Adopted Rule 10/22/12

Readopt with amendments Part Ins 4101, Part Ins 4102 and Part Ins 4103, effective 04/09/10 (Doc. 9690), as amended, effective 06/10/11 (Doc. 9938), to read as follows:

CHAPTER Ins 4100 REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS


PART Ins 4101 REQUIREMENTS GOVERNING ALL ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS

Ins 4101.01 Purpose. The purpose of this part is to establish requirements for all filings of accident and health insurance rates covered by this chapter.

Ins 4101.02 Applicability and Scope. This part shall apply to rate filings for all accident and health insurance policies covered by this chapter, except long term care insurance policies or certificates under RSA 415-D, Medicare supplement insurance policies or certificates under RSA 415-F, credit insurance policies or certificates under RSA 408-A, or group disability income insurance as defined by Ins 1901.06 (h).

Ins 4101.03 Federal Regulations Apply. The provisions of the US Department of Health and Human Services regulation, 45 CFR Subtitle A, Subchapter B Part 158 Issuer Use of Premium Revenue Reporting and Rebate, dated December 1, 2010, wherein referenced shall apply to all carriers subject to the provisions of Ins 4100.

Ins 4101.04 Definitions. For the purposes of this part:

(a) “Carrier” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services;

(b) "Commissioner" means the insurance commissioner of this state;

(c) "Covered person" means a policyholder, certificate holder, subscriber, member, enrollee, dependent, or other individual entitled to benefits under a health benefit plan;

(d) "National Association of Insurance Commissioners (NAIC)" means the organization of state insurance regulators of the 50 United States, Washington, DC and the 5 US territories; and

(e) "NAIC System for Electronic Rate and Form Filing (SERFF)" means the automated system for handling insurance policy rate and form filings between regulators and insurance companies.

Ins 4101.05 Rate Filing, Review and Inventory Procedures.

(a) All submissions shall be made by the carrier or by a licensed rating organization on behalf of the carrier.

(b) When a submission is made on behalf of a carrier, a letter or other document authorizing the rating organization to file on behalf of the carrier shall be included with the submission.

(c) All submissions and all related correspondence shall be made via SERFF.
(d) All submissions shall include a fully completed NAIC uniform transmittal document that is signed by a representative of the carrier authorized to certify compliance. This document shall be available from the NAIC, http://www.naic.org/industry_rates_forms_trans_docs.htm.

(e) All submissions shall include a complete list identifying by number and title each form to which the rates apply.

(f) The department may request additional information as necessary. Carriers shall have 30 days to respond to a request from the department for further information pursuant to this chapter.

(g) Carriers resubmitting a previously disapproved submission shall submit a complete, new submission that identifies and is responsive to all comments made by the Department. The new submission shall include all correspondence from the previously disapproved submission.

(h) All submissions shall specify the date that the rates are intended to be effective. Rate submissions shall remain confidential until approved and effective. Effective dates shall not precede the approval date. All approved submissions shall be available for public review upon the effective date of the rates.

Ins 4101.06 Rate Filing Submission Requirements.

(a) A rate filing shall be submitted whenever a new policy, rider, or endorsement form that affects benefits is submitted for approval or whenever there is a change in the rates applicable to a previously approved form. If the form does not require a change in the premium, the submission shall include a complete explanation of the effect of the rider or endorsement on the anticipated loss ratio.

(b) The rate filing shall include all rates and rating formulae.

(c) Rates, other than rate revisions, shall be filed with the policies, riders or endorsements to which they apply, and not separately.

(d) Every rate submission shall contain:

(1) Carrier information, including the name and address of the carrier and the name, signature, title, direct toll-free telephone number and e-mail address of the person responsible for the filing;

(2) Scope and purpose of filing specifying whether this is a new form filing, a rate revision or a justification of an existing rate;

(3) Description of benefits provided by each policy form and any riders or endorsements that may be used with the form;

(4) In-force business statistics, including policy count and annualized premium of New Hampshire policyholders or certificate holders, as well as the number of covered persons who will be affected by the proposed rate revision;

(5) Proposed effective date, including a description of how the proposed rate revision will be implemented, such as the next anniversary date or next premium due date; and

(6) The reasons for the revision, if the filing is for a rate revision.
PART Ins 4102 REQUIREMENTS FOR INDIVIDUAL HEALTH INSURANCE SUBJECT TO RSA 420-G

Ins 4102.01 Purpose. The purpose of this part is to provide requirements for the submission and the filing of individual health insurance rates for all products that meet the definition of health coverage under RSA 420-G:2, IX. This part establishes standards for determining the reasonableness of the relationship of benefits to premiums.

Ins 4102.02 Applicability and Scope. This part shall apply to all rate filings for individual health coverage plans subject to RSA 420-G.

