PENNSYLVANIA INSURANCE DEPARTMENT
ACCIDENT AND HEALTH ACTUARIAL REVIEW DIVISION

Rate Approvals: Every HMO is required to file with the Insurance Department the rates for policies it proposes to issue on a group or individual/direct pay basis. These filings shall be made no less than 45 days prior to their proposed effective date. An HMO may use a rate filing unless it is disapproved by the Department within 45 days of filing. The Department is allowed to extend the review period by an additional 45 days if a base rate has not yet been established for the policy and for base rate changes of more than 10% within any 12 month period. However, if a rate filing is part of a COA application it can not be used until a COA is issued to the HMO, even if the Department does not disapprove it.

Disapproval of a Rate Filing by the Commissioner may be appealed under 2 Pa. C.S. (relating to administrative law and procedure).

Rate Filings: New HMOs must provide a rate development for each benefit plan and rider to be marketed. All rate benefit plan developments are to be filed using the *Department's Standardized Rate Filing Format* (Attachment A). All rider rate developments need not be submitted using the standardized format, however, all cost and utilization assumptions shall be shown and supported.

The standardized format should improve the Department's turn around time, while ensuring consistency in the HMO rate review process. Additionally, all HMOs need to review the Accident and Health Filing Reform Act (Act 1996-159), Sections 3 and 4 and the Pennsylvania Insurance Regulations, Title 31 Pa. Code Section 301.63, which give the Department its authority for reviewing HMO rate submissions. In addition, Section 301.42 of the Regulations itemizes the information that is mandated for all HMO rate submissions. This data forms the basis for the standardized format.

This format includes:

1. Membership projections for the rate projection period.

2. Projected demographics of the HMO's membership by contract type (i.e. single, family, etc.) and contract size.

3. A per member per month (PMPM) rate development, by medical service provided, showing the projection period, the average utilization of each service per 1,000 members and the average cost per service for each. Include all reinsurance expense and recoveries, incentive comp, COB, etc. necessary to develop the total required revenue. A project factor of up to 5% of total required revenue may be included in the rate. Administration is limited to a maximum 15% of total required revenue. Additionally, the dollar amount of administrative

expenses on a PMPM basis is currently limited to a maximum increase of 4% per year. Include an actuarial memorandum documenting all assumptions used to derive the projected utilization, costs, and quarterly trends.

4. A separate rate page for each benefit plan and rider illustrating the rate for each quarter for each type of contract (i.e. single, family, etc.), which also includes the rates applicable to those members converting from the group to a non-group conversion basis under the plan (any additional costs, up to 20% (maximum) of premiums, must be fully documented).

Additional Information Required by the Accident and Health Actuarial Review Division:

- Describe the Benefit Package, Identify the Class of Membership (Group, Group Conversion, Non-Group, and the like) and Indicate the Form Number of the Contract Form to which the proposed Premium Rates will apply. (Copies of the actual Contract Forms are required by the Actuary to verify benefits against actual contract language).

- Describe the Procedure and Identify the Inflationary Trend Factors used to Project the Proposed Premium from the Initial Rating Period to Each Succeeding Rate Period.

- For Contractual Capitation Arrangements, indicate the Effective and Termination Dates of Current Contracts, the Current Capitation Amounts and the proposed Capitation Amounts for Contracts due to be renewed during the rating period. Identify the Premium Rate Components which in total equal the average capitation amounts paid to providers.

- Show in a Table the Proposed Premium Rates and supporting documentation separately from the other information in the rate filing.

Rating Environment

All HMOs operating in Pennsylvania are Community Rated unless a variable rating methodology is submitted to the Department under the file and use provisions of Act 159. Types of variable rating methods and requirements available for use in rating groups are:

- Rate Reallocation - requires a minimum of 25 eligible employees.

- Community Rating by Class (CRC) - requires minimum of 100 eligible employees (not including dependents).

- Group Specific Community Rating (GSCR) - requires a minimum of 250 enrolled employees for the most recent 12 months. The group (no minimum size) must have been enrolled in the HMO for 36 consecutive months. New HMOs may not file GSCR.

Adjusted Community Rating (ACR) - requires the HMO to be federally qualified. The HMO serves as an intermediary to Health Care Financing Administration (HCFA) to administer a Medicare risk contract to Medicare eligible individuals.

HMO RATE FILINGS
STANDARDIZED FORMAT
LINE ITEM DESCRIPTION

When submitting data in the standardized HMO rate filing format please include documentation for all assumptions included in the rate development. The Department expects clear justification for each line item.

