CHAPTER Ins 4100  REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS

Statutory Authority:  RSA 400-A:15, I; RSA 404-G:6, IV; RSA 415:16; RSA 415:18, I; RSA 415:24, II(h); RSA 415-A:6; RSA 415-H:5; RSA 420-A:31; RSA 420-B:21; RSA 420-G:14; 45 CFR Part 158.130

Readopt Ins 4101.01, effective 11-1-12 (Document #10212), cited and to read as follows:

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.

Readopt with amendment Ins 4101.02, effective 11-1-12 (Document #10212), to read as follows:

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.

Readopt Ins 4101.03, effective 11-1-12 (Document #10212), to read as follows:

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.

Readopt with amendment Ins 4101.04, effective 11-1-12 (Document #10212), to read as follows:

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) “Department” means the New Hampshire insurance department;

(e) “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

(f) “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.

Readopt with amendment Ins 4101.05, effective 11-1-12 (Document #10212), as amended effective 7-10-15 (Document #10880), to read as follows:
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, effective as of January 1, 2019, that is signed by a representative of the carrier authorized to certify compliance. This document shall be available as referenced in Appendix B and at 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 shall 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. Unless specified otherwise in this chapter, 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. Filings for individual and small group market plans, including stand-alone dental plans, shall be available for public review no later than the start of the annual open enrollment period set by the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1803 l (c)(6)(B).

Readopt with amendment Ins 4101.06, effective 11-1-12 (Document #10212), to read as follows:

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) The scope and purpose of filing specifying whether this is a new form filing, a rate revision, or a justification of an existing rate;
(3) A 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) A 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.

Readopt Ins 4102.01 – Ins 4102.03, effective 11-1-12 (Document #10212), cited and to read as follows:

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;

Readopt with amendment Ins 4102.04 – Ins 4102.06, effective 11-1-12 (Document #10212), to read as follows:

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:6, VI or VII; and

   (3) May limit health coverage offered to individuals based on health status only to the extent allowed under federal law.

(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; and

   (3) The smoking status of the covered individuals

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

Ins 4102.05 Renewal Requirements. 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.

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, the carrier shall consider 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) The carrier shall consider 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 shall be 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.

Readopt with amendment Ins 4101.07, effective 11-1-12 (Document #10212), as amended effective 7-10-15 (Document #10880), to read as follows:

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, but the ratio of the largest factor attributable to age to the lowest factor attributable to age shall not exceed 3.0; and

(2) Carriers may use tobacco use, but 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 in paragraphs (e) through (m) below; 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 an electronic 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. Primary Care Provider (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 per member per month (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 in SERFF labeled “Supporting Public Information” with an attached portable document file (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 in SERFF 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 in SERFF 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 an electronic 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 in SERFF 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 in SERFF 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 shall use the calendar year as the rate effective period, such that:
1. Rates quoted and established for new issues and renewals shall not vary within the rate effective period; and
2. Rates shall be guaranteed to the policyholder, and shall not change, for 12 months from issue or renewal.

(o) Carriers shall file rates each year on or before the uniform filing date established by the department, consistent with annual guidance from the Center for Medicare and Medicaid Services (“CMS”), for the coming calendar year. For rates subject to 45 CFR Part 154, carriers shall, in addition to filing with the department, make all filings required with CMS under federal regulations.
(p) Final approved rates for all individual market filings shall be available for public review no later than the start of the annual open enrollment period set by the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1803 l(c)(6)(B).

(q) 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).

Readopt with amendment Ins 4102.08, effective 11-1-12 (Document #10212), to read as follows:

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, that is they are no longer being actively marketed, 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 submit rate revisions in future years to recoup rate revisions disallowed by this section.

(g) Carriers shall not 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.

Readopt Ins 4103.01 and Ins 4103.02, effective 11-1-12 (Document #10212), cited and to read as follows:

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.