Ins 4102.03 Definitions. For the purposes of this part:

(a) “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries;

(b) “Actuarial memorandum” means the document describing the basis on which rates were determined and that includes other supporting documentation as required;

(c) “Anticipated loss ratio” means the calculation of the medical loss ratio over a period that is at least as great as the anticipated policy lifetime that does not exceed 20 years;

(d) "Case characteristics" means demographic or other relevant characteristics considered by the individual carrier in the determination of premium rates for an individual;

(e) "Durational medical loss ratio" means the medical loss ratio calculated for a specified duration not to exceed 12 months;

(f) "Earned premium" means premium revenue pursuant to 45 CFR Part 158.130;

(g) "Earned premium adjustments" means federal and state taxes and licensing and regulatory fees pursuant to 45 CFR Part 158.161 (a) and 158.162 (a)(1) and (b)(1);

(h) "Health coverage" means "health coverage" as defined in RSA 420-G:2, IX;

(i) "Incurred claims" means reimbursements for clinical services provided to enrollees, pursuant to 45 CFR Part 158.140;

(j) "Medical loss ratio" means medical loss ratio defined in 45 CFR Part 158.221(a);

(k) "Member" means "covered person" as defined in Ins 4101.04(c);

(l) "Premium" means the total amount due from a policyholder to an individual carrier for the provision of health coverage;

(m) "Premium rate" means an amount per covered person used to calculate premium;

(n) "Quality improvement expenses" means amounts expended for activities that improve health care quality pursuant to 45 CFR 158.150 and 45 CFR 158.151;

(o) "Tier" means a category of enrollment to which enrolled individuals can elect coverage, and includes at a minimum, single person, couple, and family tiers;

Ins 4102.04 Underwriting and Issue Requirements.
(a) A carrier offering health coverage in the individual market:

   (1) Shall make all of its individual health plans available for purchase;

   (2) Shall not make available or offer any coverage that has been discontinued in accordance with RSA 420-G:5, VI. or VII.; and

   (3) May limit health coverage offered to individuals based only on health status.

(b) Carriers shall vary rates for health coverage in the individual market by using only the following allowable case characteristics:

   (1) The attained ages of the covered individual and any covered dependents;

   (2) The tier category, or the number of covered individuals;

   (3) The smoking status of the covered individuals; and

   (4) The health status of the covered individuals.

(c) Rating factors based on attained age, smoking status and health status shall be guaranteed for a 12 month rating period.

Ins 4102.05 Renewal Requirements.

(a) A carrier offering health coverage in the individual market shall renew all of its individual health insurance plans provided such plans are currently available for purchase.

(b) Rating factors based on health status shall not change at renewal due to changes in an individual's health status.

Ins 4102.06 Data Considerations and Notice Requirements.

(a) Carriers shall maintain records of earned premiums, incurred claims and reserves for each calendar year and for each policy form, including data for rider and endorsement forms that are used with the policy form for so long as the carrier maintains rates on the policy.

(b) Notwithstanding (a) above, the carrier:

   (1) May maintain separate data for each rider or endorsement form;

   (2) May submit a request to the department to combine experience for the purposes of evaluating the data for rider and endorsement forms in relation to premium rates and rate revisions if the rider and endorsement forms provide similar coverage and provisions, are issued to similar risk classes, and are issued under similar underwriting standards, subject to the following:

       a. Once a carrier combines experience pursuant to this paragraph, the carrier shall not again separate the experience; and
b. The carrier shall provide experience data for all issue years for all of the rider and endorsement policy forms that have been combined for this purpose; and

(3) Shall provide the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates.

(c) In determining the credibility and appropriateness of experience data, due consideration shall be given to the following relevant factors:

(1) Statistical credibility of premiums and benefits, including:
   a. Low exposure; and
   b. Low loss frequency;

(2) Experience and projected trends relative to the kind of coverage, including:
   a. Inflation in medical expenses; and
   b. Economic cycles affecting disability income experience;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations; and

(4) The mix of business by risk classification.

(d) Due consideration shall be given to the effect of making the following adjustments on the anticipated loss ratio:

(1) Substitution of actual claim run-offs for claim reserves and liabilities;

(2) Determination of loss ratios with the increase in policy reserves subtracted from premiums rather than added to benefits;

(3) Accumulation of experience fund balances;

(4) Substitution of net level policy reserves for preliminary term policy reserves;

(5) Adjustment of premiums to a monthly mode basis; and

(6) Other adjustments or schedules suited to the form and to the records of the company.

(e) The data used to make adjustments as required in (d) above shall be reconciled to the data required to calculate the anticipated loss ratio as prescribed.

(f) If a carrier provides a quote to a policyholder or prospective policyholder, where an alternative design exists with premium savings that are greater than the anticipated out of pocket expenses, the carrier shall disclose the availability of this policy alternative. Deductibles, co-insurance and elimination periods are examples of benefit designs that shall be considered in calculating this difference. Variations in co-pays shall not be considered due to uncertainty with regard to utilization.

(g) Pursuant to (f) above, this policy alternative shall be made available on a guaranteed issue basis for renewal quotes.

(h) The carrier shall provide written notice to individuals in the event that:
1. The carrier declines to offer coverage as applied for;

2. The carrier makes an offer for coverage similar to any offering of the New Hampshire Health Plan pursuant to RSA 415:18, but at a premium rate that is greater than the New Hampshire Health Plan’s premium rate; or

3. The carrier provides a renewal quote for coverage similar to any offering of the New Hampshire Health Plan pursuant to RSA 415:18, but at a premium rate that is greater than the New Hampshire Health Plan’s premium rate;

(i) The notice shall specify:

1. That the person may be able to purchase health insurance from the New Hampshire Health Plan pursuant to RSA 415:18 or the federally qualified high risk pool pursuant to RSA 404-G:5-g; and

2. Contact information for the New Hampshire Health Plan pursuant to RSA 415:18 and the federally qualified high risk pool pursuant to RSA 404-G:5-g.

Ins 4102.07 Rate Filing Standards.

