Eff. 10/28/99

REGULATION H-99-4
COMMUNITY RATING
AND APPROVAL OF COMMUNITY RATING FORMULAS

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A. DEFINITIONS

"COMMUNITY RATING" means a rating process that produces average premium rates for a defined community of insureds in the State of Vermont for the given policy period. The averaging process includes various geographic rating areas, if any, within Vermont, ages and genders of the Vermont insureds, industrial classifications within Vermont, if any, Vermont claims experience, size of group within the small group definition, and duration of coverage. Different community rates are appropriate for the different insurance models which may be represented by indemnity coverage, indemnity coverage with managed care, preferred provider organizations and any other health insurance model as approved by the Commissioner.

"DEMOGRAPHIC RATING" means a rating process that adjusts the community rate for a specific small group, based on that small group's deviation from the average age and gender in the community rate.

"EXPERIENCE RATING" means a rating process that adjusts the community rate for a specific small group, based on the deviation of the group's own claim experience from the average claim experience in the community rate. The definition recognizes that an experience rating formula for small groups may give only partial credit to the group's own experience in any experience rating plan.

"GEOGRAPHIC AREA RATING" means a rating process that adjusts the community rate for a specific small group, based on the deviation of the claims experience in the area in which the group is located from the average claims experience in the community rate.

"INDUSTRY RATING" means a rating process that adjusts the community rate for a specific small group, based upon the deviation of the experience of its industrial classification from the average experience in the community rate.

"PRE-EXISTING CONDITION" means a condition that exists during the twelve-month period before the effective date of coverage.

"DURATIONAL RATING" means a rating process that adjusts the community rate for a specific small group, based on the group's deviation from the average claims experience assumed in the community rate due to the period of time the policy has been in force.

"TIER RATING" means a rating process that assigns small groups to one of a series of rating tiers, based upon claims experience of the group, or based upon one or a combination of demographic, industry, and geographic rating factors.

"CREDIBILITY" means a measure of the degree of statistical significance that can be assigned to the claims experience of a small group when it is used as a basis for projecting a future rate.

"HEALTH INSURANCE TREND FACTOR"means a projection factor that is an estimate of the unit cost increases and utilization increases that are expected to be incurred in a health benefits plan. The estimate of unit cost increases and utilization increases may include consideration of erosion of deductibles, medical technology, general inflation and cost shifting.

"SMALL GROUP PLAN"means a Small Group Plan as defined in Title 8 V.S.A., Section 4080a.

"SMALL EMPLOYER" means a Small Employer as defined in Title 8 V.S.A., Section 4080a.

"REGISTERED SMALL GROUP CARRIER" means a Small Group carrier as defined in Title 8 V.S.A., Section 4080a.

B. COMMUNITY RATING METHODOLOGY

1. This community rating regulation applies to registered small group carriers providing small group health plans to small groups. For purposes of this regulation, Multiple Employer Trusts, Multiple Employer Welfare Associations and other associations that are made up of a collection of small groups are included (Section B9 refers to certain conditions under which general associations may be excluded).

2. To be considered acceptable by the Commissioner, the community rates submitted by a registered small group carrier must be effective for at least a six- month policy period.

3. Premiums shall be submitted for "single", "two person" (two adults or one adult and one child) and "family" membership classifications. Other or different classifications may be filed and used, provided they are approved by the Commissioner.

4. Community rates shall be calculated in such a manner that appropriate and separate rates are available for each insurance model for each month in which small groups renew policies or new small group business is written by a carrier. Compliance with this regulation can be accomplished in many ways, some of which are listed here:

4.1 a set of community rates is calculated for a calendar quarter, and applies to the renewals in that quarter. The rates are to be effective for at least six months.

4.2 a set of community rates is calculated for the first month of a six-month period. The rates are designed to be effective for at least six months for accounts renewing in that month. Monthly trend factors are supplied that, when applied, provide community rates for the remaining five months of renewals, all of which are to be effective for a minimum of six months.

4.3 other methodologies that are submitted and approved by the Commissioner, but filings should be made no more frequently than once a quarter.

5. Medical underwriting and screening to exclude or individually rate small group insureds is not allowed. Therefore, the community rating plan for a registered small group carrier may not contain any provisions for adjustments that are based on medical underwriting and/or medical screening.

