



GOBIERNO DE PUERTO RICO
OFICINA DEL COMISIONADO DE SEGUROS

16 de noviembre de 2012

CARTA CIRCULAR NÚM.: 2012-1822-AV

A TODOS LOS ASEGURADORES DE INCAPACIDAD Y ORGANIZACIONES DE SERVICIOS DE SALUD QUE SUSCRIBEN PLANES MÉDICOS EN PUERTO RICO

REVISION DE AUMENTOS EN TARIFAS RELACIONADAS CON LOS PLANES MÉDICOS

Estimados señoras y señores:

Por disposición de la Ley Federal conocida como el "Patient Protection and Affordable Care Act" (PPACA), los aseguradores de incapacidad y organizaciones de servicios de salud que suscriben planes médicos en Puerto Rico están obligados a presentar ante la Oficina del Comisionado de Seguros ("OCS"), para su revisión y aprobación, todo aumento de tarifas igual o mayor al diez por ciento (10%) sobre la tarifa actual, y que cobre vigencia a partir del 1ro de septiembre de 2011.

Al respecto, le recordamos que dicho requisito de presentación de tarifas, previo a su implementación, aplica a contratos de mercado individual y a los contratos de grupos pequeños que no tengan el estatus de plan protegido "grandfathered" y que dicha presentación debe hacerse con no menos de sesenta (60) días de anticipación a la fecha de vigencia programada.

Con el fin de facilitar la realización de las labores delegadas a esta Oficina relacionadas con la revisión de tarifas, todos los aseguradores y organizaciones de servicios de salud que suscriben planes médicos en Puerto Rico deberán utilizar las instrucciones suministradas en el Anejo A¹ de esta Carta Circular para calcular los aumentos en tarifas. Igualmente, deberán someter a esta Oficina los Manuales de Tarifación y/o Suscripción en o antes del 20 de diciembre de 2012.

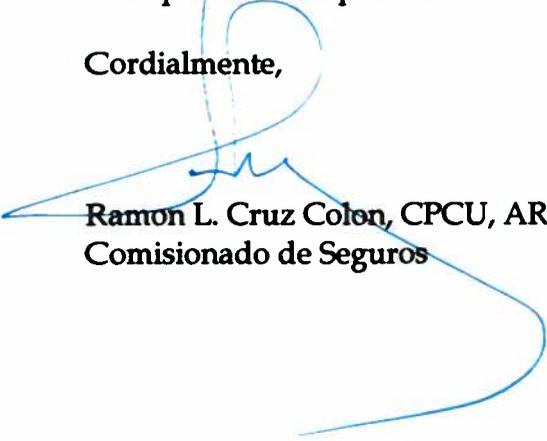
¹ Dudas relacionadas a estas instrucciones serán discutidas en el entrenamiento que se ofrecerá a la industria próximamente.

Por último, los aseguradores y organizaciones de servicios de salud deberán presentar ante la OCS la información solicitada en el Anejo B de esta Carta Circular, completada en todas sus partes, para cada uno de los productos² disponibles. Esta información deberá ser presentada, en un CD sin ningún tipo de protección utilizando el formato Excel 97-2003 en o antes del 20 de diciembre de 2012.

De tener alguna duda o pregunta referente a esta carta circular, favor de comunicarse con la División Actuarial, al 787-304-8686, extensión 4100.

Se requiere el cumplimiento estricto con lo aquí dispuesto.

Cordialmente,



Ramón L. Cruz Colón, CPCU, ARe, AU
Comisionado de Seguros

² Producto se define como cubierta de servicios de salud ofrecida en el mercado individual o en el mercado de grupos pequeños, al cual cada asegurador u organización de servicios de salud le asigna un nombre comercial y un número de identificación único, cuyas tarifas son determinadas utilizando metodologías matemáticas y actuariales.

Rate Increase Calculation for Comparison to the 10% Threshold

The rate increase for threshold comparison is calculated across all contract options. Contract options may include differing cost-sharing levels and/or riders. A contract is the smallest level of aggregation for which a carrier would submit a preliminary justification. In determining the threshold rate increase, the proposed increase must be combined with any previous increases during the one-year time period ending on the effective date of the proposed rate increase for any contract.

When all rates are increased on one date in the year, the average rate increase is calculated by determining the total premium for all current members using the new rates and using the current rates. Since the rate increase should not consider the impact of ages increasing in the year, the current ages should be used in calculating the premium one year earlier. If premium rates are determined for new business and renewal premiums using a rate manual applied consistently to all individuals or small groups and the rate manual is modified once a year, the same methodology can be used if renewal rates are increased on renewal dates that differ throughout the year consistently from one year to the next. That is if 1/12 of the annual rate increase is implemented every month in both the base year³ and projection year⁴, the same methodology can be used.