(a) Carriers shall calculate the market rate in accordance with the following:

1. The calculation shall reflect the carrier's experience for all the products it sells and maintains in the individual health insurance market;

2. Plan relativity factors that are used to modify the carrier's experience to a common market rate shall be the same factors that were used to calculate the health coverage plan rates during the experience period;

3. The market rate shall be normalized for the average plan relativity factor; and

4. Other assumptions used by the carrier in the calculation of the market rate shall be specified.

(b) The carrier shall calculate from the market rate the health coverage plan rates for the coverages it will offer. The carrier shall provide plan relativity factors used to calculate the health coverage plan rates from the market rate. Any changes to the health coverage plan rates from the previously approved set of plan relativity factors shall be highlighted and the basis for the same shall be documented;

(c) Carriers shall calculate premium rates for individual policyholders from the health coverage plan rates through the application of factors for allowable case characteristics as follows:

1. Carriers may use attained age, however the ratio of the largest factor attributable to age to the lowest factor attributable to age shall not exceed 4.0;

2. Carriers may use health status, however the ratio of the largest factor attributable to health status to the lowest factor attributable to health status shall not exceed 1.5; and

3. Carriers may use tobacco use, however the ratio of the largest factor attributable to tobacco use to the lowest factor attributable to tobacco use shall not exceed 1.5.
(d) All submissions shall:

(1) Include an actuarial certification and an actuarial memorandum consisting of various sections as prescribed herein;

(2) Be provided as electronic documents, in formats as prescribed herein; and

(3) Be attached to the SERFF filing under the supporting documents tab with the named components as prescribed herein.

(e) The actuarial memorandum shall include a component labeled "Public Information" that contains a Microsoft Excel or compatible workbook that includes:

(1) A worksheet named "Cover Sheet" that includes the following information:

   a. Contact information; and

   b. A statement indicating that the filing includes all of the carriers individual health insurance rates, or an explanation as to why it does not;

(2) A worksheet named "Proposed Rate Change and Enrollment By Health Coverage Plan" that includes the following information for each health coverage plan:

   a. Plan codes or suitable plan identifier;

   b. The number of expected or enrolled policyholders and covered dependents;

   c. The number of expected or enrolled policyholders and covered dependents that will be impacted by the proposed rate change; and

   d. The proposed health coverage plan rate;

(3) A worksheet named "Plan Design and Plan Relativity Factors" that includes the following information:

   a. Carrier plan code or name;

   b. PCP office visit copay;

   c. Specialist office visit copay;

   d. Emergency department copay;

   e. Outpatient surgery copay;

   f. In-network single deductible;

   g. In-network coinsurance;

   h. In-network single out-of-pocket maximum;
i. Indication if the deductible applies to all medical services;

j. Services to which the deductible does not apply;

k. Indication if the deductible applies to pharmacy services;

l. Indication if preventive services are covered in full;

m. Indication if the health coverage plan type covers mental health and substance services;

n. Indication if the health coverage plan has a tiered network component;

o. Retail pharmacy single deductible generic;

p. Retail pharmacy single deductible brand formulary;

q. Retail pharmacy single deductible brand non-formulary;

r. Retail pharmacy copay generic;

s. Retail pharmacy copay brand formulary;

t. Retail pharmacy copay brand non-formulary;

u. Plan relativity factors for proposed rates;

v. Policy form number;

w. Indication if the health coverage plan is open or closed;

x. Indication if the health coverage plan is grandfathered or non-grandfathered by federal definition;

y. Renewability of the health coverage plan;

z. General marketing method;

aa. Issue age limits; and

ab. Indication if the health coverage plan is new;

(4) A worksheet named "Experience Used in the Rate Development" that includes a brief description of the source for the experience data and PMPM claims information for:

a. Inpatient facility;

b. Outpatient facility;

c. Professional services;
d. Prescription drugs;
e. Capitation arrangements;
f. Other provider payments; and
g. Other;

(5) A worksheet named "Administrative Charges" that includes administrative charges as PMPM amounts;

(6) A worksheet named "Retention Charges" that includes information for retention charges segmented by:
   a. Administrative costs;
   b. Investment income credits;
   c. Contributions to surplus or profit; and
d. Other;

(7) A worksheet named "Illustrative Rates" that delineates the final rates for 2 hypothetical policyholders;

(8) A worksheet named "Summary of Rating Factors" that provides information regarding the carrier's utilization of allowable rating factors;

(9) A worksheet named "Health Coverage Plan Rate PMPM Development for Standard Health Coverage Plan" that delineates how the health coverage plan rate is calculated for prescribed standard plans including the following information:
   a. PMPM experience data;
   b. Annual trend factor;
   c. Months of trend;
   d. Trend adjustments; and
e. PMPM retention; and

(10) A worksheet named "Medical Loss Ratio Exhibit for Individual Market" that includes documentation regarding calculation of the anticipated loss ratios with the following information:
   a. Member months;
   b. Incurred claims;
c. Earned premium;


d. Quality improvement expenses;

e. Earned premium adjustments; and

f. Interest rate assumption.

(f) The actuarial memorandum shall include a component on the supporting documentation tab labeled "Supporting Public Information" with an attached PDF document that includes:

(1) An exhibit titled "Discussion of Credibility" that includes references to the sources for experience data, limitation on using plan specific experience and any explanation for experience adjustments;

(2) An exhibit titled "Illustrative Rates" that delineates the rate development for 2 hypothetical policyholders;

(3) An exhibit titled "Rating Factors" that includes rate factor tables for each rating factor;

(4) An exhibit titled "Expected Distribution of Rating Factors" that includes information delineating the expected distribution of membership by allowable rating factors with tier and conversion factors; and

(5) An exhibit titled "Description of Methodology for the Projected Medical Loss Ratio" that includes a discussion of data sources and pricing assumptions used to calculate the anticipated loss ratio.