6. Proposed community rates should be based upon reasonable projections of Vermont small group experience that has been incurred by the registered small group carrier. To the extent that the carrier's Vermont claims experience is not deemed to be fully credible, it can be combined with the carrier's small group experience from other states, if that experience is adjusted to reflect Vermont benefit differences, demographics differences, geographic differences, etc., that, if not otherwise made, would render the out-of-state experience invalid for Vermont insureds. Carriers may be required to provide such Vermont-based data as the Commissioner deems necessary. Projection of the base claims experience forward to the period for which the proposed community rates are designed to be effective should be accomplished with the use of an appropriate health insurance trend factor.

7. In addition to the expected claims costs, the carrier's community rates may contain appropriate allowances for administrative expense, taxes, profit, the cost for reinsurance, if any, and the other elements used by the carrier.

8. For a particular small group, the approved community rates for a given benefit package may be adjusted for the following rating classifications:

8.1 demographics
8.2 geographic area
8.3 industrial class
8.4 the group's experience
8.5 durational rating
8.6 tier rating
8.7 other factors that the Commissioner would approve

The total premium charged shall not deviate above or below the community rate filed by the carrier by more than twenty percent (20%) except for hospital or medical service corporations that qualify for tax-exempt status, pursuant Title 8 V.S.A., Section 4516.

8A. Notwithstanding the above, as of January 1, 2000, no small group carrier may deviate from the community rate when writing new business. Additionally, small group carriers must phase out deviations in business existing as of January 1, 2000, according to the following schedule:

All renewals of business with anniversary dates on or after January 1, 2000 through December 31, 2000: reduce deviation to 15%.

All renewals of business with anniversary date on or after January 1, 2001 through December 31, 2001: reduce deviation to 10%.

All renewals of business with anniversary dates on or after January 1, 2002 through December 31, 2002: reduce deviation to 5%.

All renewals of business with anniversary dates on or after January 1, 2003: no deviations.

9. The percentage increase in the premium charged to a small employer for a new 12-month period may not exceed the sum of the following:

a. the percentage change in the community rate for a new rating period; and any adjustment, not to exceed fifteen percent (15%) annually, due to a change in the deviation calculated for a new rating period based on a change in the case characteristics of the group as permitted under paragraph B(8) of this regulation.

b. Notwithstanding Section 9a of this paragraph, a carrier may seek relief from the premium increase limitation by requesting a determination from the Commissioner that such a limitation will have a substantial adverse effect on the financial soundness and safety of the carrier.

10. The Commissioner may exempt from the requirements of Title 8 V.S.A., Section 4080a(d)(1) an association as defined in Section 4079(2) of this title which:

10.1 offers a small group plan to a member small employer which is community rated in accordance with the provisions of this section. The plan may include rating classifications in accordance with this section;

10.2 offers a small group plan that guarantees acceptance of all persons within the association and their dependents; and

10.3 offers one or more of the common health care plans approved by the Commissioner.

The exemption referred to in this paragraph consists of allowing an association to restrict access to small group accident and health insurance to members of the association or a class of members of the association with the approval of the Commissioner. The Commissioner may revoke or deny the exemption if it is determined that because of the nature, size or other characteristics of the association and its members, the employees or members are in need of the protection provided by this

section or the exemption would have a substantial adverse effect on the small group market.

C. APPROVAL OF COMMUNITY RATES AND RATING METHODOLOGY

1. Each registered small group carrier shall file its community rates, and the method used to derive them, at least sixty days prior to their first intended use. The rates filed may not be used until approved by the Commissioner.

2. This filing should contain, at a minimum, the following information:

   2.1 A description of the base claims experience data.

   2.2 Actuarial support for the health insurance trend factor used to project the base claims experience data forward to the rating period.

   2.3 A description of the elements of retention.

   2.4 A description of other adjustments or elements included in the rates.

   2.5 An identification of the exact effective date that the rates were designed for and the effective period of the rates. One way to appropriately make this identification would be to include a statement in the filing similar to the following:

   > "These premium rates have been designed to apply to all small groups renewing in the third calendar quarter of 1992, and will remain in effect for twelve months for each renewal,"

   2.6 A description of the rating classifications that are part of the rating plan, including a demonstration of how the requirement that the premium for any given group should not deviate by more than twenty percent (20%) from the carriers approved community rate is being met.

   Filings made after the initial approved filing should also identify what changes, if any, are made in the use of rating classification factors as compared to the last filing. Similarly, if no changes are proposed in the use of rating classification factors as compare to the last filing, this should also be noted. The rating factors shall be applied in their entirety without exception or adjustment.

