Puerto Rico

Rate Filing Instruction Manual

Overview

This instruction manual supports implementation of the requirement of Ruling Letter No. CN-2017-218-AS of March 6, 2017. For all ACA compliant products, rates for new products and all rate changes must be submitted to the OCI for approval.

For all grandfathered products only rate increases must be filed with the OCI. Under Section 2794 of the Public Health Service Act, as amended by Section 1003 of the Federal Patient Protection and Affordable Care Act ("PPACA"), disability insurers that write medical plans in Puerto Rico have the obligation to submit to the Office of the Commissioner of Insurance ("OCI","OCS"), for review and approval, any rate increase for non-grandfathered plans where the average increase is equal to or greater than ten percent (10%) of current rates, effective September 1, 2011. For Health Service Organizations all rate increases must be submitted to OCI no matter the amount of the increase. The purpose of this requirement is to allow the OCI (OCS) to determine whether the proposed rate increase for small group and individual markets is unreasonable. Rates that are subject to approval by the OCI (OCS) must be submitted at least sixty (60) days before the effective date.[1] If there is an objection from the OCI (OCS), the time required for the objection to be answered will not be included in the 60 days and therefore may delay the implementation date.

The carrier MUST only use the rates filed and approved.

A complete rate filing must include all of the information required by Ruling Letter No. CN-2017-218-AS, as applicable. The manual and templates do not supersede the regulations, they merely standardize and make explicit the information already required or allowed to be requested by those regulations.

Carriers must use SERFF to submit their rate filings as required by Ruling Letter 2012 140-AV of February 7, 2012. Carriers must fill out all the SERFF data elements, including Affordable Care Act ("ACA") data elements, or the filing will be rejected as incomplete. ACA requires that if there is any rate change to an ACA compliant product, rates for all ACA compliant products in that market (individual or small group) must be filed together. That is if any rates change all previously filed rates must be filed again with the new rates.

Under the Affordable Care Act and rules that became effective on 9/1/2011, carriers with average rate increases of more than 10% per year must submit rate justification information to the Federal Center for Consumer Information and Insurance Oversight ("CCIIO"). For non-ACA compliant products[2], the federal rate summary worksheet and Preliminary Justification also should be submitted to the Centers for Medicare & Medicaid Services ("CMS") on the same date as the filing with the OCI (OCS). Please note that the information submitted to the OCI (OCS) should be consistent with the information submitted to the "CCIIO" and "CMS." In Puerto Rico, all rate increases by HMOs must be filed with the OCI (OCS) if they are ACA compliant or not.

[1] To ensure that rates are approved before they are effective the OCI is requesting that all rates be filed 90 days before they are used. This will be May 30, 2014 for rate filings for 2015 rates.

[2] Non-ACA compliant policies include grandfathered policies and transitional policies.

Consistent with ACA, the OCI (OCS) requires rate filings to include the following parts, if there is any change in rates or plans offering of ACA compliant products in a market. For all ACA compliant products the following should be filed once a year even if there is no rate change. For ACA compliant products and all grandfathered HMO rate increases and non-HMO rate increases over 10% should also submit the following:

1) Federal Rate Review Justification Part I: Unified Rate Review Template (URRT);
2) Public form of the rate filing information to be placed on the OCI (OCS) website and used for the HIOS Federal Rate Review Justification Part II: Written explanation of any rate increase that is 10% or over;
3) Actuarial Memorandum meeting the requirements of Puerto Rico and the federal 2014 Actuarial Memorandum and Certification Instructions 2.0 (Part III).
4) Puerto Rico actuarial certification;
5) Actuarial value calculator screenshots (for ACA compliant only);
6) SERFF Rate template;
7) Rate manual
8) Puerto Rico Benefits Map (if different from the Benefits Map already filed with the OCI (OCS) or not Benefits Map has been filed; and

Section I: Unified Rate Review Template (URRT)

Provide a copy of the URRT template in Excel and also in a PDF printout version. The URRT should be completed with all HIOS information.