Readopt with amendment Ins 4103.03 and Ins 4103.04, effective 11-1-12 (Document #10212), to read as follows:

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; and

(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; and

(2) Shall not make available for offer any coverage that has been discontinued in accordance with RSA 420-G:6.

(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 2 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.

Readopt Ins 4103.05 and Ins 4103.06, effective 11-1-12 (Document #10212), to read as follows:

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, in accordance with Ins 401. The department shall approve forms that meet the requirements in this section.

Readopt with amendment Ins 4103.07, effective 11-1-12 (Document #10212), as amended effective 7-10-15 (Document #10880), to read as follows:
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 may use attained age, however, the ratio of the largest
factor attributable to age to the lowest factor attributable to age shall not exceed 3.0; and

(2) 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 the sections
prescribed herein;

(2) Be provided as electronic documents, in formats as prescribed in paragraphs (e) through
(m) below; 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 an electronic 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 in SERFF labeled “Confidential Information” that contains an electronic 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 rate 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 an electronic 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 in SERFF 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 in SERFF 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 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 shall make an annual filing for rates. Carriers shall file rates each year on or before the uniform filing date established by the department, consistent with annual guidance from the Center for Medicare and Medicaid Services (“CMS”), for the coming calendar year. For rates subject to 45 CFR Part 154, carriers shall, in addition to filing with the department, make all filings required with CMS under federal regulations. Final approved rates for all small group market filings shall be available for public review no later than the start of the annual open enrollment period set by the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1803 l(c)(6)(B).

(o) In addition to the required annual rate filing, carriers may make interim filings no more than quarterly. Rate effective dates shall begin on the first day of each quarter. Rates for interim quarterly filings shall be available for public review on the rate effective date.

(p) Upon issuance or renewal of a policy, the rates for that policy shall be guaranteed to the policyholder, and may not change, for 12 months from issue or renewal.
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).

Readopt Ins 4103.08, effective 11-1-12 (Document #10212), cited and to read as follows:

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.

Readopt with amendment Ins 4104 – Ins 4106, effective 6-10-11 (Document #9938), to read as follows:

PART Ins 4104 REQUIREMENTS FOR LARGE EMPLOYER GROUP HEALTH INSURANCE

Ins 4104.01 Purpose. The purpose of this part is to provide requirements for filing large employer group health insurance rates and to establish standards for determining the reasonableness of the relationship of benefits to premiums.

Ins 4104.02 Applicability and Scope. This part shall apply to every large employer health insurance policy, rider, or endorsement form affecting health coverage as that term is defined by RSA 420-G:2, IX.

Ins 4104.03 Definitions. For the purposes of this part:

(a) “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries, stating that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with all of the applicable laws and rules and that the benefits are reasonable in relation to the premiums;

(b) “Actuarial memorandum” means the document describing the basis on which rates were determined and that indicates and describes the calculation of the anticipated loss ratio;

(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 but does not exceed 20 years;
(d) “Case characteristics” means demographic or other objective characteristics of a large employer that are considered by the large employer carrier in the determination of premium rates for the large employer;

(e) “Carrier” means any entity that provides health insurance in this state, including insurance companies, health services corporations, health maintenance organizations, fraternal benefit societies and other entities subject to state insurance regulation;

(f) “Covered person” means any person covered through large employer group health insurance and includes enrolled employees and, if applicable, their dependents;

(g) “Durational medical loss ratio” means the medical loss ratio calculated for a specified duration not to exceed 12 months.

