VERMONT DEPARTMENT OF BANKING, INSURANCE AND SECURITIES

REGULATION 93-5 (Amended Rule)
MINIMUM REQUIREMENTS FOR COMPLIANCE
WITH TITLE 8 V.S.A., SECTION 4080b

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Section 1. Purpose

The purpose of this regulation is to set forth rules for the enrollment of registered non-group carriers, requirements for the sale of individual insurance, requirements for the filing of rates, and standards and the process for approval of common health care plans.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner of Banking, Insurance and Securities ("Commissioner") by Title 8 V.S.A., Sections 75, 4071, and 4080b(c).

Section 3. Applicability and Scope

This regulation applies to any person who issues a non-group plan. A non-group plan includes a health insurance policy, a nonprofit hospital or medical service contract or a health maintenance organization health benefit plan offered or issued to an individual. The term does not include disability insurance policies, long-term care insurance policies, Medicare supplement insurance policies, civilian health and medical program of the uniformed services supplement policies, accident indemnity or expense policies, student or athletic expense or indemnity policies or dental policies. The term also does not include hospital indemnity policies or specified disease policies, provided such policies are sold only as supplemental coverage when a common health care plan or other comprehensive health care policy is in effect.

This regulation applies to any contract issued to or renewed by a Vermont resident.

Section 4. Definitions

A. "Community rating" means a rating process that produces average 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 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 models approved by the Commissioner.

B. "Credibility" means a measure of the degree of statistical

significance that can be assigned to the claims experience of a plan when it is used as a basis for projecting a future rate.

C. "Demographic rating" means a rating process that adjusts the community rate for a specific plan, based on that plan's deviation from the average age and gender in the community rate.

D. "Department" means the Department of Banking, Insurance and Securities.

E. “Deviation plan” means a plan, subject to the Commissioner’s approval, which describes how the premium shall deviate from a filed community rate as provided in Title 8 V.S.A. § 4080b(h)(2).

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

G. "Experience rating" means a rating process that adjusts the community rate for a specific plan issued to an individual or group of individuals. The experience rating plan changes the individual's premium or rates based upon a deviation of the individual's or group of individuals' claims experience from an average claims experience.

H. "Geographic area rating" means a rating process that adjusts the community rate for a specific plan based on the deviation of the claims experience in the area where the insured person lives from the average claims experience in the community rate.

I. "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.

J. "Industry rating" means a rating process that adjusts the community rate for a specific plan, based upon the deviation of the experience of the industrial classification of the insured from the average experience in the community rate.

K. "Non-group plan" or "plan" has the same meaning as found in

Title 8 V.S.A., Section 4080b(a)(2). The term "non-group plan" also includes any exempt plans listed in Section 4080b(a)(2), if coverage enhancements to those exempt plans make them substantially similar to any approved non-group plan.

L. "Pre-existing condition" means the existence of symptoms which would cause an ordinary, prudent person to seek diagnosis, care or treatment or those conditions for which medical advice or treatment was recommended by or received from a physician or other medical professional during the 12-month period preceding the effective date of coverage.

M. "Tier rating" means a rating process that assigns rates of a set of plans to one of a series of rating tiers, based upon claims experience of the set of plans, or based upon one or a combination of demographic, industry, and geographic rating factors.

N. "Rating manual rule" includes, but is not limited to, any procedures, manuals, rules, or rating plans used to develop a premium from a filed community rate.

O. "Registered non-group carrier" ("carrier") means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a non-group plan and who is registered and approved as such by the Commissioner.

P. "Resident" means a person as defined in Title 18 V.S.A., Section 9402(8). A resident also includes a dependent as defined in Title 8 V.S.A., Section 4090 and a dependent child attending school outside Vermont.

Section 5. Registration

No carrier may offer a non-group plan as defined in Section 3(B) of this regulation unless such carrier registers as a non-group carrier as required by Title 8 V.S.A., Section 4080b(c) and is approved by the Commissioner. The following are the minimum requirements for registration as a non-group carrier:

A. The carrier must apply in writing to the Commissioner to be a registered non-group carrier.

B. The carrier must either be licensed or authorized to provide health insurance in Vermont, be a nonprofit hospital service corporation, nonprofit medical service corporation or be a health maintenance organization.

