806 KAR 38:070. Health maintenance organization subscriber fee filings.

RELATES TO: KRS 304.38-050, 304.38-070

STATUTORY AUTHORITY: KRS 304.38-150

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.38-150 provides that the Commissioner of Insurance may promulgate administrative regulations necessary for the proper administration of KRS Chapter 304, Subtitle 38. KRS 304.38-050 requires, in part that any schedule of fees or other periodic charges to be paid by enrollees and submitted to the commissioner is to be accompanied by adequate supporting information to show that such charges or fees are not excessive, inadequate, or unfairly discriminatory. This administrative regulation establishes the minimum amount of supporting information which may be considered adequate.

Section 1. Definitions.

(1) Terms defined in KRS 304.38-030 shall have the meanings stated therein.

(2) "Uncovered expenditures" are health care service costs that are covered by a health maintenance organization and are rendered by providers not under contract with the HMO. These are expenditures for health care services for which the HMO is at risk.

(3) "Actuary" means a member of the American Academy of Actuaries, a qualified Health Service Corporation Actuary or a person who has demonstrated to the commissioner that his qualifications are substantially equivalent to those required for such qualification.

(4) "Community rating system" means a system of fixing rates of payments for health services. Under such system, rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized, such rates must be equivalent for all individuals and for all families of similar composition.

(5) "Capitation rates" are the per-person rates which form the basis of a community rating system.

(6) "Contingency reserve" means the unassigned funds held over and above any known or estimated liabilities of the organization for the protection of its enrollees against insolvency of the HMO.

Section 2. General Principles.

(1) Rates will be considered excessive if it appears that their use will result in an unjustified accumulation of a contingency reserve in excess of that prescribed in KRS 304.38-070.

(2) Rates will be considered inadequate if it appears that their use will result in a contingency reserve less than that prescribed in KRS 304.38-070.

(3) If the HMO's contingency reserves fall outside of the range defined herein, the commissioner may require the HMO to submit new budget projections, a revised estimate, certified by an actuary, of the appropriate contingency reserve level and/or rate filings to correct the deficiencies.

(4) An unfairly discriminatory rate is a rate for a person or class of persons which gives that person or class an advantage or a disadvantage in comparison with others involving essentially the same hazards, services, deductibles, copayments or expense factors. Charges applicable to an enrollee shall not be individually determined based on the status of his health.

(5) Community rating is not mandated by these rules, but an HMO which proposes to use another rating system should be prepared to demonstrate that its rating system does not violate the principles of these rules.

(6) Any rate filing, any demonstration of the need for additional contingency reserves, or qualification of the HMO for waiver of the deposit requirements of KRS 304.38-070 shall

take the following factors into account:

(a) Benefit type, including the proportion of uncovered expenditures and the potential for loss from uncollected copayments.

(b) Underwriting classifications, such as individual enrollees, small groups, Medicare complementary enrollees, etc., which may differ significantly in utilization patterns.

(c) Risk classification, including any characteristics which would cause delay in implementation of rate increases and any limited risk arrangements.

(d) Concentration of risk, such as the result of environmental hazards in a limited geographic area or the existence of a single large group.

(e) Trends, which should differ between uncovered expenditures and directly provided services and between services and administrative charges.

(f) Competition, which affects the degree to which fluctuation of actual-to-expected results may be covered in rates charged and inversely the degree to which contingency reserves must be relied upon to lessen the impact of such fluctuations.

(g) Catastrophes and epidemics, to the extent not considered elsewhere, and to the extent not covered by insurance or reinsurance.

(h) Mandated benefits for which rating information may not exist.

(i) Provider contracts, as they affect the level of uncovered expenditures.

(j) Health care development. This should be explained as a budgetary item, and any reserve for such development should be separate from the organization's contingency reserve.

(k) Fluctuation in asset values and investment income.

Section 3. Contents of Rate Filing. Each rate filing shall include:

(1) A cover letter outlining the scope and reason for the filing.

(2) A certification by an actuary as to the appropriateness of the proposed charges.

(3) The capitation rates for the plan affected and the formula to be used in deriving rates to be charged from the capitation rates, if the filing is for community rates.

(4) The organization's budget for the period for which rates are to be effective, which should be in such form as to relate easily to the elements (capitations, benefit variations, etc.) of the proposed rates.

(5) Sufficient recent financial data to support the proposed budget and any trends.

(6) Any other supporting information which the organization may wish to include or which the commissioner deems necessary to determine whether the proposed rates should be approved or disapproved.

(9 Ky.R. 754; eff. 2-2-83; TAm eff. 8-9-2007; Crt eff. 2-26-2020; TAm eff. 3-10-2020.)