(g) The actuarial memorandum shall include a component on the supporting documentation tab labeled "Confidential Information" that contains a Microsoft Excel or compatible workbook that includes a worksheet named "Detail on Final Trend Assumptions" with trend assumptions segmented by:

(1) Service categories, including:

   a. Inpatient facility;

   b. Outpatient facility;

   c. Professional services;

   d. Prescription drugs; and

   e. Other; and

(2) Changes in:

   a. Unit cost; and

   b. Utilization.

(h) The actuarial memorandum shall include a component on the supporting documentation tab labeled "Supporting Confidential Information" with an attached PDF document that includes:
(1) An exhibit titled "Description of Trend Development" that includes an explanation of the process used to develop trend assumptions; and

(2) An exhibit titled "Supporting Schedules for Trend Development" that includes documentation and other data to support the trend assumptions.

(i) Actuarial memoranda for rate revisions shall modify the worksheets required above as follows:

(1) The worksheet named "Cover Sheet" shall include the following additional information:

   a. A statement certifying that there have been no changes to rating methodology since the most recently approved filing or a brief description of any such proposed changes; and

   b. A statement certifying that there have been no benefit changes to any of the plans for which rates are being revised or a description of those benefit changes;

(2) The worksheet named "Proposed Rate Change and Enrollment by Health Coverage Plan" shall include the following additional information:

   a. PMPM health coverage plan rate in effect 12 months prior to the proposed rate effective date; and

   b. PMPM health coverage plan rate from the most recently approved filing;

(3) The worksheet named "Plan Design and Plan Relativity Factors" shall include:

   a. Plan relativities for coverage in effect on the rate effective date one year prior to the rate filing effective date; and

   b. Supporting documentation for plan relativity factor changes that exceed 5%;

(4) The worksheet named "Detail on Final Trend Assumptions" shall include the total annualized trend assumption from the most recently approved rate filing;

(5) The worksheet named "Administrative Charges" shall include:

   a. The administrative charges used for coverages in effect on the rate effective date one year prior to the rating filing effective date; and

   b. The administrative charges from the carrier's most recently approved filing;

(6) The worksheet named "Retention Charges" shall include:

   a. The retention charges used for coverages in effect on the rate effective date one year prior to the rate filing effective date; and

   b. The retention charges from the carrier's most recently approved filing;

(7) The worksheet named "Summary of Rating Factors" shall include an indication as to which of the rating factors have changed since the most recently approved rate filing; and
(8) The worksheet named "Health Coverage Plan Rate PMPM Development for Standard Health Coverage Plan" shall include:

a. The standard health coverage plan rates, PMPM, for coverages in effect on the rate effective date one year prior to the rate filing effective date; and

b. The standard health coverage plan rates, PMPM, which were approved in the carrier's most recently approved filing.

(j) Actuarial memoranda for rate revisions shall include a component titled "Additional Required Public Information for Rate Revisions" that contains a Microsoft Excel or compatible workbook with the following:

(1) A worksheet named "History of Rate Changes" that summarizes rate filings the carrier made over the prior 3 years including:

a. The rate effective date;

b. The average, annual proposed rate change; and

c. The average, annual approved rate change.

(2) A worksheet named "Distribution of Rate Changes" that includes the number of enrolled policyholders and covered dependents that will be impacted by the proposed change segmented by the anticipated rate change; and

(3) A worksheet named "Components of Average Proposed Rate Change" that includes the average rate change attributable to rate changes in:

a. Utilization;

b. Unit costs;

c. Retention;

d. Benefit changes required by law;

e. Other benefit changes;

f. Over or under statement of prior rates; and

g. Other.

(k) The actuarial memorandum for rate revisions shall include a component on the supporting documentation tab titled "Supporting Documentation for the Additional Required Public Information for Rate Revisions" with a PDF document titled "Description of Rating Factors" that includes supporting documentation for any proposed changes to the rating factors.

(l) Carriers shall submit a complete filing, at least annually, that includes all of the documentation required for rate revisions even if no changes in rates are being proposed. The purpose of the rate filing shall be to demonstrate that the continued use of the previously approved rates is appropriate.
(m) All submissions shall include an actuarial certification provided as a PDF document attached to the supporting documentation tab under the public information component with the following statements:

(1) A statement indicating that the filing conforms to generally accepted actuarial principals;

(2) A statement that the entire filing is in compliance with all applicable laws and rules;

(3) A statement that the premiums are not inadequate, excessive, unfairly discriminatory, or unreasonable in relation to the benefits;

(4) A statement that variations in health coverage plan rates:

   a. Shall not exceed the maximum possible difference in benefits unless they are based on the following:

      1. Expected utilization differences attributable to plan design;

      2. Expected administrative cost differences attributable to plan design; and

      3. Provider reimbursement variances attributable to plan design; and

   b. Do not vary based on the health status/morbidity or other demographics of the populations electing the varying plans;

(5) A statement indicating that premium rates are calculated from health coverage plan rates and that premium rates vary from health coverage plan rates using only allowable rating factors;

(6) A statement that benefits are neither excluded nor vary by any of the allowable rating factors; and

(7) A statement indicating that the health plan coverages for which rates are being filed are being actively marketed and are available to both new issues and renewing policyholders.

(n) Carriers may make an interim filing between the required annual filing, to propose rating adjustments.

(o) In accordance with RSA 91-A:5, IV, the department shall maintain the confidentiality of the commercial and proprietary trend assumptions and supporting documentation that is required to be submitted under Ins 4102.07 (g) and (h).