When rates are increased on other than an annual basis and multiple increases⁵ are applied in a year, the carrier must perform a separate threshold rate test for each increase effective date. The average annual rate increase can easily be calculated as the total projected premium for all current members at the new rates compared to the total premium for the same members using the rates in effective one year prior. The average rate increase for this rate increase compared to rates prior to the increase can easily be calculated as the total projected premium for all current members (\$2,056,660 in the example below) compared to the total premium for the same members using the rates in effective one year prior to the proposed effective date (\$1,921,580 in the example below).

Example of calculating an annual rate increase: Carrier X has a base rate for a small group contract and applies factors for contract type (employee only, employee and spouse, employee and child(ren), and family), age, and geographic area. Carrier X is increasing the base rates. To calculate the annual rate increase Carrier X can simply divide the new projected annual premium by the annual premium using base rates for each option in effect one year ago and the current population and then subtract 1.

<u>Option</u>	<u>Last</u>	<u>Last</u>	<u>Proposed</u>	<u>Projected</u>
---------------	-------------	-------------	-----------------	------------------

³ The base year is the experience used as the basis of the rate development

⁴ The projection year is the period of time that rates are being estimate for starting with the proposed effective date

⁵ Multiple increases occur when rate increases are more frequent than annual, such as monthly or quarterly rate increases and result in the need to calculate the effect of all combined increases. The methodology explained here does that.

	<u>Members</u>	<u>Year's Annual Premium⁶</u>	<u>Year's Base Rate</u>	<u>Base Rate</u>	<u>Annual Premium</u>
A	208	\$588,050	\$235.22	\$251.35	\$628,375
B	167	\$485,740	\$242.87	\$264.34	\$528,680
C	125	\$401,340	\$267.56	\$281.74	\$422,610
D	83	\$285,480	\$285.48	\$302.76	\$302,760
E	42	\$160,970	\$321.94	\$348.47	\$174,235
Total	625	\$1,921,580			\$2,056,660

The formula is $\$2,056,660 / \$1,921,580 - 1$ or 7%.

HHS Guidance

The section on pages 9-11 of the Rate Review Instructions Manual (http://cciio.cms.gov/resources/files/issue_manual_updated_091411.pdf) (copied below) provides further explanation of the calculation of the rate increase percentage for comparison to the rate review threshold.

3.1.2 Calculation of the "Subject to Review" Threshold

The Rate Review Regulation states that in the first year of the rate review program (September 1, 2011 through August 31, 2012), a rate increase exceeds the subject to review threshold if the average rate increase for enrollees is at or above 10%.

Issuers must identify and report on "subject to review"⁷ rate increases at the contract level.

This process is intended to measure changes in the underlying rate structure, not changes resulting from the application of previously approved elements of premium such as aging, moves across different geographic rating zones, population changes, benefit changes, or even changes in the employer contribution for small group resulting in a change in the employee's contribution for coverage. Of course, a filing that proposes a change in the factors underlying such elements as aging, geography, or benefits would be considered a rate change and would be studied as part of the rate filing.

If an increase is implemented within 12 months of a previous increase the combined effect of the two increases will be considered. Thus, the threshold test that determines whether an increase is subject to review would include the combined effect of any increases implemented within a year of the increase being considered. The frame of reference is the effective date of any increase.

If an increase does not trigger the threshold and become subject to review, a later increase will not cause that filing to change status and become subject to review should their combined effect trigger the threshold.⁸

⁶ The premium for the same contract holders using rates in effect 1 year prior to the proposed effective date for the new rates.

⁷ Over 10% annually

⁸ This is saying that if a rate increase in less than 10%, it will not become subject to review if a later increase causes the combined annual increase to exceed 10%. Note, that the second increase will be subject to review since the two combined are more than 10%.

When only the combined effect of two increases triggers the threshold, then only the later filing for the incremental increase would become subject to review. The earlier filing will not retroactively be made subject to review, it can only become so when tested at the time it is filed (or for States that do not requires an increase to be filed, when first implemented).⁹

Examples:

- 1) If there was a simple 12% increase effective on January 1, the threshold test would be triggered as this exceeds the 10% threshold.
- 2) If there was a simple 8% increase effective on January 1, the threshold test would not be triggered as this does not meet or exceed the 10% threshold.
- 3) If there were already a simple 8% increase effective January 1, and there was a second 4% increase effective July 1 added to the same contract, then, using the annual window and the point of reference of the effective date of the 8% increase January, 1 the combined increase¹⁰ for one year would be 12% which exceeds the 10% threshold and makes the increase subject to review.