Below is a brief description of each line item in the standardized HMO rate filing format. Following this list of line item descriptions is "Additional Notes", which explains the Department's expected handling of specific situations.

Any questions should be referred to the Pennsylvania Insurance Department, Office of Rate and Policy Regulation, Bureau of Accident and Health Insurance, Actuarial Review Division, (717)787-4192.

HOSPITAL SERVICES

INPATIENT

IN-AREA

NON-MATERNITY -- inpatient hospital services rendered in the service area that are not related to maternity (excluding physician services).

MATERNITY

NORMAL -- inpatient hospital services rendered in the service area for maternity cases delivered normally (excluding physician services and obstetrical testing).

C-SECTION -- inpatient hospital services rendered in the service area for maternity cases delivered C-section (excluding physician services and obstetrical testing).

OUT-OF-AREA -- inpatient hospital services that are rendered at hospitals outside of the service area (excluding physician services).

SPU -- Short Procedure Units or same-day surgical procedures, which should occur only at in-area hospital facilities by design (excluding physician services).

OUTPATIENT -- outpatient services provided by hospitals (excluding physician services).

EMERGENCY ROOM

IN-AREA -- emergency room services provided by hospitals in the service area (excluding physician services).

OUT-OF-AREA -- emergency room services provided by hospitals outside the service area (excluding physician services).

SNF -- Skilled Nursing Facility.

MISCELLANEOUS -- other hospital services not itemized above, please list and explain separately, total here (excluding physician services).

PHYSICIAN SERVICES

PCP VISITS -- Primary Care Physician office, home, and hospital visits including well child care.

CONSULTANTS

HOSPITAL BASED -- consultant/specialist services provided in the hospital, including pathologist, etc. (excludes emergency room physician and anesthesiologist).

NON-HOSPITAL BASED -- non-hospital based referral/specialist services provided by referral from PCP.

SURGERY

INPATIENT -- physician services for inpatient surgery.

OUTPATIENT -- physician services for outpatient surgery or office surgery/operation.

ASSISTANT -- physician assistant(s)/nurse(s) for surgery.

ANESTHESIA -- anesthesiologist services for surgery.

EMERGENCY ROOM -- physician services in the emergency room.

OBSTETRICS

NORMAL -- physician services for normal (non-C-section) deliveries including obstetrical tests.

C-SECTION -- physician services for C-section deliveries including obstetrical tests.

MISCELLANEOUS -- other physician services not itemized above, please list and explain separately, total here.

ALCOHOL ABUSE (mandatory benefit)

HOSPITAL BASED

INPATIENT

HOSPITAL SERVICES -- hospital services, including room and board, provided for the treatment of alcohol abuse on a hospital or treatment facility inpatient basis.

PHYSICIAN SERVICES -- physician services provided for the treatment of alcohol abuse on a hospital or treatment facility inpatient basis.

OUTPATIENT -- physician services provided for the treatment of alcohol abuse on a hospital or treatment facility outpatient basis.

NON-HOSPITAL BASED -- physician services provided for the treatment of alcohol abuse on an office visit basis.

DRUG ABUSE (mandatory benefit)

HOSPITAL BASED

INPATIENT

HOSPITAL SERVICES -- hospital services, including room and board, provided for the treatment of drug abuse and chemical dependency on a hospital or treatment facility inpatient basis.

PHYSICIAN SERVICES -- physician services provided for the treatment of drug abuse and chemical dependency on a hospital or treatment facility inpatient basis.

OUTPATIENT -- physician services provided for the treatment of drug abuse and chemical dependency on a hospital or treatment facility outpatient basis.

NON-HOSPITAL BASED -- physician services provided for the treatment of drug abuse and chemical dependency on an office visit basis.

MENTAL HEALTH

HOSPITAL BASED

INPATIENT

HOSPITAL SERVICES -- hospital services, including room and board, provided for the treatment of mental health disorders on a hospital or treatment facility inpatient basis.

PHYSICIAN SERVICES -- physician services provided for the treatment of mental health disorders on a hospital or treatment facility inpatient basis.

OUTPATIENT -- physician services provided for the treatment of mental health disorders on a hospital or treatment facility outpatient basis.

NON-HOSPITAL BASED -- physician services provided for the treatment of mental health disorders on an office visit basis.

DIAGNOSTIC TESTS

LABORATORY

HOSPITAL BASED -- hospital provided laboratory services, including physician services.

NON-HOSPITAL BASED -- non-hospital provided laboratory services, including physician services.

X-RAYS -- X-ray services provided including physician services.

MAMMOGRAMS -- (mandatory benefit) mammogram testing services provided including physician services.