(h) “Earned premium” means premium revenue pursuant to 45 CFR Part 158.130;

(i) “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 large employer's health benefit plan;

(j) “Employee” means an employee under Section 3(6) of Title I of the Employee Retirement Income Security Act of 1974 (ERISA);

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

(l) “Health coverage” means “health coverage” as defined in RSA 420-G:2, IX;

(m) “Incurred claims” means reimbursements for clinical services provided to enrollees, pursuant to 45 CFR Part 158.140 plus amounts expended for activities that improve health care quality pursuant to 45 CFR Part 158.150;

(n) “Large employer” means any person, firm, corporation, or partnership that is actively engaged in business that, on at least 50 percent of the working days during the preceding calendar year, employs at least 51 employees who are eligible for employer sponsored coverage, and the majority of whom are employed within this state;

(o) “Large employer carrier” means a carrier that offers health insurance to one or more large employers in this state;

(p) “Medical loss ratio” means “medical loss ratio” as defined in 45 CFR Part 158.221 (a); and

(q) “Tier” means a category of enrollment to which enrolled employees can elect coverage and includes, at a minimum, single employee, couple, and family tiers. The term includes “tier membership”.

Ins 4104.04 Underwriting and Issue Requirements.

(a) Large employer carriers shall file a report with the department on or before March 1st of each year detailing for the prior calendar year any instances where the carrier declined to offer coverage as applied for and any instances where the carrier's quoted renewal rate represented an increase larger than the change in the health coverage plan rate plus 10 percent.

(b) The report shall include the following information:
(1) Policyholder identification number;

(2) Number of enrolled employees and number of covered lives in both the calendar year for which the report is made and the prior calendar year, if known; and

(3) The reason for the declination or the rate increase.

(c) Carriers shall specify the case characteristics used to vary rates.

(d) For each case characteristic in (c), the filing shall specify:

(1) How the underwriting factor for that case characteristic is used in the determination of the large employer's premium rate;

(2) The range of factors and the corresponding range of impact on premium rates; and

(3) The expected average factor based on the assumed distribution of business and the actual average factor based on the actual distribution of business over the past 3 rating periods.

Ins 4104.05  Renewal Requirements.  A large employer carrier shall renew all its RSA 420-G:2, IX large employer health insurance plans provided such plans are currently available for purchase.

Ins 4104.06  Rate Filing Standards.

(a) Carriers shall calculate a market rate that is representative of all of the RSA 420-G:2, IX health coverage plans offered to large employers as follows:

(1) Carriers shall provide the plan relativity factors that are used to modify experience under its existing coverages so that the coverages can be combined in the calculation of the market rate.  The plan relativity factors used to modify experience shall be the same as those used to establish the health coverage rates when the coverages were offered;

(2) Carriers shall provide annualized trend information detailed to include cost, utilization, technology and other components; and

(3) Carriers shall specify all other assumptions used in the calculation of the market rate.

(b) A carrier shall calculate health coverage plan rates for the coverages it will offer as follows:

(1) A carrier shall provide the plan relativity factors used to calculate the health coverage plan rate from the market rate.  Any changes to the health coverage plan rate from the previously approved set of factors shall be highlighted and the basis for the same shall be documented;

(2) Variations in the health coverage plan rate shall be attributable to variations in expected utilization or claims severity; and

(3) Plan relativity factors shall not assume that there are differences in the morbidity among individuals electing varied coverages.

(c) Carriers shall calculate premium rates for each large employer from the health coverage plan rate through the application of factors for case characteristics that are filed and approved by the department.

(d) Supporting documentation shall include:
(1) Recent claims for the previous 3 years under the previously approved rates;

(2) A projection of how such experience compares to what was expected;

(3) A breakdown for each previous calendar year and each policy year of collected premium, earned premium, paid claims, paid loss ratio, change in claim liability and reserve, incurred claims, incurred loss ratio, expected incurred claims, actual-to-expected claims, and active life reserves;

(4) Delineation of any changes in assumptions from those used in the demonstration of the most recently approved rates;

(5) Demonstration of compliance with the limitations delineated above;

(6) Formulae, factors, and sample calculations demonstrating how premium rates are actually computed;

(7) Excerpts from the underwriting manual indicating how company personnel are to apply rating variations;

(8) Indication of the range of variation provided by the proposed factors for each allowable case characteristic;

