PUBLIC PROTECTION CABINET
Department of Insurance
Division of Health and Life Insurance and Managed Care
(Amended at ARRS Committee)

806 KAR 17:070. Filing procedures for health insurance rates.

RELATES TO: KRS 304.14-120, 304.14-130, 304.17-380, 304.17A-005(22)
STATUTORY AUTHORITY: KRS 304.2-110
NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the Commissioner of Insurance to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010 . This administrative regulation establishes additional filing procedures for health insurance rates.

Section 1. Definitions.

(1) "Accumulated value" means the amount of which a sum of money would have increased as of the valuation date, if invested at a specific date in the past, subject to the investment earnings attributable to the policies.

(2) Insurer is defined by KRS 304.1-040.

(3) "Loss ratio" means the ratio of the sum of incurred losses divided by the earned premiums.

(4) "Present value" means the amount of money needed as of the valuation date to produce, when accumulated at interest, a specified amount on a specific future date. The "present value of future benefits" and "present value of future premiums" are the sums of those values that take into account not only the interest assumption, but the assumed persistency and mortality of the business.

(5) "Qualified actuary" means a member of the American Academy of Actuaries, a fellow or associate of the Society of Actuaries, the Institute of Actuaries, the Faculty of Actuaries, the Casualty Actuarial Society, or a fellow or member of the Conference of Actuaries in Public Practice that is compliant with continuing professional development in the area of health insurance.

Section 2. Scope. This administrative regulation shall apply to individual health insurance products and Medicare supplement plans. This administrative regulation shall not apply to health benefit plans as defined by KRS 304.17A-005(22).

Section 3. Classification of Policies. For the purposes of this administrative regulation, policies are classified by type of benefit, renewal clause, and average annual premium.

(1) Types of benefits recognized are:

(a) Medical expense, including hospital indemnity policies, as well as hospital, surgical, major medical, cancer, critical illness, or any other policies providing insurance against the expenses resulting from accident or sickness, as well as indemnity or lump sum benefits payable upon a medical event or diagnosis;

(b) Medicare supplement policies; and

(c) Loss of income.

(2) Categories of renewal clause are as follows:

OR	Optionally renewable: renewal of individual policies is at the option of the insurer.
CR	Conditionally renewable: renewal can be declined by the insurer only for a stated reason other than deterioration of health.

GR Guaranteed renewable: renewal cannot be declined by the insurer for any reason, but the insurer can revise rates on a class basis.

NC Noncancellable: renewal cannot be declined nor can rates be revised by the insurer.

(3) Recognized categories by average annual premium per policy are:
(a) Less than $250 ;
(b) A minimum of at least $250 but less than $500 ; and
(c) $500 or more.

Section 4. Filing of Rates. Every policy, rider, or endorsement form affecting benefits that are submitted for approval shall be accompanied by a rate filing unless the rider or endorsement form does not directly or indirectly produce a change in the benefit level. Any subsequent addition to or change in rates applicable to the policy, rider, or endorsement shall also be filed.

(1) The following items shall be included in individual health insurance rate filing submissions for rates on a new product:
(a) Policy form, application, endorsements, HIPMC-F1 incorporated by reference in 806 KAR 14:007,and filing fee.
(b) Rate sheet.
(c) Actuarial memorandum including:
1. A brief description of the type of policy, benefits, renewability, general marketing method, and issue age limits.
2. A brief description of how rates were determined, including the general description and source of each assumption used. If assumptions are materially different from the insurer's experience on similar policies, the reasons for their choice shall be explained. Margins, both implicit and explicit, shall be estimated. For expenses, show those that are percent of premium, dollars per policy and dollars per unit of benefit, separately, by policy year.
3. Estimated average annual premium per policy.
4. Anticipated loss ratio, including a brief description of how it was calculated, and a projection of year-by-year expected loss ratios.
5. Anticipated loss ratio presumed reasonable according to Section 5 of this administrative regulation.
6. If subparagraph 4 of this paragraph is less than subparagraph 5 of this paragraph, supporting documentation for the use of the proposed premium rates shall be filed.
7. An actuarial report signed by a qualified actuary as to whether or not, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and administrative regulations of the state, the Actuarial Standards of Practice available at http://www.actuarialstandardsboard.org/standards-of-practice/, and that the premiums are:
a. Reasonable in relation to the benefits;
b. Adequate;
c. Not excessive; and
d. Not unfairly discriminatory .
8. A comparison of the rates with those of any similar policies currently or recently issued by the insurer.
(d) A statement as to the status of the filing in the insurer's home state, and a statement as to any variations in rates or loss ratio assumptions required by or used in other states.

(2) The following items shall be included in individual health insurance rate filing submissions for rate increases on an existing product:

(a) New rate sheet, HIPMC-F1 incorporated by reference in 806 KAR 14:007, and filing fee.

(b) Actuarial memorandum including:

1. A brief description of the type of policy, benefits, renewability, general marketing method, issue age limits, the first and last year the policy form was issued, and the anticipated loss ratio of its original rates.

2. The scope and reason for rate revision including a statement of whether the revision applies only to new business, only to in-force business, or to both, and outline of all past rate increases on this form.

