

**South Carolina
Department of Insurance**

NIKKI R. HALEY
Governor

DAVID BLACK
Director of Insurance

BULLETIN NUMBER 2011-11

TO: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and All South Carolina Licensed Health Maintenance Organizations.

FROM: David Black 
Director

SUBJECT: New Rate Filing Procedures to Comply with 45 C.F.R. Part 154 as Promulgated by the Center for Consumer Information and Insurance Oversight and Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services (HHS) as amended by CMS on September 6, 2011

DATE: October 18, 2011

I. PURPOSE

The purpose of this bulletin is to inform South Carolina health insurance issuers of the new rate requirements and filing procedures that the Department is adopting to comply with 45 C.F.R. Part 154 as amended on September 6, 2011, and the related additional reporting requirements that must be met prior to implementing rate increases for association coverage issued or extended to residents of South Carolina. The Department is requiring this additional information in accordance with the Director's authority under South Carolina Code of Laws sections 38-13-160 and 38-71-750. This bulletin supersedes and replaces any and all other bulletins which did not require the submission of rate filings by associations or trusts.

II. BACKGROUND AND DEFINITIONS

On May 23, 2011, 45 C.F.R Part 154, titled as the HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS rule, was published in the Federal Register. The rule establishes the requirements for health insurance issuers offering health insurance coverage in the small group or individual markets, to report information on rate increases that are above a specific threshold and designated as subject to review. The rule establishes the process by which such increases are reviewed to determine whether they are unreasonable.

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On September 6, 2011, CMS published an amendment to the Rate Increase Disclosure and Review Regulation (45 CFR Part 154). The amendment changes the definition of individual and small group markets to include: 1) coverage that is considered to be large group coverage under State law; or 2) is otherwise excluded from a State's definition of individual or small group coverage under applicable rate filing laws but which otherwise would be regulated as individual market coverage or small group market coverage as such terms are defined in Section 2791(e)(1)(A) and 2791(e)(5) of the Public Health Service Act, respectively ("association coverage"). Association coverage includes coverage issued to a trust or to insure persons who are associated in a common group for purposes other than the obtaining of insurance. It also includes coverage extended to residents of this State under a policy issued outside of this State. According to 45 C.F.R. §154.103, association coverage may be subject to rate review as individual coverage if it appears to be individual coverage marketed through an association. Group coverage marketed through an association to small employers will be regulated as small group health insurance coverage.

Further, the terms "health insurance issuers," "health insurance coverage," "small group market" and "individual market" shall have the meaning set forth in the Affordable Care Act ("ACA").

III. APPLICABILITY AND SCOPE

On September 6, 2011, CMS amended the definitions of individual and small group markets in 45 C.F.R. §154.103 to read as follows:

Individual market has the meaning given the term under the applicable State's rate filing laws, except that:

- (1) Where State law does not define the term, it has the meaning given in section 2791(e)(1)(A) of the PHS Act; and
- (2) Coverage that would be regulated as individual market coverage (as defined in section 2791(e)(1)(A)) if it were not sold through an association is subject to rate review as individual market coverage.

Small group market has the meaning given under the applicable State's rate filing laws, except that:

- (1) Where State law does not define the term, it has the meaning given in section 2791(e)(5) of the PHS Act; provided, however, that for the purpose of this definition, "50" employees applies in place of "100" employees in the definition of "small employer" under section 2791(e)(4); and
- (2) Coverage that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

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45 C.F.R. Part 154 requires certain information to be reported for rate increases that are above a specific threshold ("additional reporting requirements"). Because South Carolina law does not recognize rate thresholds, the Department is requiring submission of the additional reporting requirements for ALL rate increases for association coverage issued or extended to residents of South Carolina. All plans must continue to comply with existing filing requirements which may be found on the Department's website, www.doi.sc.gov. This additional information will enhance the Director's or his designee's ability to determine whether a health insurance product meets the definition of individual or small group and whether the rate for that product is unreasonable in accordance with the requirements of §38-71-310 and §38-71-920 through §38-71-970.

IV. ADDITIONAL REPORTING REQUIREMENTS

At least 90 days in advance of the anticipated rate increase effective date for association coverage, all health insurance issuers shall submit the following information:

- (1) Rate Increase Summary (Part I), as described in 45 C.F.R §154.215 (e). The rate increase summary should be submitted in the standard excel format as provided by HHS.
- (2) Written Explanation of the Rate Increase (Part II), as set forth in 45 C.F.R. §154.215 (f).
- (3) Rate Filing Documentation (Part III), as set forth in 45 C.F.R. §154.215 (g).

The Department will use this information to evaluate the proposed rate increase and to make a determination as to whether the rate increase is unreasonable in accordance with the standards set forth in §38-71-310(B) for the individual market and §38-71-970 for the small group market. The evaluation will include, but will not be limited to, an examination of the following:

- (1) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions; and
- (2) The health insurance issuer's data related to past projections and actual experience.

This examination will take into consideration the following twelve factors to the extent applicable to the filing under review, namely:

- The impact of medical trend changes by major service categories
- The impact of utilization changes by major service categories

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- The impact of cost-sharing changes by major service categories
- The impact of benefit changes
- The impact of changes in enrollment risk profile
- The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase
- The impact of changes in reserve needs
- The impact of changes in administrative costs related to programs that improve health care quality
- The impact of changes in other administrative costs
- The impact of changes in applicable taxes, licensing or regulatory fees
- Medical loss ratio
- The health insurance issuer's capital and surplus

Health insurance issuers must submit any additional information required by the Department in conducting these reviews.

All filings and other submissions must be filed through the SERFF system. In addition to noting that the filing is a rate increase for association coverage, health insurance insurers must provide the following information for each filing:

- An indication as to whether the coverage is "Open" or "Closed" for new enrollees;
- An indication as to whether the coverage is sold in the "Individual" market or the "Small Group" market;
- If the coverage is sold in both the Individual market and the small group market, then the filing should indicate that it is sold in both markets and be labeled as "Small Group":

The Department will provide a link to the information contained in Parts I and II of the Preliminary Justifications for proposed rate increases that CMS makes available to the public on its website. Further, the Department will establish a dedicated electronic mailbox as a mechanism for receiving public comments on those proposed rate increases.

V. FILING INFORMATION

To assist insurers with the filing requirements set forth in this bulletin, the Department shall make available on its website (www.doi.sc.gov) the HHS Rate Increase Summary excel spreadsheet and the instructions from HHS for its completion.

VI. EFFECTIVE DATE

The additional reporting requirements apply to any rate increase for association coverage filed in South Carolina on or after November 1, 2011. To allow the Department sufficient time for

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review, all filers should submit this information at least 90 days in advance of the anticipated rate increase effective date.

VII. QUESTIONS

Questions regarding this Bulletin should be addressed to:

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