(9) Indication of the expected distribution of rate factors, for each allowable case characteristic, the carrier expects will apply as it underwrites large employers;

(10) Indication of the actual distribution of rate factors applied by the carrier versus the expectation delineated in the rate filing where rates were previously approved;

(11) A description of the morbidity basis used for the form, including its source, any adjustments from the source, and supporting data that justifies the morbidity basis;

(12) The average monthly premium rate anticipated per enrolled employee and per covered individual;

(13) For proposed rate adjustments, the average percentage increase, and the largest percentage increase in the monthly premium rate anticipated per enrolled employee and per covered individual, where the average increase is determined by comparing the aggregate premium before and after the increase assuming no lapses for all policies affected by the rate adjustment and where the maximum increase is the largest increase for an in-force policy, accounting for changes due to trend, aging, and allowable rating factors but excluding changes in the group's covered population;

(14) The medical trend assumption and supporting documentation for the same;

(15) Experience upon which rating assumptions can be based, except that when there is insufficient experience within New Hampshire upon which rating assumptions can be based, the carrier may use nationwide experience provided that appropriate adjustments shall be made, including adjusting premiums to New Hampshire levels and adjusting claims to represent New Hampshire utilization and prices;

(16) Premium adjustment information, except that no adjustment shall be made if nationwide premiums include area factors that adjust premiums for variations in utilization and price
levels, provided that these factors result in the same percentage adjustment to both premiums and claims;

(17) A history of prior rate adjustments, including the approval date and average percentage rate adjustments for the past 3 years;

(18) Certification that the policy forms for which rates are being filed are being actively marketed and are available to both new issues and renewing policyholders;

(19) Certification by a qualified actuary that, to the best of the actuary’s knowledge and judgment, the entire rate filing is in compliance with the applicable laws of New Hampshire and with the rules of the department;

(20) A description of the benefits provided via the form;

(21) A description of the expense assumptions;

(22) Rate calculations for at least 2 different hypothetical groups; and

(23) Sufficient documentation so that premium rates could be calculated for any group.

(e) Carriers shall submit a complete filing annually that includes all the documentation required by this [sub]section.

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

Ins 4104.07 Loss Ratio Standards for New 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 85 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.

PART Ins 4105 REQUIREMENTS FOR GROUP STOP LOSS INSURANCE

Ins 4105.01 Purpose. The purpose of this part is to provide requirements for the submission and the filing of group stop loss insurance rates and to establish standards for determining the reasonableness of the relationship of benefits to premiums.
Ins 4105.02 Applicability and Scope. This part shall apply to every group stop loss health insurance policy, rider, certificate, or endorsement form affecting stop loss health coverage.

Ins 4105.03 Definitions. For the purposes of this part:

(a) “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries, stating that to the best of the actuary's knowledge and judgment, the entire rate filing is in compliance with all of the applicable laws and rules and that the benefits are reasonable in relation to the premiums;

(b) “Actuarial memorandum” means the document describing the basis on which rates were determined and that indicates and describes the calculation of the anticipated loss ratio;

(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 but does not exceed 20 years;

(d) “Case characteristics” means demographic or other objective characteristics of a small employer that are considered by the small employer stop loss carrier in the determination of premium rates for the small employer;

(e) “Carrier” means any entity that provides stop loss health insurance in this state, including insurance companies, health services corporations, health maintenance organizations, fraternal benefit societies, and other entities subject to state insurance regulation;

(f) “Durational medical loss ratio” means the medical loss ratio calculated for a specified duration not to exceed 12 months;

(g) “Earned premium” means all monies paid by a policyholder as a condition of receiving coverage;

(h) “Eligible employee” means any employee who is eligible for the employer's sponsored health benefit plan. 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;

(i) “Employee” means an employee under Section 3(6) of Title I of the Employee Retirement Income Security Act of 1974 (ERISA);

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

(k) "Health coverage" means “health coverage” as defined in RSA 420-G:2 IX;

