DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

Guidance 1163: 5

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Pursuant to Senate Bill 1163 (Chapter 661, Statutes 2010), the California Department of Insurance issues the following guidance regarding compliance. [1] Further guidance may be forthcoming in the future.

Section A: Unreasonable Rate Increases for Large Group Policies with 250 or Fewer Certificate Holders

Rate increases for large group health insurance policies[2] that cover 250 or fewer certificate holders, with effective dates on or after October 1, 2012, must be filed pursuant to Insurance Code section 10181.4 if the proposed rate increase is greater than five percent (5%) on an annualized basis for the time period the rating formula is proposed to be effective. As an alternative to such filing, if the premium rate for the policy is based on a manual rate formula without regard to the actual claims experience of the large group policy, the filing requirement will be satisfied by a submission of the manual rate formula, accompanied by the information described in this Guidance regarding the factors in the manual rate formula that generated the increase.

Insurers are encouraged to provide preliminary information regarding proposed rate increases no later than 120 days before the first date the increase in manual rates would be

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[1] Senate Bill 1163 provides, at Insurance Code section 10181.2, that Article 4.5 (Insurance Code section 10181 *et seq.*) does not

> apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

Accordingly, the above guidance does not apply to the types of insurance listed in Insurance Code section 10181.2.

[2] "Large group policy" means a policy that covers a number of certificate holders in excess of the upper limit of the definition of "small employer" in Insurance Code section 10700 (w). See Insurance Code section 10181 (a).

effective as to any group contract holder. The preliminary information should be provided to the Department through SERFF, with a notation in the SERFF "Filing Description" field that it is preliminary rate information. Thereafter, a rate filing reflecting the preliminary information, and including any changes or additions to the preliminary information, must be filed with the Department at least 60 days prior to the first date increases in manual rates would be effective as to any group contract holder. The rate filing should be filed through SERFF as an amendment to the preliminary information, with a "Note to Reviewer" sent through SERFF indicating that the rate filing has been submitted, and describing any changes or additions.

Section B: Unreasonable Rate Increases in Large Group Policies with More Than 250 Certificate Holders

Rate increases for large group policies that cover in excess of 250 certificate holders, with effective dates on or after October 1, 2012, must be filed pursuant to Insurance Code section 10181.4 if (1) the rate increase is in excess of 5% on an annualized basis, and (2) the Insurance Commissioner notifies the insurance company that a filing for the particular rate increase is required.

Section C: Unjustified Rate Increases

For all health insurance filings, for the purpose of the actuarial certification required under Insurance Code section 10181.6 (b)(2) and review under Insurance Code section 10181.11 the factors the Department will consider in determining whether a rate increase is "unjustified" include, but are not limited to, the following:

1) The relationship of the projected aggregate medical loss ratio to the medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law. See Insurance Code section 10112.25. See also interim final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act" (45 C.F.R. sections 158.101- 158.232, 75 Fed. Reg. 74921-74928, (December 1, 2010)), and final rule entitled "Medical Loss Ratios Under the Patient Protection and Affordable Care Act" (45 C.F.R. sections 158.101- 158.232, 76 Fed. Reg. 76574-76594 (December 7, 2011)) incorporated herein by reference.

2) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

4) Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the Department in connection with the filed rate increase are incomplete, inadequate, fail to provide sufficient clarity and detail such that a qualified health actuary could not make an objective appraisal of whether the rate is

reasonable and/or justified, or which otherwise does not provide a basis upon which the reasonableness or justification of the rate may be determined.

5) Whether the filed rates result in premium differences between insureds within similar risk categories that:

(A) Are otherwise not permissible under applicable California law; or

(B) Do not reasonably correspond to differences in expected costs.

6) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data for the prior three years, including comparisons of experience data to projections submitted as support for prior rate filings.

7) The rate of return of the insurance company and the parent corporation/ultimate controlling party of that insurer, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

8) The annual compensation of each of the 10 most highly paid officers, executives, and employees of both the insurer submitting the rate filing and the parent corporation/ultimate controlling party of that insurer.

9) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

10) Whether the cumulative impact of the filed rate, combined with the previous increases, would cause the rate to be unreasonable or unjustified.

11) The insurer's surplus condition and dividend history.

12) Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of the proposed rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group, including consideration of the minimum and maximum rate increases a policyholder could receive, and how many policyholders will be subject to increases lower and higher than the average.

13) The nature and amount of transactions between the filing insurer and any affiliates over the prior three years.

Section D: Actuarial Certification

14) Per Insurance Code section 10181.6, the filing shall be accompanied by an actuarial certification.

(A) The certification required under Insurance Code section 10181.6 (b)(2) is a "Statement of Actuarial Opinion," as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a "Health Filing," as defined in Actuarial Standard of Practice No. 8 promulgated by the Actuarial Standards Board, and it is also an "Actuarial Communication," as defined in Actuarial Standard of Practice No. 41 promulgated by the Actuarial Standards Board.

(B) The certification required under Insurance Code section 10181.6 (b)(2) must include the following information:

(1) A statement of the qualifications of the actuary issuing the certification. The actuary's qualifications must meet the standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Insurance Code section 10181.6 (b)(3).

(2) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate for the market segment. Premium rates are actuarially sound if, for business in California and for the period covered by the certification, the total of projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income is adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

(3) For each contract or insurance policy included in the filing, a complete description of the data, assumptions, rating factors, and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract or policy form included in the filing.

(4) A statement of opinion, with respect to each rate increase included in the filing, whether the rate increase filed is justified or unjustified and, if justified, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is justified shall address the factors listed in Section C, "Unjustified Rate Increases," of this Guidance.

(5) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(2) and (B)(4) above, including any independent rating models and rating factors utilized.

(C) All of the information required in (B), above, must be contained within the actuarial certification.

Section E: Annual Aggregate Filing

No later than January 15 of each year, each insurer who has submitted a large group rate filing during the preceding calendar year shall submit to the Department an aggregate rate filing report, using the California Annual Aggregate Rate Filing Form, that includes the information required under Insurance Code section 10181.4 (c). Please see Guidance 1163:3.

For questions, please contact Bruce Hinze at bruce.hinze@insurance.ca.gov .