earned premiums by the following categories:
      • Activities that improve health care quality as referenced in Section 2718 of the Public Health Service Act,
      • Federal and state taxes and licensing or regulatory fees as referenced in Section 2718 of the Public Health Service Act,
      • Total annual compensation of the ten highest paid officers or employees,
      • Total annual compensation for staff other than ten highest paid officers or employees,
      • Agents and brokers fees and commissions,
      • Other General and Administrative Expenses,
      • Any credit from forecasted investment earnings on claim reserves or other similar liabilities, and
      • A reasonable provision for projected profit, contribution to surplus, contingency charges, or risk charges. For the purposes of this section, “projected profit, contribution to surplus, contingency charges, or risk charges” means the portion of the “projected earned premiums” not associated directly with the “claims” or “expenses.”
   f) Factors used to derive the projected rate change and the specific rate for any individual, employee, or employer including built-in trend factors, duration factors (such as durational loss ratio), age, geography, family size, industry, health status and other applicable rating factors.
   g) Documentation and justification for the credibility factors used in the rate projection if the experience of the plans included in the rate filing is not credible.
   h) Changes to the rating factors from prior rate filing to this rate filing and the impacts on the rate projection. Health insurance issuer must provide a justification for the changes to the rating factors. For example, if the age factors are modified from the prior rate filing, the issuer must show that the revenues projected before and after changing the age factors are the same.
   i) Base rates and plan relativities if two or more plans are included in the rate filing. For the purposes of this section, base rate means the rate for any plan prior to the adjustment for any rating factors. The plan relativities mean the relative values of the benefit plan.
j) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, including the minimum and maximum rate change for any individuals or covered persons, the range of rate change by the distribution of members or groups. The methodology must be detailed enough to allow the reviewer to replicate the calculation of premium rates if given the necessary data.

7. Provide the documentation and calculations of the overall average rate increase and each component of rate change as described in Section 1.C. Efforts should be made to break down the medical utilization and price changes consistent with the data required under this section and into the following categories: inpatient hospital, outpatient hospital, physician, pharmacy, laboratory, imaging, emergency room, and other.

8. A certification by a member of the American Academy of Actuaries that rates for the plans included in this filing are reasonable in relation to the benefits provided.

9. The requirements of subsections (2) through (7) may be modified by the health insurance issuer if a reasonable explanation is provided. For example, if the rate filing involves capitation contracts that would make it difficult to breakdown the categories as required by subsection (4), the issuer may modify the categories for the purposes of reporting.

10. Since the rate filing cannot be understood without a wider understanding of the company, the health insurance issuer’s most recent Annual Financial Statement and related supplemental filings may be accessed at the following website: https://eapps.naic.org/insData/. The following pages or exhibits from an insurer’s filing provide information that can be helpful in understanding the insurer’s financial position:

- Assets
- Liabilities, Capital, and Surplus
- Statement of Revenue and Expenses
- Analysis of Operations by Line of Business
- Underwriting and Investment Exhibit—Analysis of Expenses
- Exhibit of Net Investment Income
- Exhibit of Capital Gains (Losses)
- Enrollment by Product Type for Health Business Only (Exhibit 1 of the Health Annual Statement Blank)
- Summary of Transactions with Providers (Exhibit 7 of the Health Annual Statement Blank).
- Notes to Financial Statements
- General Interrogatories
- Five-Year Historical Data
- Exhibit of Premiums, Enrollment, and Utilization
- Management’s Discussion and Analysis
- Accident and Health Policy Experience Exhibit
- Supplemental Compensation Exhibit
- Supplemental Health Care Exhibit (now being developed by E Committee)

(Note: The data included in the above is companywide information and reported on a calendar year basis. The data submitted in the rate filing is information assigned or allocated to the plans referenced in the rate filing and may not be on a calendar year basis.)

Definition and Glossary of Terms: Some items mentioned throughout these three sections are yet to be determined. (For example, what kind of activities can be classified as activities that improve health quality?) It is recommended that a link to the Definition and Glossary of Terms be included.