(l) “Incurred claims” means paid claims plus any changes to claim reserves;

(m) “Large employer” means any person, firm, corporation, or partnership that is actively engaged in business that, on at least 50 percent of the working days during the preceding calendar year, employs at least 51 employees who are eligible for employer sponsored coverage, and the majority of whom are employed within this state;

(n) “Medical loss ratio” means the ratio of incurred claims to earned premiums;

(o) “Premium” means the total amount due from a small employer policyholder to a small employer stop loss carrier for the provision of stop loss health coverage;
(p) “Rate” or “premium rate” means an amount per covered person or an amount per enrolled employee used to calculate premium;

(q) “Small employer” means any person, firm, corporation, or partnership that is actively engaged in business that, on at least 50 percent of the working days during the preceding calendar year, employed fewer than 50 employees, the majority of whom were employed within this state;

(r) “Small employer stop loss carrier” means a carrier that offers stop loss health insurance to one or more small employers in this state; and

(s) “Tier” or means a category of enrollment to which enrolled employees can elect coverage and includes, at a minimum, “single employee” and “family” tiers. The term shall include “tier membership”. Ins 4105.04  Underwriting and Issue Requirements.

(a) Small employer stop loss carriers shall file a report with the department on or before March 15th of each year detailing for the prior calendar year any instances where the carrier declined to offer coverage as applied for and any instances where the carrier's quoted renewal rate represented an increase larger than 20 percent. This report shall be filed at the same time as the actuarial certification required pursuant to RSA 415-H.

(b) The report in (a) shall include the following information:

   (1) Policyholder identification number;

   (2) Number of enrolled employees in both the calendar year for which the report is made and the prior calendar year, if known; and

   (3) The reason for the declination or the rate increase.

(c) Carriers may only vary rates for stop loss health coverage provided to small employers by using allowable case characteristics.

(d) Allowable case characteristics shall include:

   (1) The attained ages of the covered population;

   (2) The number of enrolled employees; and

   (3) The type of industry in which the small employer is engaged.

(e) For purposes of (c) above, small employer stop loss health carriers may use approximations to calculate allowable case characteristics provided such approximation methods are used uniformly among all small employer groups.

(f) Acceptable approximation methods include:

   (1) Using the attained ages of enrolled employees with tier based membership factors to approximate the attained ages of the covered population; and

   (2) Using a prior census to estimate the actual enrollment.

(g) 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 4105.05 Rate Submission Requirements. Rate filings for small and large employer group stop loss insurance shall include the following:

(a) The specific formulas and assumptions used in calculating gross premiums, including any changes in assumptions or formulas made since the last filing;

(b) The expected claims costs;

(c) Identification of morbidity and mortality tables or experience studies used and sufficient explanation for evaluation of their validity, including copies of such tables if they are not currently published;

(d) The range of commission rates and other fees payable to producers or other persons except regularly salaried employees, stated separately for new and renewal business;

(e) The expected loss ratio by policy duration;

(f) The anticipated loss ratio calculated over the anticipated lifetime of the block of business, or 20 years, whichever is shorter;

(g) Methods and assumptions used for making projections, including any changes in methods or assumptions made since the last filing; and

(h) Actual rates, or rating factors, and formulae sufficient to calculate rates given the underwriting characteristics of the policyholder.

Ins 4105.06 Annual Filing Required. Small employer stop loss carriers shall submit a filing that includes all documentation required of this subsection at least annually.

Ins 4105.07 Interim Filing. Small employer stop loss carriers may make an interim filing between its required annual filings, to propose adjustments to only certain factors.

PART Ins 4106 REQUIREMENTS FOR OTHER TYPES OF HEALTH INSURANCE

Ins 4106.01 Purpose. The purpose of this part is to provide requirements for the submission and the filing of disability income health insurance rates, blanket coverage, group supplemental coverage, and any other type of health insurance that is defined as an excepted benefit under RSA 420-G:2, IX. This part establishes standards for determining the reasonableness of the relationship of benefits to premiums.