If these increases were filed separately the first 8% increase would not trigger the threshold and it would not become subject to review. The second increase however would trigger the threshold and become subject to review since it is really part of a combined increase (two increases implemented within one year).

- 4) If there was a 6% increase implemented semi-annually beginning January 1, this would trigger the threshold since the annual increase is a combined increase comprised of two 6% pieces, or 12%. If the first 6% increase (January) was filed separately from the second (July) the first 6% increase would not trigger the 10% threshold in and of itself. The second semi-annual increase when combined with the first 6% increase would result in a combined 12% average annual increase and trigger the threshold from the point of reference of the effective date of the second increase.

In the case of rolling periodic increases¹¹, each set of increase, or combined increase would be examined from within the one year window period measured from the effective date of each increase. Thus, in the case of quarterly increases implemented effective January 1, and quarterly thereafter, each quarter the combined four quarter increase spanning the annual period ending on the effective increase date would be tested against the 10% threshold. If the threshold rate increase meets or exceeds the threshold value then the combined increase would trigger reporting. If it does not meet or exceed the threshold increase it would not be subject to review. Thus, a 2.5% combined quarterly increase would equal a 10% annual increase and trigger the threshold using the frame of reference of the fourth such quarterly increase.

A 10% increase applied to monthly cohorts upon renewal would represent an average 10% increase in the threshold test and trigger the threshold.

⁹ This is further explanation of the situation described in the prior footnote.

¹⁰ The combined increase is the combination of the 8% increase and the 4% increase. This is the amount that will be calculated by dividing the total projected premium and the premium for the same members using rates in effect one year prior to the proposed effective date.

¹¹ A rolling increase is a pre-determined series of increases typically taking place monthly or quarterly affecting new contract options or contract options renewing in the period.

In the case of any set of combined increases¹² considered together, if any threshold rate increase value exceeds 10% the set of increases would be subject to review.

¹² This would be a situation with a set of increases (like the rolling increases described) that are filed as one rate increase.

ANEJO B

Puerto Rico Benefits Map Instructions

The Benefits Map spreadsheet should be filled out for each product and for each deductible and copay combination. If benefits change, a new Benefits Map should be provided to the OCI using the updated benefits and a Benefits Map for the benefits that are no longer being offered should be provided to the OCI with the termination date indicated.

When the initial Benefits Map(s) for a product are submitted they should include the financial experience for the prior calendar year. Financial experience includes:

- 1) Member months covered in the prior year;
- 2) Earned premium in the prior year;
- 3) Allowed claims cost in the prior year;
- 4) Incurred claims in the prior year; and
- 5) Cost sharing paid by the members in the prior year (this amount should be the difference between the allowed claims cost and the incurred claims cost).

For product name include the common name of the product, such as \$1,000 deductible Choice Plan. If the deductible option also includes copayment alternatives, indicate the alternatives included in the Benefits Map.

When completing the Benefits Map some items may not apply, such as coinsurance. For each item that does not apply use the following amounts:

- 1) Deductible - \$0
- 2) Maximum out-of-pocket (OOP) – blank
- 3) Copay - \$0
- 4) Maximum days – blank
- 5) Maximum services – blank
- 6) Maximum benefit dollars – blank
- 7) Coinsurance – 0%

If a product has cost sharing for a service that is not specifically listed, the cost sharing and service area should be included in the email or letter accompanying the Benefits Map.

GENERAL
Carder Name: NALC Company Code: Contract Name: Product Name: Edition Name: Termination Date or Change Date: *
* Termination date should be left blank until there is a change in benefits

FINANCIAL
Contract Effective in Prior Calendar Year Member needs Dental premium Allowed claims costs Allowed claims costs Cost sharing

MEDICAL
Deductible and Out-of-pocket (OOP) Max Individual Deductible Maximum OOP per FTDN Maximum OOP per Family Copay and Maximum Copay Per day/visit/infusion Max days per admission Max services per year Max benefit dollars per year Equipment Outpatient Emergency room Physician: PCP Physician: specialist - MH and CD Physician: specialist - non-MH and non-CD Office surgery Preventive Diagnostic - X-ray/phi Dental Medical Equipment Laboratory Outpatient Pharmacy Chiropractic In-network

PRESCRIPTION DRUG
Prescription Drug Covered Benefit (Y/N) Deductible Copay Coinsurance Preferred Non-preferred Specialty Other tier

MISCELLANEOUS
Miscellaneous Covered Benefit (Y/N, as part of Major Medical or Drug Class) Copayment Coinsurance Max services per year Max benefit dollars per year