Ins 4102.08  Loss Ratio Standards.

(a) Carriers shall estimate the average monthly premium for each health plan coverage based on an anticipated distribution of business by all significant criteria having a price difference, including:

   (1) Age;

   (2) Coverage amount;

   (3) Dependent status; and
(4) Rider frequency.

(b) Carriers shall assume all policyholders elect the monthly mode, unless such mode is not available, and shall consider fractional premium loads in the average monthly premium calculation. If the monthly mode is not available, carriers shall assume the mode selected, or anticipated to be selected by the greatest proportion of policyholders.

(c) For new health plan coverages, benefits shall be deemed reasonable in relation to the proposed premiums provided that the anticipated loss ratio is at least as great as 70%.

(d) For rate revisions:

(1) If the policy forms constitute an open block, that is they are still being actively marketed, then benefits shall be deemed reasonable in relation to premiums provided the revised rates meet the following standards derived from the previously approved rate filing for the form or forms:

   a. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage shall be at least as great as the anticipated loss ratio calculated over the entire future period using the durational loss ratios from the previously approved rate filing; and

   b. The anticipated loss ratio shall be at least as great as the anticipated loss ratio from the previously approved; and

(2) If the policy forms constitute a closed block then the loss ratios in (d)(1) above shall be adjusted so that no additional revenue is generated to support the administration of these policy forms unless the demonstration includes supporting documentation demonstrating that the cost to administer this business has increased.

(e) Carriers may modify the loss ratio standards in (c) and (d) based on anticipated enrollment and the credibility adjustments allowed pursuant to 45 CFR Part 158.230.

(f) Carriers that fail to review their experience and file rate revisions at least annually shall not be permitted to increase rates beyond what would be needed to provide for just one year of experience deviations. Carriers shall not be permitted to submit rate revisions in future years to recoup rate revisions disallowed by this subsection.

(g) Carriers shall not be permitted to use rate revisions to recoup a prior year's losses.

(h) Carriers under receivership or some other similar department oversight shall be exempt from the restrictions in (f) and (g) above.

PART Ins 4103 REQUIREMENTS FOR SMALL EMPLOYER GROUP HEALTH INSURANCE SUBJECT TO RSA 420-G

Ins 4103.01 Purpose. The purpose of this part is to provide requirements for the submission and the filing of small employer group health insurance rates subject to RSA 420-G and to establish standards for determining the reasonableness of the relationship of benefits to premiums.

Ins 4103.02 Applicability and Scope. This part shall apply to every small employer health insurance policy, rider or endorsement form affecting health coverage that constitutes health coverage as defined under RSA 420-G:2, IX. Franchise insurance as defined in RSA 415:19 which is not group
supplement insurance shall be considered individual health insurance. Group supplemental insurance offered under RSA 415:19 shall not be subject to this part.

Ins 4103.03 Definitions. For the purposes of this part:

(a) "Actuarial certification" means a written statement signed by a member of the American Academy of Actuaries;

(b) "Actuarial memorandum" means the document describing the basis on which rates were determined and that includes other supporting documentation as required;

(c) "Anticipated loss ratio" means the calculation of the medical loss ratio over the 12 month period that begins on the rate effective date;

(d) "Case characteristics" means demographic or other relevant characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer;

(e) "Earned premium" means premium revenue pursuant to 45 CFR Part 158.130;

(f) "Earned premium adjustments" means federal and state taxes and licensing and regulatory fees pursuant to 45 CFR Part 158.161 (a) and 158.162 (a)(1) and (b)(1);

(g) "Eligible employee" means any employee who is eligible for the employer's sponsored health benefit plan and who regularly works at least 15 hours per week, or at least half the weekly hours full-time employees work, whichever is greater. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if these individuals are included as employees under the small employer's health benefit plan;

(h) "Employee" means employee under Section 3(6) of Title I of the Employee Retirement Income Security Act of 1974 (ERISA);

(i) "Enrolled employee" means an eligible employee who has elected coverage in the employer's sponsored health benefit plan;

(j) "Health coverage" means "health coverage" as defined in RSA 420-G:2, IX;

(k) "Incurred claims" means reimbursements for clinical services provided to enrollees, pursuant to 45 CFR Part 158.140;

(l) "List bill" means a method for computing premium rates that are based on each enrolled employee's attained age;

(m) "Medical loss ratio" means "medical loss ratio" as defined in 45 CFR Part 158.221 (a);

(n) "Member" means "covered person" as defined in Ins 4101.04(c);

(o) "Premium" means the total amount due from a small employer policyholder to a small employer carrier for the provision of health coverage;

(p) "Premium rate" means an amount per covered person or an amount per enrolled employee used to calculate premium;
(q) "Quality improvement expenses" means amounts expended for activities that improve health care quality pursuant to 45 CFR 158.150 and 45 CFR 158.151;

(r) "Small employer" means any person, firm, corporation, partnership or group of affiliated companies that are eligible to file a combined tax return and that is actively engaged in business that, on at least 50 percent of the working days during the preceding calendar year, employed at least one employee and no more than 50 eligible employees, the majority of whom are employed within this state;

(s) "Small employer carrier" means a carrier that offers health insurance to one or more small employers in this state;

(t) "Small employer health insurance plan" means all policies or plans sold or marketed by a carrier that meet the definition of health coverage under RSA 420-G:2, IX;

(u) "Subscriber" means an enrolled employee as defined in (i) above;

(v) "Tier" means a category of enrollment to which enrolled employees can elect coverage, and includes at a minimum, "single employee," "couple," and "family" tiers.