Ins 4106.02 Applicability and Scope. This part shall apply to disability income insurance, blanket coverage, group supplemental coverage, and any other type of health coverage that is identified as an excepted benefit under RSA 420-G:2, IX.

Ins 4106.03 Definitions. For the purposes of this part:

(a) “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries that, to the best of the actuary’s knowledge and judgment, the entire rate filing is in compliance with all of the applicable laws and rules and that the benefits are reasonable in relation to the premiums;

(b) “Actuarial memorandum” means the document describing the basis on which rates were determined and that indicates and describes the calculation of the anticipated loss ratio;

(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 but does not exceed 20 years;
(d) “Blanket accident and health insurance” means that form of accident and health insurance:

(1) Not requiring individual applications from covered persons;
(2) Not requiring a carrier to furnish each person with a certificate of coverage;
(3) Not constituting health coverage as that term is defined in RSA 420-G:2, IX; and
(4) Covering special groups of persons as enumerated in one of the following:
   a. Under a policy issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all or any class of persons who may become passengers on such common carrier;
   b. Under a policy issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined solely by reference to exceptional hazards incident to such employment; and
   c. Under a policy issued to a college, school, or other institution of learning, or to the head or principal thereof, who or which are deemed the policyholder, covering students;

(e) “Disability income insurance” means a policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of both.

(f) “Duration medical loss ratio” means the medical loss ratio calculated for a specified duration not to exceed 12 months;

(g) “Earned premium” means all monies paid by a policyholder as a condition of receiving coverage;

(h) “Group supplemental health insurance” means any accident or health policy or certificate that is sold or issued to a small employer, large employer, licensed purchasing alliance, or a qualified association trust that does not constitute health coverage as that term is defined under RSA 420-G:2, IX;

(i) “Incurred claims” means paid claims plus any changes to claim reserves;

(j) “Medical loss ratio” means the ratio of incurred claims to earned premiums; and

(k) “Tier” or means a category of enrollment to which enrolled employees can elect coverage and includes, at a minimum, “single employee” and “family” tiers. The term shall include “tier membership”.

Ins 4106.04 Submission Requirements.

(a) All submissions shall include an actuarial memorandum, as follows:

(1) For new policy forms, the actuarial memorandum shall include:
   a. A brief description of:
      1. The type of policy;
      2. Benefits;
      3. Renewability;
4. General marketing method;
5. Issue age limits; and
6. Rate determination, including all assumptions;

b. Expense assumptions developed on a unit basis, including:
   1. Percent of premium;
   2. Dollars per policy;
   3. Dollars per unit of benefit; or
   4. Any combination of the above;

c. Estimated average annual premium per policy;

d. Anticipated loss ratio, including a brief description of how it was calculated, and anticipated durational loss ratio assumptions;

e. Anticipated trend information by cost, utilization, technology, and other components;

f. Anticipated loss ratio presumed reasonable according to this part;

g. Actuarial certification; and

h. Rate sheet; and

(2) For rate revision requests, the actuarial memorandum shall include:

a. A brief description of the:
   1. Type of policy;
   2. Benefits;
   3. Renewability;
   4. General marketing method; and
   5. Issue age limits;

b. A statement indicating whether the policy forms are:
   1. An open block that is still available to new issues; or
   2. A closed block that is no longer being sold;

c. Scope and reason for the rate revision, including a statement indicating whether the revision applies only to:
   1. New business;
   2. Existing business; or
   3. Both new and existing business;
d. An outline of all past increases that have been approved and implemented on the form;

e. The estimated average annual premium per policy calculated both before and after the rate increase;

f. A description of the relationship of the proposed rate scale to the current rate scale;

g. Past experience as specified in paragraph (b) below;

h. A brief description as to how revised rates were determined, including a general description of and a source for each assumption used;

i. Expense assumptions developed on a unit basis, including:
   1. Percent of premium;
   2. Dollars per policy;
   3. Dollars per unit of benefit; or
   4. Any combination of the above;

j. The anticipated future loss ratio and a description as to how it was calculated;

k. The anticipated loss ratio that combines past and future experience and a description as to how it was calculated;

l. Anticipated trend information by cost, utilization, technology, and other components;

m. The anticipated loss ratio presumed reasonable according to this part;

n. Actuarial certification;

o. Current rate sheet for previously approved rates; and

p. New rate sheet for proposed rates.

