Department of Regulatory Agencies

Division of Insurance
Marcy Morrison
Commissioner

COLORADO DIVISION OF INSURANCE

FREQUENTLY ASKED QUESTIONS FOR HEALTH CARRIERS

HB 08-1389: Concerning Increased Oversight of Health Insurance Rates ("Prior Approval") (Emergency Regulations 08-E-04 and 08-E-05, Regulations 4-2-11 and 4-4-1)

General Questions

Q1. How does HB 08-1389 change the filing process for health insurance carriers?

A. HB 08-1389 requires the carrier to submit for prior approval its expected health rate increases to the Colorado Division of Insurance (Division) at least 60 days prior to the proposed implementation of the rates.

Q2. What is prior approval and what does it mean?

A. "Prior approval" is where a carrier must submit proposed rates to the Division for approval before it begins using them. Health insurance carriers are required to support the need for a rate increase or decrease (same for "file and use"). The Division reviews the proposed rate change and supporting documentation to determine whether the company has provided all the information required by law and whether or not the requested rate is justified. If a requested rate increase is not justified, HB08-1389 gives the Division the authority to disapprove the rate or to request additional supporting documentation from the carrier. Also, if a filing requesting a rate increase is incomplete (i.e., carrier did not provide all the required justification) the filing may be disapproved. However, if the rate increase is justified and meets all applicable laws and regulations, the Division will approve the filing.

Q3. When does the health rate prior approval process go into effect?

A. Proposed health rate increases that are expected to take effect on or after January 1, 2009 and which are submitted to the Division on or after July 1, 2008 are subject to the prior approval process.

Q4. As a result of HB 08-1389, are all sickness, accident or health insurance rate filings now subject to prior approval?

A. No, only proposed health rate "increases" or, for dental insurance, a proposed rate increase of 5% or more, are subject to prior approval. In addition, non-developed rates including Medicaid, Medicare and the Children's Basic Health Plan are not subject to prior approval.

Q5. In the health rate filing, what if the carrier is proposing to increase rates for some policyholders and decrease rates for others?

A. "Rate increase" is defined as an increase in the current rate charged to any policyholder or certificate holder. So if, in the same rate filing, some policyholders are receiving a rate increase, and some are receiving a rate decrease or no change in rates, the whole rate filing would be subject to prior approval. If the carrier does not wish for the portion of the filing that is requesting a rate decrease to be subject to prior approval, then the carrier must submit two rate filings – one for the rate increase portion and one for the rate decrease portion. The rate filing requesting the rate increase would be subject to prior approval. The rate filing requesting the rate decrease would be considered "file and use", meaning that the carrier can use the rates concurrently with, or after, filing the rates. NOTE: Health carriers typically won't make two filings: one with an increase and one with rates remaining the same or decreasing. They typically do one filing, because of the programming required to come up with the correct rate and delaying either the increase or decrease may require another filing to adjust the rates – if rates do not develop as anticipated. Also, the cost in creating multiple filings and filing them is not always justified.

Q6. What if the Division fails to either approve or disapprove the rates within the 60-day period?

A. All filings that are not returned on or before the 30th day after the Division received the filing will be considered to be complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified to the carrier on or before the 45th day after the Division received the filing. If the Division does not approve or disapprove the rates within 60 days after the receipt date, then the carrier may implement the rates on the condition that the Division may require correction of any deficiencies upon later review if the rate charged is found to be excessive, inadequate, or unfairly discriminatory. If any rate adjustment is necessary due to a deficiency identified by the Division, the rate adjustment shall be required to be made on a prospective basis only.

Q7. Can the Division disapprove a rate filing after 30 days if the rate filing is incomplete?

A. No. HB 08-1389 requires that the Division make a determination of the completeness of the rate filing no later than 30 days after the Division receives the filing. The Division still has the authority to disapprove the rate filing after the 30th day (and on or before the 60th day) after receipt, but the rate filing cannot be disapproved solely on the basis of incompleteness during this period.

Q8. Are rate increases on long-term care policies subject to prior approval?

A. Yes. Although the long-term care law has not specified if rates are prior approval or file and use, companies have had to file long-term care rates the same as any health rate pursuant to §§10-16-107 and 10-19-104, C.R.S.

Q9. Are rate increases on Medicare supplement insurance policies subject to prior approval?

A. The prior approval provisions of HB 08-1389 do not apply to Medicare supplement insurance policies, since this law applies to regular health insurance under Article 16 of Title 10 and Medicare supplement has its own article, Article 18. However, Medicare

supplement insurance policies are already subject to prior approval under §§10-18-101 through 10-18-109, C.R.S., and Colorado Insurance Regulation 4-3-1.

Q10. Did HB 08-1389 add additional filing requirements for health insurance carriers?

A. Yes. HB 08-1389 requires small group carriers to file complete and detailed descriptions of their rating practices and renewal underwriting practices. In addition, all health insurance carriers doing business in the state of Colorado must submit certain specified cost information to the Division by June 1 of each year.

Q11. If a health insurance carrier is not writing new business in the state of Colorado, do they need to file the cost information required under HB 08-1389?

B. Yes. HB 08-1389 specifies certain cost information (referred to as the Annual Cost Report in Emergency Regulation 08-E-4 and amended Regulation 4-2-11) to be submitted to the Division on or before June 1 of each year. This cost information must be submitted by all carriers "doing business" in the state of Colorado. The phrase "doing business" is not defined in the law. As such, it should be interpreted in the most broad sense and would include all carriers with any health insurance policies or certificates in force in the state of Colorado, as well as health insurance carriers with no in force business in the state but who are actively offering health insurance products in the state of Colorado. It is possible that some of the items specified in the filing may not be applicable to a particular carrier for the previous calendar year. In such a case, the carrier should specify in the filing which items are not applicable, but the carrier is still required to make the filing.