   Once the rating plan together with rating classifications has been approved, the carrier shall not selectively apply the rating factors: every approved rating factor contained in the rating plan shall be applied in respect to every small group without any adjustment unless such adjustment has been approved by the Commissioner.

   2.7 A statement by a qualified actuary who is a member of the American Academy of Actuaries that the rates and proposed rating methodology meet the requirements of this section, that they are reasonable in relation to the benefits

provided, and that they are neither excessive, deficient, nor unfairly discriminatory.

2.8 The filing form shown in Attachment 1 shall be used for each premium rate submission to the Commissioner.

D. UNDERWRITING STANDARDS FOR REGISTERED SMALL GROUP CARRIERS

1. A registered small group carrier shall guarantee acceptance of all small groups as defined in Title 8 V.S.A., Section 4080a(1) for any small group plan offered by the carrier. A registered small group carrier shall, upon application by any small group which is currently insured by another carrier, accept such small group and grant insurance under a plan with substantially comparable benefits without imposing any additional restrictions for pre-existing conditions and may restrict coverage only to the extent provided in Title 8 V.S.A., Section 4080a(g).

2. A registered small group carrier shall also guarantee acceptance of all employees or members of a small group, each spouse of an employee or member and dependent children, including disabled children. Insurers may gather medical information from employees of small employers in order to make informed decisions concerning reinsurance or for other non-underwriting purposes.

3. Registered small group carriers are required to accept groups of one, who are self-employed persons. The carrier may require proof of current Vermont residency and that such residency has endured for a continuous period of at least one year. In addition, the carrier may require appropriate federal tax records which demonstrate bona fide self-employment. (The intention is the protection of the financial integrity of small group health plans against adverse selection).

4. The provisions of these regulations shall not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy; provided that no person may offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of this section. The Commissioner shall adopt standards and a process to carry out the provisions of this section.

5. A registered small group carrier which is not a nonprofit health maintenance organization shall require that at least 75 percent of the employees or members of a small group participate in the carrier's plan, provided that if a nonprofit health maintenance organization provides a small group plan to more than 25 percent of the employees or members of the small group, a registered small group carrier may offer or continue to provide its small group plan to the remaining employees or members.

6. For the purpose of calculating whether or not a small group meets the minimum enrollment requirements, the number of eligible employees shall be counted as the total number of full-time employees and part-time employees who work thirty hours per week or more. Any full-time or part-time employee who is covered as a spouse or a dependent on another health insurance plan are excluded from the count.

7. The minimum participation requirements shall be calculated on an employer-by-employer basis if the small group is part of an association, trust or other substantially similar arrangement.

8. In performing the computation to determine the actual enrollment required for qualification as a small group plan, the registered small group carrier must calculate seventy-five percent (75%) of the actual number of eligible employees and round any fractional number to the higher integer.

9. Registered small group carriers are required to renew every small group plan as the policy anniversary comes due. In addition, all employees or members and their dependents must be renewed. If the insurer has the necessary information to renew, it shall confirm in writing at least forty-five days prior to renewal, the premium at which the policy is to be renewed.

10. If the small group health plan falls below the seventy-five percent (75%) minimum enrollment or if it fails to pay its premiums on a timely basis or if it provides fraudulent information to the registered small group carrier or if the small employer ceases to exist, the small group carrier may cancel the policy with thirty days written notice that provides for a time period of at least thirty days. If, during a policy period, an employer no longer satisfies the minimum enrollment requirements, coverage must be continued to the end of that rate period.

11. Separability. Should a court hold any provision of this regulation invalid in any circumstances, the invalidity shall not affect any other provisions or circumstances.

12. This regulation shall become effective upon passage and supersedes Regulation 91-4A.

ATTACHMENT 1

WORKSHEET

The purpose of this worksheet is to provide the Commissioner with appropriate information to judge the reasonableness of premium rates submitted by registered small group carriers. While it can be used by the carrier to actually determine its premium rates, it need not be. The carrier is free to use its own techniques. However, the carrier is required to then provide the base claims cost information requested, as well as the expected claims cost for the period of the proposed rates. The resulting trend factor will be reviewed by the Commissioner for reasonableness.

The carrier is required to file for approval each time any rate for small group coverage is proposed to change.