(b) 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, however, the carrier:

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

(2) May submit a written 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, the carrier shall consider 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) The carrier shall consider 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 an annual 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) Rate variations for different benefit plans shall not exceed the maximum possible difference in benefits unless the carrier demonstrates that the rate variation is based on expected utilization differences attributable to the plan designs, independent of the anticipated variation in health status or other demographics of the populations electing the varying plans.

(g) 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 shall be examples of benefit designs that should be considered in calculating this difference. Variations in co-pays shall not be considered due to uncertainty with regard to utilization.

(h) Pursuant to (g) above, this policy alternative shall be made available on a guaranteed issue basis for renewal quotes.
Ins 4106.05  Loss Ratio Standards for New 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, including:

(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 new forms, benefits shall be deemed reasonable in relation to the proposed premiums provided the anticipated loss ratio is at least as great as:

(1) Sixty percent for optionally renewable;
(2) Fifty-five percent for conditionally renewable;
(3) Fifty percent for guaranteed renewable;
(4) Forty-five percent for non-cancelable; and
(5) Sixty percent for short term, limited duration medical expense coverage.

(d) For policy forms that provide automatic indexing of benefits in relation to some base that is not subject to control by either the carrier or the insured, the carrier may file rates on a basis that provides for automatic adjustment of premium rates on an actuarial basis, appropriate in relation to the automatic adjustment in the benefits.

(e) 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.

Ins 4106.06  Loss Ratio Standards for Rate Revisions.

(a) Carriers shall estimate the average annual premium, both before and after the revision, per policy form 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 annual 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) 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:

1. 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

2. The anticipated loss ratio shall be at least as great as the anticipated loss ratio from the previously approved filing where the anticipated loss ratio shall be computed by dividing:
   a. The sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits; and
   b. The sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums.

(d) If the policy forms constitute a closed block, that is, they are not still being actively marketed, then the loss ratios in Ins 4106.05 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 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 rate revisions in future years to recoup rate revisions disallowed by this subsection.

(f) Carriers shall not be permitted rate revisions to recoup prior year losses.

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

Adopt Ins 4107 to read as follows:

PART Ins 4107 WAIVER OF RULES

Ins 4107.01 Waiver of Rules.

(a) The commissioner, upon the commissioner’s own initiative or upon request by an insurer, shall waive any requirement of this chapter if such waiver does not contradict the objective or intent of the rule and:

1. Applying the rule provision would cause confusion or would be misleading to consumers;

2. The rule provision is in whole or in part inapplicable to the given circumstances;

3. There are specific circumstances unique to the situation such that strict compliance with the rule would be onerous without promoting the objective or intent of the rule provision; or
(4) Any other similar extenuating circumstances exist such that application of an alternative standard or procedure better promotes the objective or intent of the rule provision.

(b) No requirement prescribed by statute shall be waived unless expressly authorized by law.

(c) Any person or entity seeking a waiver shall make a request in writing.