For a more complete description of the items in the URRT, please refer to the Department of Health and Human Services (HHS) instructions.

Section II: Written Explanation

For all rate increases that are greater than the review threshold, a brief written explanation of the rate increase must be submitted. This written explanation must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase. This includes:

1) Brief description in simple language the reasons why the rate increase is being requested;
2) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increase reported in the rate increase summary; and
3) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

This summary will be uploaded to the OCI website for public use and it will also be used for the HIOS Preliminary Justification Part II that is required for all rate increases over 10%.

Section III: Federal Actuarial Memorandum and Certification[3]

The Actuarial Memorandum and Certification documents the methodology used in developing the rates and includes an actuarial opinion signed by a qualified actuary providing an opinion that the rate filing was developed according to actuarial standards and principles and the laws of Puerto Rico.

A Part III Federal Actuarial Memorandum, including a corresponding actuarial certification, must be submitted with each Part I Unified Rate Review Template.

The purpose of the Part III actuarial memorandum is to provide support for the values entered into the Part I Unified Rate Review Template. The documentation should clearly identify the plans applicable to each piece of information. All assumptions should be adequately justified with supporting data, where possible, and the rationale for the use of the chosen assumptions.

For a more complete description of the items in the Part III Actuarial Memorandum and Certification, please refer to the Department of Health and Human Services (HHS) instructions.

Section IV: Puerto Rico Actuarial Memorandum

In order to review rates in Puerto Rico the OCI requires information in addition to the federal actuarial memorandum. We encourage carriers to submit both the federal information and the additional Puerto Rico information in the same document. Information that we believe to be in addition to the federal requirements is italicized below. This difference may change in the future as the federal requirements change.

The carrier must provide a detailed description of the method used to develop the premium rates. Since there is much overlap with the Federal Actuarial Memorandum, one actuarial memorandum can be submitted as long as it contains all of the information required in both memorandums. The major difference is the Puerto Rico requirements is the addition of quantitative support for assumptions. The memorandum should also include more detail on any item that the carrier believes is driving the rate increase projections or would be of particular concern when reviewing the rate filing.

Overview of Rate Increase

Provide a brief explanation of why a rate increase is being requested and on what policy forms including the names of the policy forms affected.

Describe the scope and driving factors impacting the rate increase including a description of how the rates were determined.

Provide a description of:

1) Type of Products;
2) Benefits;
3) General Marketing Method;

[3] See Appendix A for Actuarial Certification

4) Premium Classifications or Rating Factors; and
5) Underwriting Method (grandfathered only).

Rate increase information including:

1) Historic rate increases for the last 3 years;
2) Proposed effective date of the rate increase (grandfathered only);
3) Requested minimum, maximum and average rate increase – from current rates and annual from one year prior; and
4) Effective through date and any rate increase schedule applicable (small group only).[4]

Base Period Experience

Provide an explanation of the base period experience used indicating the basis of the data used, the first incurred date included and the last incurred date included. The last paid date used should be provided, which indicates the paid through date for the base period experience.

Provide an explanation of how incurred claims were estimated from paid claims including the average completion factor[5] used and an explanation of adjustments made to base period claims experience.

If contract reserves were established for these contracts, describe what they are for, how they were developed and how they impacted the rate development.

Describe the treatment of large claims and claims pooling, if any.

Treatment of commercial reinsurance, if any. This is separate from the Transitional Federal Reinsurance program, but is adjustments for commercial reinsurance purchased by the carrier to protect against the risk of large claims.

Provide an exhibit showing current age distribution and the age distribution anticipated for projection period, if different.

Capitation Payments

Describe what is covered by any capitation payments and the PMPM impact.

Projection Factors and Claims Trends

Provide documentation of all assumptions and methodologies used in the development of the impact of morbidity and enrollee mix.

If there were changes in the benefits covered, provide a description of all benefit changes and quantitative support of their impact.

[4] Small group rate increases can only be on a quarterly basis.