3. The estimated average annual premium per policy, before and after rate increase and a comparison of proposed rate scale with current rate scale.

4. Past experience, the statistical credibility of the experience data and any other available data the insurer may wish to provide. If policy reserves are other than net level reserves based on the rate assumptions underlying the existing rates, an estimate of the effect of using the reserves shall be provided.

5. A brief description of how revised rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy, dollars per unit of benefit as separate items, and the unamortized initial expenses to be recovered from future premiums shall be shown.

6. The anticipated future loss ratio described in Section 5(2)(a) of this administrative regulation and a description of how it was calculated.

7. The anticipated loss ratio that combines cumulative and future experience described in Section 5(2)(b) of this administrative regulation, and a description of how it was calculated.

8. Anticipated loss ratio presumed reasonable according to Section 5 of this administrative regulation.

9. If subparagraphs 6 or 7 of this paragraph is less than subparagraph 8 of this paragraph, supporting documentation for the use of the premium rates.

10. An actuarial report signed by a qualified actuary as to whether or not, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and administrative regulations of the state, the Actuarial Standards of Practice available at http://www.actuarialstandardsboard.org/standards-of-practice/, and that the premiums are:

a. Reasonable in relation to benefits;

b. Adequate;

c. Not excessive; and

d. Not unfairly discriminatory .

11. The number of policies in force in Kentucky and approximate annual premiums.

(c) A statement as to the status of the filing in the insurer's home state, and a statement as to any variations in rates or ratio assumptions required by or used in other states.

Section 5. Reasonableness of Benefits in Relation to Premiums.

(1) New forms.

(a) With respect to a new form other than a Medicare supplement form under which the average annual premium, as defined in the table below is expected to be at least $500 , benefits shall be found as reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%

Loss of Income and Other 60% 55% 50% 45%

(b) For a policy form, including riders and endorsements, under which the expected average annual premium per policy is $250 or more but less than $500 , subtract five (5) percentage points from the numbers in the table above, or less than $250 , subtract ten (10) percentage points.

(c) The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

(d) The loss ratio for a Medicare supplement policy shall be as provided in 806 KAR 17:570 , regardless of renewal clause or average premium.

(2) Rate revisions. Except as provided in subsection (3) of this Section, with respect to filings of rate revisions for a previously approved form, benefits shall be determined reasonable in relation to premiums if both of the following loss ratios meet the standards for new forms as established in subsection (1) of this Section and the loss ratio described in paragraph (b) of this subsection meets or exceeds the initial filed expected loss ratio.

(a) The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;

(b) The anticipated loss ratio derived by dividing "A" by "B" where:

1.

a. "A" is the sum of the accumulated value of the benefits, from the original effective date of the form or the effective date of this administrative regulation, whichever is later, to the effective date of the revision, and the present value of future benefits; and

b. "B" is the sum of the accumulated value of the premiums from the original effective date of the form or the effective date of the administrative regulation, whichever is later, to the effective date of the revision, and the present value of future premiums.

2. The present values shall be taken over the entire period that the revised rates are computed to provide coverage, and the values shall be calculated from the last date that accounting has been made to the effective date of the revision.

(3) Anticipated loss ratios other than those indicated in subsection (1) or (2) of this section shall require justification based on the special circumstances that may be applicable.

(a) Coverages for which a lower loss ratio may receive special consideration are as follows:

1. Accident only;
2. Short term nonrenewable, e.g., airline trip, student accident;
3. Specified peril, e.g., common carrier; and
4. Other special risks.

(b) Factors for which lower loss ratios may receive special consideration are as follows:

1. Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
2. Extraordinary expenses;
3. High risk of claim fluctuation because of the low loss frequency or the catastrophic, or experimental nature of the coverage;
4. Product features such as long elimination periods, high deductibles and high maximum limits;

5. The industrial or debit method of distribution; and

6. Forms issued prior to the effective date of these guidelines.

(c) Insurers shall review their experience periodically and file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of unacceptable large rate increases. For rate increases of more than thirty (30) percent, insurers may be requested to implement the increase over two (2) or more years.

(d) An example of factors for which higher loss ratios may be required:

1. A form on which all initial expenses have been amortized.

2. A form on which rates have been increased to at least double their original level.

3. A form on which insurers have not filed rate increases in a timely manner pursuant to subsection 3(c) of this section.

(e) When rates are submitted for new forms, the Department may require subsequent filings to demonstrate that the loss ratio required by subsection (1)(a) of this section is being met.

Section 6. Miscellaneous Considerations.

(1) Additional data that may be included in the support of rate filings includes data such as the substitution of actual claim run-offs for claim reserves and liabilities, in order to avoid the problems of short-term developments, accident-year loss ratios supporting trends, the operation of any experience funds or stabilization reserves, and the adjustment of premiums to an annual mode basis.

(2) All additional data shall be reconciled, as appropriate, to the required data, and any missing data explained.

Section 7. Severability. If any provision of this administrative regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this administrative regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

(8 Ky.R. 955; eff. 4-7-1982; 21 Ky.R. 1961; eff. 4-6-1995; TAm eff. 8-9-2007; Crt eff. 2-26-2020; 47 Ky.R. 2726; 48 Ky.R. 1151; eff. 1-4-2022.)

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