(d) A request for a waiver shall specify the basis for the waiver and proposed alternative, if any.
### APPENDIX A

<table>
<thead>
<tr>
<th>Rule</th>
<th>Specific State Statute the Rule Implements</th>
</tr>
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<tbody>
<tr>
<td>Ins 4101.01</td>
<td>RSA 400-A:15, I; RSA 415:1; RSA 415:24; RSA 420-A:2; RSA 420-A:8; RSA 420-B:20; RSA 420-G:1; RSA 420-G:4; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4101.02</td>
<td>RSA 400-A:15, I; RSA 415:1; RSA 415:24; RSA 420-A:2; RSA 420-A:8; RSA 420-B:20; RSA 420-G:1; RSA 420-G:4; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4101.03</td>
<td>RSA 400-A:15, I; 45 CFR Subtitle A, Subchapter B Part 158</td>
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<td>Ins 4101.04</td>
<td>RSA 400-A:15, I; RSA 420-B:20; RSA 420-G:1; RSA 420-G:2</td>
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<td>RSA 400-A:15, I; RSA 415:1; RSA 420-A:2; RSA 420-A:8; RSA 420-B:20; RSA 420-G:1; RSA 420-G:4; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4102.01</td>
<td>RSA 400-A:15, I; RSA 415:24; RSA 420-A:8; RSA 420-G:1; RSA 420-G:2, IX; RSA 420-G:4; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4102.02</td>
<td>RSA 400-A:15, I; RSA 420-G:1; RSA 420-G:4; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4102.03</td>
<td>RSA 400-A:15, I; RSA 420-B:1; RSA 420-G:2; 29 U.S.C. 18 § 1001 et seq.; 45 CFR Parts 158.130, 158.140, 158.150, 158.151, 158.221(a), 158.161(a), and 158.162(a)(1) and (b)(1)</td>
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<td>Ins 4102.05</td>
<td>RSA 400-A:15, I; RSA 420-G:1; RSA 420-G:4; RSA 420-G:5; RSA 420-G:6; RSA 420-G:11; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4102.06</td>
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<td>Ins 4102.08</td>
<td>RSA 400-A:15, I; RSA 420-G:1; RSA 420-G:2; RSA 420-G:4; RSA 420-G:11; RSA 420-G:12; 45 CFR Part 158.230</td>
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<td>Ins 4103.01</td>
<td>RSA 400-A:15, I; RSA 420-G:1; RSA 420-G:4; RSA 420-G:12; RSA 420-G:13</td>
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<td>Ins 4103.02</td>
<td>RSA 400-A:15, I; RSA 415:19; RSA 420-G:1; RSA 420-G:2, IX; RSA 420-G:3; RSA 420-G:4; RSA 420-G:11; RSA 420-G:12; RSA 420-G:13</td>
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<td>RSA 400-A:15, I; RSA 420-B:1; RSA 420-G:2; 29 U.S.C. 18 § 1001 et seq.; 45 CFR Parts 158.130, 158.140, 158.150, 158.151, 158.221(a), 158.161(a), and 158.162(a)(1) and (b)(1)</td>
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<td>Ins 4103.06</td>
<td>RSA 400-A:15, I; RSA 415:1; RSA 420-G:1; RSA 420-G:4; RSA 420-G:11; RSA 420-G:12; RSA 420-G:13</td>
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<tr>
<td>Ins 4103.07</td>
<td>RSA 400-A:15, I; RSA 420-A:2; RSA 420-A:8; RSA 420-B:20; RSA 420-G:1; RSA 420-G:4; RSA 420-G:11; RSA 420-G:12; RSA 420-G:13; 42 U.S.C. 1803 l(c)(6)(B)</td>
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<td>Ins 4103.08</td>
<td>RSA 400-A:15, I; RSA 420-G:4(h); RSA 420-G:13; RSA 420-G:14; 45 CFR Part 158.230</td>
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Adopted 06/04/2019
### APPENDIX B

**Incorporation by Reference Information**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Title of Material</th>
<th>Publisher; How to Obtain; Cost</th>
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</thead>
</table>
| Ins 4101.05(d) | Accident & Health Transmittal Document developed by the National Association of Insurance Commissioners, effective as of January 1, 2019 | Published by the NAIC  
Available for no cost at:  
https://www.naic.org/industry_rates_forms_trans_docs.htm |