Ins 4103.04 Underwriting and Issue Requirements.

(a) A small employer carrier:

(1) Shall make all of its small employer health insurance plans available for purchase;

(2) Shall not make available for offer any coverage that has been discontinued in accordance with RSA 420-G:5;

(3) May limit coverage offers and renewals to small employer groups having one employee to specified time periods, as follows:

   a. All small employer carriers shall offer and renew all available small employer health coverages to small employers having one employee during the months of April and October; and

   b. Carriers electing to limit the time periods during which it offers and renews coverages to small employer groups having one employee shall act uniformly with respect to all such small employers; and

(4) May refuse to issue or renew coverage to any small employer where the number of enrolled employees is not at least as great as the minimum participation percentage times the total number of eligible employees.

(b) The minimum participation percentage shall be:

(1) Seventy-five percent when the plan is the sole plan being sponsored by the employer group; and

(2) Thirty-seven point five percent when the plan is one of two or more plans being sponsored by the employer group.

(c) For the purposes of (a)(4) above, the total number of eligible employees shall not include eligible employees who decline coverage and are covered as a dependent on another person's health coverage.
(d) Carriers shall only vary rates for health coverage provided to small employers by using allowable case characteristics that shall include:

(1) The attained ages of the covered population;
(2) The tier categories;
(3) The number of enrolled employees; and
(4) The type of industry in which the small employer is engaged.

(e) For purposes of (d) above, small employer carriers may use approximations to calculate allowable case characteristics provided such approximation methods:

(1) Are used uniformly for all small employer groups;
(2) Use the attained ages of enrolled employees with tier based membership factors to approximate the attained ages of the covered population; and
(3) Use a prior census to estimate the actual enrollment.

(f) Rates calculated at issue, or at renewal, shall not change throughout the policy year if the allowable case characteristics of a small employer group change.

Ins 4103.05 Renewal Requirements.

(a) A small employer carrier shall renew all its small employer health insurance plans provided such plans are currently available for purchase.

(b) Carriers shall use the same rating methodology, list bill or composite bill, as in the prior period unless the small employer consents in writing to a change in the calculation methodology.

Ins 4103.06 Disclosure.

(a) A health carrier shall provide the rate disclosure form with each premium rate quote.

(b) The rate disclosure form shall include the health coverage plan rate for the coverage elected, and any adjustment thereto, for allowable case characteristics.

(c) For composite billed groups, the disclosure form shall be provided for the single employee rate. For list billed groups, the disclosure form shall be provided for each enrolled employee's rate.

(d) Carriers may submit forms for department review. The department shall approve forms that meet the requirements in this section.

Ins 4103.07 Rate Filing Standards.

(a) Carriers shall calculate a market rate in accordance with the following:

(1) The calculation shall reflect the carrier's experience for all the products it sells and maintains in the small group health insurance market;

(2) Plan relativity factors that are used to modify the carrier's experience to a common market rate shall be the same factors that were used to calculate the health coverage plan rates during the experience period;
(3) The market rate shall be normalized for the average plan relativity factor; and

(4) Other assumptions used by the carrier in the calculation of the market rate shall be specified.

(b) The carrier shall calculate health coverage plan rates for the coverages it will offer from the market rate. The carrier shall provide plan relativity factors used to calculate the health coverage plan rates from the market rate. Any changes to the health coverage plan rates from the previously approved set of plan relativity factors shall be highlighted and the basis for the same shall be documented.

(c) Carriers shall calculate premium rates for each small employer from the health coverage plan rate through the application of factors for allowable case characteristics as follows:

(1) Carriers electing to use age as an allowable case characteristic shall comply with the following:

   a. Tabulations by age shall be made using the age brackets delineated in RSA 420-G:4, I. (e)(2); and

   b. Acceptable tabulation methods shall include:

      1. Actual enrollment and ages of all covered persons;

      2. Actual enrollment, ages of all enrolled employees and the tier to which they enrolled;

      3. Estimated enrollment and ages of all covered persons; and

      4. Estimated enrollment, ages of all enrolled persons and the tier to which they are assumed to enroll;

(2) Carriers electing to use group size as an allowable case characteristic shall comply with the following:

   a. Variations in group size shall be based on the number of enrolled employees in all of the plans offered by the small employer carrier to the small employer's employees; and

   b. Carriers may estimate the number of enrolled employees as long as the estimation methods used are uniform for all small employers;

(3) Carriers electing to use the type of industry in which the small employer is engaged shall apply industry variations uniformly for all small employers; and

(4) The total variation attributable to allowable case characteristics shall be subject to the following standards:

   a. The ratio of the following calculation shall not exceed 3.5:

      1. The largest premium rate obtainable from the application of the allowable case characteristics for any small employer group having no covered persons or enrolled employees less than 19 years old; and

      2. The smallest premium rate obtainable from the application of the allowable case characteristics for any small employer group having no covered persons or enrolled employees less than 19 years old.
(d) All submissions shall:

(1) Include an actuarial certification and an actuarial memorandum, consisting of the sections prescribed herein;

(2) Be provided as electronic documents, in formats as prescribed herein; and

(3) Be attached to the SERFF filing under the supporting documentation tab with the components prescribed herein.