OTHER -- diagnostic testing services, including physician services, other than laboratory, X-rays, and mammograms.

OTHER

PHYSICAL THERAPY -- physical therapy services, including speech, occupational, etc. and physician services, as included in the basic benefit plan.

CHEMOTHERAPY -- chemotherapy treatments including radiation treatment, etc. and physician services, as included in the basic benefit plan.

AMBULANCE -- ambulance services as included in the basic benefit plan.

HOME HEALTH -- medical services for home health care as included in the basic benefit plan.

DME -- Durable Medical Equipment, including prosthetics, orthotics, etc., as included in the basic benefit plan.

REFRACTION -- vision care services, by other than PCP, as included in the basic benefit plan (PCP vision care services will be under PHYSICIAN SERVICES, PCP VISITS).

DENTAL -- dental care services, other than medically necessary, as included in the basic benefit plan (medically necessary dental care services will be under the appropriate HOSPITAL SERVICES and PHYSICIAN SERVICES).

PRESCRIPTION DRUG -- non-hospital prescription drug costs as included in the basic benefit plan (prescription drug costs incurred in the hospital will be under the appropriate category of HOSPITAL SERVICES).

MISCELLANEOUS -- other medical services not itemized above but included in the basic benefit plan, please list and explain separately, total here.

ADJUSTMENTS

DEBITS

REINSURANCE -- expense for reinsuring against large claims.

INCENTIVE COMPENSATION -- program funds / pool used as provider incentive to control utilization and cost increases.
DEBT SERVICE -- debt expense for non-subordinated debts.
CONTINGENCY / PROFIT -- expense for contingency reserves (non-profit HMO) or profit margin (for profit HMO).
ADMINISTRATIVE EXPENSE -- expenses for administration and marketing of plans (includes data processing).

CREDITS

COB -- credit for Coordination Of Benefits (COB).
REINSURANCE RECOVERIES -- credit for recoveries from reinsurance contract.
INVESTMENT INCOME CREDIT -- credit for interest earned.

HMO RATE FILINGS
ADDITIONAL INFORMATION

Filing Deadlines

Rate submissions shall be made to the Department no less than 45 days prior to the proposed effective date of the rates. 45 days represents the file and use period pursuant to the Accident and Health Filing Reform Act (Act 1996-159). Please note that the Department is allowed to extend the review period by an additional 45 days if a base rate has not yet been established for the policy and for base rate changes of more than 10% within any 12 month period.

If a rate filing is part of a COA application, it can not be used until a COA is issued to the HMO. The Department strongly recommends that HMOs file their rate submissions 90 days prior to the requested effective date of the rates. This allows for the statutory review time and for correspondence between the Department and the HMO.

Capitated Services

Services may be capitated at a higher level than the specific line items in this standardized format (e.g. Physician Services). It is important to remember that these "higher level" capitations are still based on assumed (or actual) utilization and agreed upon prices (however discounted they may be).

The Department expects the HMO to identify the component pieces of capitated services according to the line items of this standardized format. In the supporting written documentation, the HMO should note the capitated line items, the grouping of such, and the aggregate capitated rate. Feel free to provide as much written documentation and supporting documents as may be necessary to substantiate your position.

By identifying the component pieces of capitated services according to this standardized format, both the Department and the HMO will benefit from a better analysis of the data. Also, the HMO will be able to utilize the detailed data in future capitation negotiations.

Riders

Because rider coverages may vary significantly between HMOs, the Department will not issue a specific standardized rate filing format for riders. Instead, the HMO should submit the rider rate filing utilizing the same general format. In other words, the Department will require the HMO to include the same columns in their rate submission, but the line items should be adjusted to reflect the specific benefits/coverages of each rider. The "Adjustments" section (e.g. COB, Administration Expense, Contingency/Profit, etc.) must also be included in all rider rate developments.

The rate submission of a Dental Rider serves as a good example. This submission would include the same three sets of columns (i.e. "Experience", "Projected", "-type of- Plan") as the standardized format. In place of the specified line items of the standardized format, this rate submission may include line items such as Check-ups, Prophylaxis, Fluoride Treatments, Fillings, Dentures, Oral Surgery, etc. (dependent on the specific benefit structure of the rider) and the "Adjustments" section of the standardized format.

Medicare Supplement

Medicare Supplement plans/riders rate submissions should follow the "Riders" guidelines above.

Medicare Risk

The Department will accept Medicare Risk plans/riders rate submissions in one of two formats: (1) in the standard HCFA format, or (2) in a format consistent with the "Riders" guidelines above.