C. The carrier shall have all non-group rates, health care

plans and forms approved by the Department prior to using them in Vermont.

D. The carrier must have licensed representatives in Vermont. The carrier must identify the representatives in the written application. If the carrier is a health maintenance organization, it shall have a sales representative in each of its service areas. The service areas shall be designated in the initial application.

E. The carrier must designate, in writing, the name and address of a representative responsible for answering questions and responding to complaints about underwriting and claims.

F. The carrier must provide insureds with a toll-free number for claims handling and customer service and supply this number to the Department in its application.

G. All advertising material about non-group insurance must clearly identify the product advertised as a "Non-group Health Insurance Plan." In addition, all registered non-group insurers shall identify the common plan(s) by name (i.e., plan "A" etc). All advertising material must be filed with the Department prior to use. The carrier may use the advertising material after receipt by the Department.

H. A registered non-group carrier who qualifies under the provisions of Title 8 V.S.A., Section 4080b, and this regulation must certify in writing by April 1 of each year that it continues to qualify. The certification shall be signed by a member of the American Academy of Actuaries.

Section 6. Withdrawal

A carrier who intends to withdraw from the non-group market must notify the Commissioner in writing at least six (6) months prior to canceling or nonrenewing any policies. This notice must include the following information:

A. a description of the plans offered by the carrier;

B. the number of policies and the total number of lives insured under each plan; and

C. the planned termination date(s).

Section 7. Common Health Care Plans

This Section sets forth the standards and process for approval of

common health care plans as required by Title 8 V.S.A., 4080b(e).

A. The standards and criteria outlined in Regulation 91-4b, Section 5(1)(a) through (h) shall be the standards adopted by this regulation. Any changes to the standards and criteria in Regulation 91-4b shall also apply to this regulation. Where Regulation 91-4b refers to certificate holder, the reader should substitute "policy holder."

B. Each common health care plan must satisfy the following minimum policy provisions:

1. A policy offered for sale after the effective date of this regulation shall not be canceled except for nonpayment of premium and eligibility for Medicare coverage due to age.

2. The policy may be nonrenewed only for the following reasons: the insured is no longer a resident of Vermont or will not be a resident on or after the renewal date, the carrier has withdrawn from the non-group market after notification as required by this regulation, the carrier has withdrawn an approved plan and/or the insured is eligible for Medicare coverage due to age.

3. The notice of cancellation for nonpayment of premium shall provide for at least 15 days notice from the date of mailing.

4. The notice of nonrenewal shall provide for at least 30 days notice from the date of mailing. If the carrier has withdrawn an approved plan, it shall provide the reasons for nonrenewal in the notice and offer to replace the plan with an approved plan.

5. A policy providing coverage for a spouse or members of a family shall not terminate because of the death of the insured. The insurer may issue a replacement policy providing substantially the same benefits to cover the surviving spouse or other dependents.

6. Termination or nonrenewal of the policy for any reason other than non-payment of premium shall provide for the payment of covered expenses from a continuous loss which started while the policy was in force, not to exceed 12 months from the date of termination or nonrenewal. The payment of benefits under the policy may be conditioned upon total disability of the covered person and the coverage limits of the policy. Policies

providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

C. For a 12-month period from the effective date of coverage a registered non-group carrier may limit coverage for pre-existing conditions. A registered non-group carrier shall waive any pre-existing conditions for all new policyholders and their dependents, who produce evidence of continuous health benefit coverage (whether group or non-group) during the previous nine months. This waiver may be conditioned upon the prior policy having provided substantially equivalent coverage to the coverage provided by the new policy.

D. No policy which is the subject of this regulation, can be issued, delivered, renewed or advertised unless the following minimum benefits are available:

1. Dependent children coverage must be provided where coverage would otherwise end for a child at a limiting age as required by Title 8 V.S.A., Section 4090.

2. Newborn coverage for routine and other care must be provided without notice or additional premiums for 31 days after birth. Coverage shall include well baby care, injury, sickness, necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as provided by Title 8 V.S.A., Section 4092.