(e) The actuarial memorandum shall include a component labeled "Public Information" that contains a Microsoft Excel or compatible workbook that includes:

(1) A worksheet named "Cover Sheet" that includes the following information:

   a. Contact information;

   b. A statement indicating that the filing includes all of the carriers small group health insurance rates, or an explanation as to why it does not; and

   c. A statement indicating whether the carrier utilizes list billing, and if so, a description of the groups being list billed;

(2) A worksheet named "Proposed Rate Change and Enrollment by Health Coverage Plan" that includes the following information for each health coverage plan:

   a. Plan codes or suitable plan identifier;

   b. The number of expected or enrolled members, subscribers and groups;

   c. The number of expected or enrolled members, subscribers and groups that will be impacted by the proposed rate change; and

   d. The proposed health coverage plan rate;

(3) A worksheet named "Plan Design and Plan Relativities" that includes the following information:

   a. Carrier plan code or name;

   b. PCP office visit copay;

   c. Specialist office visit copay;

   d. Emergency department copay;

   e. Outpatient surgery copay;

   f. In-network single deductible;
g. In-network coinsurance;

h. In-network single out-of-pocket maximum;

i. Indication if the deductible applies to all medical services;

j. Services that deductible does not apply to;

k. Indication if the deductible applies to pharmacy services;

l. Indication if preventive services are covered in full;

m. Indication if the health coverage plan covers mental health and substance services;

n. Indication if the health coverage plan has a tiered network component;

o. Retail pharmacy single deductible generic;

p. Retail pharmacy single deductible brand formulary;

q. Retail pharmacy single deductible brand non-formulary;

r. Retail pharmacy copay generic;

s. Retail pharmacy copay brand formulary;

t. Retail pharmacy copay brand non-formulary;

u. Plan relativity factors for proposed rates;

v. Policy form number;

w. Indication if the health coverage plan is open or closed;

x. Indication if the health coverage plan is grandfathered or non-grandfathered by federal definition;

y. Renewability of the health coverage plan;

z. General marketing method;

aa. Issue age limits; and

ab. Indication if the health coverage plan is new;

(4) A worksheet named "Experience Used in the Rate Development" that includes a brief description of the source for the experience data and PMPM claims information for:

a. Inpatient facility;

b. Outpatient facility;
c. Professional services;
d. Prescription drugs;
e. Capitation arrangements;
f. Other provider payments; and
g. Other;

(5) A worksheet named "Administrative Charges" that includes administrative charges as PMPM amounts;

(6) A worksheet named "Retention Charges" that includes information for retention charges segmented by:
   a. Administrative costs;
   b. Investment income credits;
   c. Contributions to surplus or profit; and
   d. Other;

(7) A worksheet named "Illustrative Rates" that delineates the final rate for 2 hypothetical groups;

(8) A worksheet named "Summary of Rating Factors" that provides information regarding the carrier's utilization of allowable rating factors;

(9) A worksheet named "Health Coverage Plan Rate PMPM Development for Standard Health Coverage Plan" that delineates how the health coverage plan rate is calculated for prescribed standard plans including the following information:
   a. PMPM experience data;
   b. Annual trend factor;
   c. Months of trend;
   d. Trend adjustments; and
   e. PMPM retention; and

(10) A worksheet named "Medical Loss Ratio Exhibit Small Group Market" that includes documentation regarding the calculation of the anticipated loss ratio with the following information:
   a. Member months;
b. Incurred claims;

c. Earned premium;

d. Quality improvement expenses; and

e. Earned premium adjustments.

(f) The actuarial memorandum shall include a component on the supporting documentation tab labeled "Supporting Public Information" with an attached PDF document that includes:

(1) An exhibit titled "Discussion of Credibility" that includes references to the sources for experience data, limitation on using plan specific experience and any explanation for experience adjustments;

(2) An exhibit titled "Illustrative Rates" that delineates the rate development for 2 hypothetical groups;

(3) An exhibit titled "Rating Factors" that includes rate factor tables for each rating factor;

(4) An exhibit titled "Expected Distribution of Rating Factors" that includes information delineating the expected distribution of membership by allowable rating factors with tier and conversion factors; and

(5) An exhibit titled "Description of Methodology for the Projected Medical Loss Ratio" that includes a discussion of data sources and pricing assumptions used to calculate the anticipated loss ratio.

(g) The actuarial memorandum shall include a component on the supporting documentation tab labeled "Confidential Information" that contains a Microsoft Excel or compatible workbook that includes a worksheet named "Detail on Final Trend Assumptions" with trend assumptions segmented by:

(1) Service categories, including:

   a. Inpatient facility;

   b. Outpatient facility;

   c. Professional services;

   d. Prescription drugs;

   e. Other; and

(2) Changes in:

   a. Unit cost; and

   b. Utilization.
(h) The actuarial memorandum shall include a component on the supporting documentation tab labeled "Supporting Confidential Information" with an attached PDF document that includes:

(1) An exhibit titled "Description of Trend Development" that includes an explanation of the process used to develop trend assumptions; and

(2) An exhibit titled "Supporting Schedules for Trend Development" that includes documentation and other data to support the trend assumptions.