[5] The average completion factor is the ratio of the incurred claims for a period of time to the paid claims for the same period as of the last paid date used for the base period experience. The incurred claims are the total claims that are expected to be paid in the base experience. The paid claims are the amounts that have actually been paid as of any point in time. As time goes on more claims are paid and the ratio is higher.

For each Essential Health Benefit (EHB) not covered previously, the additional cost per-member-per-month (PMPM) with an actuarial explanation of how the additional cost was developed.

Provide a description of all changes in the rating structure, if any, and provide quantitative support of their impact including all assumptions used.

Provide quantitative support of the impact due to changes to network, if any.

If there are other changes impacting rates, provide a description and quantitative documentation of all factors, including any adjustments for past experience due to actual loss ratios differing from target loss ratios.

Provide quantitative documentation of the trend development including as well as an explanation of the data, assumptions, and periods used.

Provide:

- Changes in medical cost trend by major service categories for the past three years and future projections.
- Changes in the use of services by major service categories for the past three years and future projections.

Historic cost and utilization assumptions used compared to the actual trends experienced. Until 2015 filings for the 2016 rates, there may be little or no information, but starting in 2015 you should provide the past projections compared to the actual experience.

Please explain significant changes in assumptions from the prior filing assumptions.

Manual Rate Development

If the experience for the product is too small to be considered credible, alternative claims experience can be used. Include detail description of all alternative experience data used and how it was adjusted to be appropriate for the market including any adjustments similar in type to the adjustments made to base data.

Credibility

Indicate the credibility methodology and credibility level of the base period experience.

Paid to Allowed Ratio

Provide a quantitative demonstration of the development of the paid to allowed ratio.[6] Since Puerto Rico has different claims distribution patterns than those used as the basis of the AVC, it has been determined that company specific projections, which will not be similar to the AVC outputs, should be used for Puerto Rico rate development and in the URRT Market Experience worksheet cell V33. [7]

Risk Adjustment and Reinsurance

Risk adjustment and reinsurance do not apply to Puerto Rico.

[6] This ratio is actually the incurred claims to allowed claims ratio

[7] The AVC should be used for the determination of metal levels unless it is replaced by a Puerto Rico specific calculator

Non-Benefit Expense Projections

The methodology used to project non-benefit expenses, including gain/loss margins, should be explained. If a loss ratio approach was used, the carrier should explain how the target loss ratio was developed.

Administrative Costs

Identify the main factors that affect changes in administrative costs. Discuss how changes in projected administrative costs and profit are impacting the rate increase and what is driving these changes.

If budgets were used, the carrier should explain when the budgets were developed and for what time period.

Provide actual administrative expenses PMPM for the last three years and explain any significant changes in administrative expenses from the prior filing.

Provide a breakdown of projected administrative expenses with any marketing, commission, and quality improvement costs separated. If there are no quality improvement costs in the administrative costs, indicate zero.

If administrative expenses vary by plan explain why.

Projected Gain/Loss Margins

Provide an explanation of how the projected gain/loss margins were developed and any changes from prior filings.

Taxes and Fees

Provide a description of applicable taxes and fees, their impacts, and an explanation of how they were allocated across plans.

Provide a breakdown of projected taxes with amounts of each and their quantitative development.

Medical Loss Ratio

Describe how the projected federal medical loss ratio was calculated. Describe how the credibility adjustment was determined. A demonstration of the projected loss ratio using the federal loss ratio formula should be provided including the values used.

If the loss ratio is less than the federal rebate requirement, explain the plan to comply with the Federal MLR requirement.

Index Rate

This documentation should provide a descriptive and quantitative development of the plan index rates starting with the market index. This development should be supported by excel exhibits with formulas intact. The following steps should be explicit:

1) Plan level adjustments

a. Projected ratio of incurred claims to allowed claims (pricing actuarial value) for each plan and any adjustment to utilization due to cost sharing (separate, if possible);

b. Provider network, delivery system and utilization management adjustment;

c. Benefits in addition to EHBs (the estimate of these benefits should be shown in a quantitative development);

d. Impact of the eligibility for the catastrophic plan; and

e. Administrative costs.