3. Home health care coverage with the minimum coverage described in Title 8 V.S.A., Section 4095 and 4096 must be offered as an option.

4. Alcoholism treatment must be provided for the necessary care and treatment of alcohol dependency as required by Title 8 V.S.A., Section 4098.

5. Coverage for screening by low-dose mammography must be provided as required by Title 8 V.S.A., Section 4100a.

6. Maternity coverage must be provided and shall be treated as any other sickness for all insureds covered by the policy as required under Regulation 89-1.

Section 8. Other Non-Group Plans

All non-group plans must satisfy the minimum policy provisions

provided in Section 7(B),(C) and (D) of this regulation.

Section 9. Health Care Advisory Committee

A. The process for the approval of the Common Health Care Plan shall be as outlined in Regulation 91-4b, Section 5(2)(f). Any changes to Section 5(2)(f) shall be incorporated into this regulation. Language in Section 5(2)(f) referring to group carrier shall be interpreted to mean non-group carrier when applying it to this regulation.

Section 10. Solicitation

A registered non-group carrier shall make available to each resident of Vermont all non-group plans approved by the Commissioner. A registered non-group carrier shall not take any action that would prevent or discourage a resident from purchasing any plan offered by the carrier. The carrier must list all plans that it is offering for sale in Vermont in any rate filing covered by this regulation to the Commissioner.

A registered non-group carrier which is also a health maintenance organization may limit applications for approved plans to residents in its service area. The health maintenance organization must state in its rate filing the service area for the plans approved by the Commissioner and how the sale may be limited.

Section 11. Community Rating Methodology

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

B. 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.

C. 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 accounts renew or new accounts are written. Compliance with this requirement can be accomplished in many ways, some of which are listed here:

    1. A set of community rates are calculated for a twelve-month period. The rates are to be effective for at least twelve months for accounts renewing in that

month. Monthly trend factors may be applied to community rates for the remaining eleven months of renewals, all of which are to be effective for twelve months. Filings should be made no more frequently than twice a year.

2. Other methodologies that are submitted to and approved by the Commissioner, but filings should be made no more frequently than quarterly.

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

E. Proposed community rates should be based upon reasonable projections of Vermont non-group experience that has been incurred by the registered non-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 non-group experience from other states, if that experience is adjusted to reflect Vermont benefit differences, demographic 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.

Projections 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.

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

G. The approved community rates for a given benefit package may be adjusted for the following rating classifications upon approval of a deviation plan by the Commissioner:

1. demographics;
2. geographic area;
3. industrial class;
4. experience;
5. tier rating;
6. durational rating; and

7. other classifications approved by the Commissioner.

After July 1, 1993, the premium charged shall not deviate above or below the community rate filed by the carrier by more than 40 percent (40%) for two years and thereafter, 20 percent (20%).

H. The registered carrier must file and request approval from the Commissioner of all rating manual rules.

Section 12. Restrictions Relating to Premium Increases

A. The percentage of increase in the premium charged to an individual account for the same coverage for a new rating period may not exceed twenty percent (20%).

B. Notwithstanding Section A 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.

Section 13. Approval of Community Rates, Deviation Plans and Rating Methodology

A. Each registered 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.

B. The filing should contain, at a minimum, the following information:

1. a description of the base claims experience data;

2. actuarial support for the health insurance trend factor used to project the base claims experience data forward to the rating period and a copy of the data used to calculate the trend factors;

3. a description of each element of retention;

4. a description of all other adjustments or elements included in or used to calculate the rates;

5. an identification of the 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 rates have been designed to apply to (identify the plans), renewing on or after XX/XX/XX and will remain in effect for twelve months for each renewal."; and

6. a description of the rating classifications and rating rules that make up the rating plan, including a demonstration of how the requirement that the premium for any given insured shall not deviate by more than 40% from the carrier's approved community rate. After July 1, 1995, the above information shall be submitted based on a deviation of not more than 20 percent.