(i) Actuarial memoranda for rate revisions shall modify the worksheets required above as follows:

(1) The worksheet named "Cover Sheet" shall include the following additional information:

   a. A statement certifying that there have been no changes to rating methodology since the most recently approved filing or a brief description of any such proposed changes; and

   b. A statement certifying that there have been no benefit changes to any of the plans for which rates are being revised or a description of those benefit changes;

(2) The worksheet named "Proposed Rate Change and Enrollment by Health Coverage Plan" shall include the following additional information:

   a. PMPM health coverage plan rate in effect 12 months prior to the proposed rate effective date; and

   b. PMPM health coverage plan from the most recently approved filing;

(3) The worksheet named "Plan Design and Plan Relativities" shall include:

   a. Plan relativities for coverage in effect on the rate effective date one year prior to the rate filing effective date; and

   b. Supporting documentation for plan relativity factor changes that exceed 5%;

(4) The worksheet named "Detail Final Trend Assumptions" shall include the total annualized trend assumption from the most recently approved rate filing;

(5) The worksheet named "Administrative Charges" shall include:

   a. The administrative charges used for coverages in effect on the rate effective date one year prior to the rating filing effective date; and

   b. The administrative charges from the carrier's most recently approved filing;

(6) The worksheet named "Retention Charges" shall include:

   a. The retention charges used for coverages in effect on the rate effective date one year prior to the rate filing effective date; and

   b. The retention charges from the carrier's most recently approved filing;
(7) The worksheet named "Summary of Rating Factors" shall include an indication as to which of the rating factors have changed since the most recently approved rate filing;

(8) The worksheet named "Health Coverage Plan Rate PMPM Development for Standard Health Coverage" shall include:

   a. The standard health coverage plan rates, PMPM, for coverages in effect on the rate effective date one year prior to the rate filing effective date; and

   b. The standard health plan coverage rates, PMPM, which were approved in the carrier's most recently approved filing; and

(9) The worksheet named "Medical Loss Ratio Exhibit Small Group Market" shall include the historical medical loss ratio for the 3 complete calendar years prior to the rate effective date.

(j) Actuarial memoranda for rate revisions shall include a component titled "Additional Required Public Information for Rate Revisions" that contains a Microsoft Excel or compatible workbook with the following:

   (1) A worksheet named "History of Rate Changes" that summarizes rate filings the carrier made over the prior 3 years including:

       a. The rate effective date;

       b. The average, annual proposed rate change; and

       c. The average, annual approved rate change;

   (2) A worksheet named "Distribution of Rate Changes" that includes the number of enrolled members, subscribers and groups that will be impacted by the proposed change segmented by the anticipated rate change;

   (3) A worksheet named "Components of Average Proposed Rate Change" that includes the average rate change attributable to rate changes in:

       a. Utilization;

       b. Unit costs;

       c. Retention;

       d. Benefit changes required by law;

       e. Other benefit changes;

       f. Over or under statement of prior rates; and

       g. Other.

(k) The actuarial memorandum for rate revisions shall include a component on the supporting documentation tab titled "Supporting Documentation for the Additional Required Public Information for
Rate Revisions" with a PDF document titled "Description of Rating Factors" that includes supporting documentation for any proposed changes to the rating factors.

(l) Carriers shall submit a complete filing, at least annually, that includes all of the documentation required for rate revisions even if no changes in rates are being proposed to demonstrate that the continued use of the previously approved rates is appropriate.

(m) All submissions shall include an actuarial certification provided as a PDF document attached to the supporting documentation tab under the public information component with the following statements:

(1) A statement indicating that the filing conforms to generally accepted actuarial principals;

(2) A statement that the entire filing is in compliance with all applicable laws and rules;

(3) A statement that the premiums are not inadequate, excessive, unfairly discriminatory, or unreasonable in relation to the benefits;

(4) A statement that variations in health coverage plan rates:

   a. Shall not exceed the maximum possible difference in benefits unless they are based on the following:

      1. Expected utilization differences attributable to plan design;

      2. Expected administrative cost differences attributable to plan design; and

      3. Provider reimbursement variances attributable to plan design;

   b. Do not vary based on the health statute/morbidity or other demographics of the population electing the varying plans;

(5) A statement indicating that premium rates are calculated from health coverage plan rates and that premium rates vary from health coverage plan rates using only allowable rating factors;

(6) A statement that benefits are neither excluded nor vary by any of the allowable rating factors; and

(7) A statement indicating that the health plan coverages for which rates are being filed are being actively marketed and are available to both new issues and renewing policyholders.

(n) Carriers may make an interim filing between the required annual filing, to propose rating adjustments.

(o) In accordance with RSA 91-A:5, IV, the department shall maintain the confidentiality of the commercial and proprietary trend assumptions and supporting documentation that is required to be submitted under Ins 4103.07 (g) and (h).

   Ins 4103.08 Loss Ratio Standards for Policy Forms.
(a) Carriers shall estimate the average annual premium per policy form based on an anticipated distribution of business by all significant criteria having a price difference, such as:

   (1) Age;
   
   (2) Coverage amount;
   
   (3) Dependent status; and
   
   (4) Rider frequency.

(b) Carriers shall assume all policyholders elect a monthly mode. The average monthly premium, for purposes of this section, shall be based on the rates being filed.

(c) With respect to all forms, benefits shall be deemed reasonable in relation to the proposed premiums provided the anticipated loss ratio is at least as great as 80 percent. Carriers may modify this standard based on anticipated enrollment and the credibility adjustments allowed pursuant to 45 CFR Part 158.230.

(d) The standards set forth in this section shall apply to all new issues and shall apply to all other policy forms that are issued or renewed that are not priced using durational premiums.

Ins 4103.09 Notice Requirements.

(a) Carriers shall notify insured members of their potential eligibility to obtain coverage in the New Hampshire Health Plan pursuant to RSA 415:18, or the federally qualified high risk pool pursuant to RSA 404-G:5-g.

(b) Carriers shall use the notice language adopted by the New Hampshire individual health plan benefits association and approved by the commissioner.

(c) At the same time notice is sent to the applicant, a copy of the notice shall be sent to the New Hampshire Health Plan.
## APPENDIX

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