2) Calibration for base characteristics to base market allowed:

a. Weighted average age;[8]

b. Calibration for family composition;[9], and

c. Calibration for tobacco usage.[10]

Provide quantitative documentation of the rating factor for tobacco.

Provide an example procedure of determining a family rate. Demonstrate that this family rating complies with the federal rating rules of the ACA.

AV Metal Values

The AV Metal Values must be determined using the Federal Actuarial Value Calculator. If an alternative methodology was used due to a unique plan design, it must be well documented.

Plan Adjusted Index Rate

Provide quantitative development in excel with all formulas of the plan adjusted index rate. This development should start with the market index rate and show all adjustments in the development of the plan adjusted index rate. The plan adjusted index rate divided by the average age factor should result in the plan base rate (age 21 non-tobacco rate).

Membership

Provide documentation of all assumptions used to project membership and provide support for those assumptions.

Company Financial Condition

Describe the financial situation of the company, including surplus, if any. Provide 5 years of RBC ratio levels.

Provide historic loss ratios for the last five years.

[8] The federal instructions only ask for a weighted average age, but we are requesting the calibration factor, which is typically the inverse of the weighted average age factor.

[9] This calibration is for the situation where there are more than three children, but only three can be included in the premium.

[10] At this time we believe that the federal instructions will be to add this calibration to the actuarial value adjustment, but we would like to see it separated out.

Small Groups Affected

The carrier should provide a list of all small groups affected by the proposed rate increase, the proposed increase for each group, the date of the group's contract renewal, and the effective date for each group 30 days prior to implementation. The list of small groups affected and renewal dates will depend on the proposed effective date of the rate increase. The carrier should list all small groups that will receive a rate increase in the next 30 day period with each group's average rate increase, renewal date and rate increase effective date in an Excel file attached to an email to the OCI. This information will eventually be posted to the OCI website.

Section V: Public Information

Every carrier must provide a written summary of the rate filing to be displayed on the OCI (OCS) public website. For rate increases over 10% this will also serve as the Preliminary Justification Part II that should be uploaded to HIOS.

Section VI: Rate Template

Provide the federal SERFF Rates Template in excel. This may need to be uploaded in a zip file if they are too large to upload to SERFF.

Section VII: Benefits Map and Actuarial Value

Every carrier should provide to the OCI a benefits map which shows, for all plans, all benefits covered and their respective cost sharing amounts and limits. If the benefits map for a plan has not changed from the prior filing, it does not need to be resubmitted. The carrier should submit a list of plans with an indication of which Benefits Maps are included and the date submitted for any that were submitted previously.

Also for all plans, screenshots of the federal Actuarial Value Calculator (AVC) populated with plan cost share information should be submitted. If the plan has a unique plan design that does not work with the federal Actuarial Value Calculator, a certification of unique plan should be submitted to the OCI as well as quantitative documentation of all adjustments and explanation of all differences that could not be accommodated using the AVC . If the plan decides not to use the AVC, they should provide a certification of unique plan design, an explanation of why they did not use the AVC, and quantitative support for the calculation of each plan's actuarial value.

If several plans are offered at the same metal level in the same region, the sponsor should provide further information on them describing what differentiates them and what the target market is for each.

Section VIII: Rate Manual

If the rate manual has changed or if a carrier has a new product, it should file the rate manual with the OCI.

Appendix A – Standardized Actuarial Certification Letter

Certification

Standardized Excel Worksheet/Written Filing Documentation/Rate Manual

I _____ hereby certify that I was in charge of the preparation, revision or supervision of the worksheet data information corresponding to the submitted rate increase filing. In addition, I certify that the submitted information is accurate, true and complete.

I also acknowledge responsibility for the validity, accuracy and completeness of the contents of the Written Filing Documentation and the Rate Manual.

_____
Signature

_____
Title

_____
Carrier

_____
Date

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