The worksheet should be filled out with information for the most popular coverage offered by the registered small group carrier. If other coverages produce health care trend factors different than the trend factor shown in Item 6, the coverages and associated trend factors should be identified on a separate sheet of paper, and attached to the worksheet. Space is provided in Item 10 for different trend factors for the same coverage with different deductibles and/or coinsurance.

In Item 1, please insert the incurred claims for a recent 12 month period for this coverage. Ideally, the 12 month incurred claims would have 3 months of runout and would then be completed to the fully incurred level with an estimate of unpaid claims.

In Item 2, the amount of claims in excess of any medical stop loss attachment point are posted.

Item 3 is the difference between Item 1 and Item 2.

The earned contract months exposed to risk for the coverage during the 12 month incurred period should be entered at Item 4.

The incurred claims cost per contract month (monthly pure premium) in Item 5 is calculated by dividing Item 3 by the “Total” contract months in Item 4.

Carriers who use this form to actually calculate their rates will enter their average annual trend factor at Item 6, and compound it for the appropriate number of months in the projection span in Item 7. The compounded trend factor is applied to the base claims cost in Item 5, and the resulting expected claims cost is entered at Item 8.

Carriers who develop their expected claims cost using some other method should fill in Item 8, and then develop the trends that result from their process, and fill them in at Items 6 and 7.

The carrier’s allocation of the total claims cost in Item 8 into single, two person, and family components is shown in Item 9.

If, for example, the primary product is a $100 deductible comprehensive major medical coverage, other deductible coverage claims costs are filled in at Item 10, along with average annual trend factors comparable to the one reported in Item 6.

Retention elements are reported in Item 11 b through g, both on a dollar basis and a percent of premium basis.

The total premium rates are filled in at Item 12. The claims cost in Item 9 and the retention in Item 11 are combined to produce these premiums rates.

Premium rates for the same period for the same coverage one year earlier are inserted at Item 13, and the annual rate increase is entered at Item 14.

Registered Small Group Carrier _____
Coverage _____
Effective Date _____

1. Base incurred claims* for the 12 month period _____. _____

2. Incurred claims in excess of reinsurance attachment point, if applicable ** _____

3. Incurred claims adjusted for the removal of claims in excess of reinsurance attachment point (1)-(2) _____

4. Earned contract months exposed to risk during the same 12 month experience period.
   a) Single _____
   b) 2 Person _____
   c) Family _____
   d) Total _____

5. Incurred claims cost per contract month (pure premium) for the 12 month period, excluding claims in excess of the reinsurance attachment point. (3) ÷ (4d) _____

6. Health insurance trend factor *** stated on an average annual basis. _____

7. Health insurance trend factor compounded as necessary for the projection span from the base experience period to the period of the proposed rates. _____

   a) State the period of the proposed rates.

      - First effective date _____
      - Last effective date _____
      - Length of rate guarantee _____

   b) State the projection span from the base experience period to the period of the rates in terms of numbers of months _____.

8. Expected claims cost per contract (pure premium) for the period of the proposed rates, excluding claims in excess of the reinsurance attachment point. (5 x 7) _____

9. Allocation of the expected claims cost into single, two person and family classifications:

Single	_____
Two Person	_____
Family	_____

10. Expected claims costs trends for other deductible and coinsurance combinations.

Coverage	Single	Two Person	Family	Average Annual Health Insurance Trend Factor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

11. Elements of the proposed composite rate expressed as a percent of total rate and as a dollar amount.

		Amount	%
a.	Expected claims cost (Item 8)	_____	_____
b.	Administrative expense	_____	_____
c.	Commissions	_____	_____
d.	Taxes	_____	_____
e.	Profit or contribution to reserves/surplus	_____	_____
f.	Reinsurance expense	_____	_____
g.	Other	_____	_____
	Total	_____	100%

12. Premium rates (Item 9 loaded with Item 11 b through g)

Single	_____
Two Person	_____
Family	_____

13. Premium rates for the same period one year earlier.

Single	_____
Two Person	_____
Family	_____

14. Annual rate increase

Single	_____
Two Person	_____
Family	_____

* State this on a fully incurred basis. This is a combined statistic for single, two person, family, and other types of membership classifications.

** This refers to the reinsurance attachment point for the period of the rates discounted at the health insurance trend factor to the base experience period.

*** The trend factor should include the effects of the fixed deductibles under a comprehensive major medical product, and the fixed reinsurance attachment point under all coverages.