C. The following statements by a qualified actuary who is a member of the American Academy of Actuaries must be included with each filing:

1. that the rates and proposed rating methodology meet all the requirements of this regulation;

2. that the rates are reasonable in relation to the benefits provided, and that they are neither excessive, deficient, nor unfairly discriminatory; and

3. that the proposed rates anticipate at least a 70% loss ratio for the period of time the rates will remain in effect.

D. Filings made after the initially-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 compared to the last filing, this should also be noted. The rating factors shall be applied in their entirety without exception or adjustment.

E. Once a rating plan with rating classifications has been approved, a carrier must apply the rating factors or rating manual rules in a uniform manner to all accounts.

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

Section 14. Underwriting Standards for Registered Non-Group Carriers

A. A registered non-group carrier shall guarantee acceptance of all applicants who are residents of Vermont for any approved plan offered by the carrier. A registered non-group carrier

shall, upon application by a resident of Vermont who is currently insured by another carrier, accept the application and provide a policy of insurance under an approved plan without imposing any additional restrictions for pre-existing conditions or waiting periods. The carrier may restrict coverage only to the extent provided in Title 8 V.S.A., Section 4080b(g). A registered non-group carrier shall also guarantee acceptance for each spouse of an applicant and dependent children including disabled children.

B. Insurers may gather medical information from insured persons in order to make informed decisions concerning reinsurance or for other non-underwriting purposes.

C. Medical underwriting or screening to exclude or limit coverage is not allowed. The community rating plan for a registered non-group carrier may not contain any provisions for adjustments that are based on medical underwriting and/or medical screening.

D. Registered non-group carriers must accept all applications for non-group coverage from residents of Vermont. The carrier may require proof of current Vermont residency. In addition, the carrier may require appropriate records which demonstrate bona fide residency in Vermont. (The intention is to protect the financial integrity of registered non-group carriers from adverse selection.)

E. Registered non-group carriers are required to renew each plan as the policy anniversary date comes due. In addition, all dependents must be renewed, unless the insured or dependent is no longer a resident of Vermont or ceases to be a qualified dependent pursuant to Title 8 V.S.A., Section 4090. If the registered non-group carrier has the necessary information, it shall confirm in writing, at least 30 days prior to renewal, the premium at which the policy is to be renewed.

Section 15. Agent/Broker Reimbursement

Agent/broker reimbursement may not be based on or related to the case characteristics or experience of an account. Commission levels of a carrier must be uniform for all accounts.

Section 16. Separability

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

Section 17. Effective Date

This regulation initially became effective April 1, 1994 and these amendments will become effective March 16, 1998.

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 non 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 non group coverage is proposed to change.

The worksheet should be filled out with information for the coverage offered by the registered non group carrier. If other coverage produce health care trend factors different than the trend factor shown in Item 6, the coverage 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 premium 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 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) _____

* 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.

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 _____

*** 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 coverage.

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

Coverage	Average Annual Health Insurance Single	Two Person	Family	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	_____

15. Please list all plans being offered for sale in Vermont. Please list the form number and the product name. Use other sheets of paper, if you need more room.

_____
_____
_____
_____

Attachment 2

Worksheet

The purpose of this work sheet is to provide the Commissioner with the information required in Section 11, G, H and Sections 13, B.4 about adjustments to the Community Rates. Adjustments based on medical underwriting and health status are not allowed. However, adjustments for demographics, geographic area, industry, claims experience, experience of the tier to which the individual is assigned, the duration of the individual's policy and other adjustments that may be approved by the Commissioner are allowed, as long as the total adjustment falls within the limiting bands.

1. Please identify the specific types or adjustments that will be used by your company by placing a check next to the appropriate adjustment.

    AGE/GENDER _____

    AREA _____

    INDUSTRY _____

    EXPERIENCE _____

    TIER _____

    DURATION _____

    OTHER _____

2. If "OTHER" has been checked, please describe the adjustment in full.

3. For each adjustment that is checked, please demonstrate how the factor was determined and what sources were used.

4. For each adjustment that is checked, please show what adjustment factors will be used and demonstrate how they will be applied. Please provide tables of adjustment factors for each type of adjustment.

5. Please demonstrate how the use of the adjustment factors will be controlled to produce no more than a 40% variation in the community rate for two years.