



GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE

July 12, 2011

RULING LETTER NO.: 2011-128-AV

TO ALL DISABILITY INSURERS AND HEALTH SERVICE ORGANIZATIONS THAT WRITE MEDICAL PLANS IN PUERTO RICO

DISCLOSURE AND REVIEW OF INCREASES IN MEDICAL PLAN RATES

Dear Sirs and Madams:

Under Section 2794 of the Public Health Service Act, as amended by Section 1003 of the federal Patient Protection and Affordable Care Act (PPACA Act), disability insurers and health service organizations that write medical plans in Puerto Rico have the obligation to submit to the Office of the Commissioner of Insurance ("OCI") for review and approval, any rate increase equal to or greater than ten percent (10%) of current rates, and that will enter into effect beginning September 1, 2011. This requirement to file rates before implementation is applicable to contracts in the individual and small group markets that are not grandfathered plans.

The purpose of this requirement is to allow the OCI to determine whether the proposed rate increase is unreasonable. A rate will be deemed "unreasonable" if the resulting rate is excessive, inappropriate or discriminatory, in accordance with Sections 11.120(7) and 19.080(2)(b) of the Puerto Rico Insurance Code.

- I. For the purposes of this ruling letter the following term will have the meanings set forth below:
1. Small group - means any individual, firm, corporation, partnership, whether or not for profit, that for at least fifty percent (50%) of its business days of the previous calendar year has employed at least two (2), but no more than fifty (50) employees.

¹Applicable to small group contracts when the rate increase is due to unilateral action taken by the insurer.

In the case of newly created employers, the number of employees at the time of the application for the medical plan will be taken into account.

2. Individual Market - market for medical plans offered directly to individuals who are not associated with any group medical plan.
3. Medical plan - means an insurance contract, policy, certificate, or subscription agreement with an insurer or health service organization, provided for consideration or in exchange for payment of a premium, or on a pre-paid basis, through which the health service organization or insurer agrees to provide or pay for certain medical, hospitalization, major medical, dental, and mental services, or services related to these.
4. Premium - means a specific amount of money paid to an insurer or health service organization as a condition for receiving the benefits of a medical plan.
5. Product - the coverage benefits of a medical plan for which an insurer or health service organization uses rating and price methodologies.
6. Rate - Element or factor that is basis for determining the premium. It is the base price calculated for the health benefits taking into consideration the cost of medical services, administrative expenses and the remainder of the premium, after covering medical services and administrative expenses.

II. Rates subject to approval of the OCI

All insurers and health service organization must file for approval by the OCI:

1. Rates that represent a ten percent (10%) or more increase over the current rates.
2. Increases of ten percent (10%) in rates applicable to increases in a single rate or multiple increases of less than ten percent (10%), made in the previous twelve (12) months and which amount to a total of ten percent (10%) or more.

In determining when a rate increase is subject to review, the increase will be considered at the product level. In spite of this, an insurer or health service organization having multiple products that are subject to review may submit a combined justification, provided that the experience of the combined products is used to calculate the rate increases and those increases are the same for all products. If the rate increase for all products equals or exceeds ten percent (10%),

it will be deemed that the rate increase must be submitted for evaluation by the OCS. The following formula should be used for this purpose:

$$\text{Weighted Average} = \frac{\Sigma(A \times B)}{C}$$

Where:

A= Increases in rates for a given category of insureds or subscribers

B =Number of insureds or subscribers affected in this category

Σ = Sum of the product of A x B for each category; and

C = Total of number of affected insureds or subscribers

Rate increases under ten percent (10%) need not be submitted for approval, except as provided in this section or in Chapter 19 of the Puerto Rico Insurance Code.

III. Submission of rates for approval

Rates that are subject to approval by the OCI must be submitted at least sixty (60) days before the effective date and must include a Preliminary Justification containing the information shown in Appendix A. At the end of the sixty (60) days, the rate increase submitted will be deemed to have been approved, unless it was affirmatively denied approval by the OCI for being unreasonable.

The Preliminary Justification should be submitted in Excel format using the model sheet of the "Health Insurance Oversight System (HIOS)" included in Appendix B.

IV. Implementation of unreasonable increases

No insurer or health service organization may implement a rate increase that has been denied approval by the OCI for being considered unreasonable.

V. Exclusions-The following medical plan rates will not be subject to review by the OCI:

1. Protected grandfathered medical plans;
2. Medical plans of employers having fifty-one (51) employees or more;
3. Medical plans providing only for retirees;

4. Rates for Health Plans of the Government of Puerto Rico, as created under Public Law No. 72, enacted on September 7, 1993, as amended;
5. Rates for medical plans under Public Law No. 95, enacted on June 29, 1963, as amended, known as the "Public Employee Health Benefits Act";
6. Rates for insurance issued by the State Insurance Fund Corporation, created under Public Law No. 45, enacted on April 18, 1935, as amended, known as the "Work Accident Compensation System Act," 11 L.P.R.A. §§1 *et seq.*;
7. Rates for the Medicare Advantage Program created under the Medicare Prescription Drug Improvement and Modernization Act, 117 STAT. 2066;
8. Rates for medical plans organized under the Employee Retirement Income Security Act (ERISA), 88 STAT. 829 and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 100 STAT. 82;
9. Rates for medical plans resulting from collective bargaining negotiations with public or private employers;
10. Rates for benefits called excepted benefits, including:
 - a. Coverage for accidents only, disability income insurance or any combination of these;
 - b. Coverage issued as supplementary to liability insurance;
 - c. Liability insurance, including general liability insurance and civil liability insurance;
 - d. Workers Compensation Insurance or any other similar insurance;
 - e. Coverage for automotive medical payments;
 - f. Credit insurance only;
 - g. Coverage limited to on-site clinics;
 - h. Dental or vision coverage with limited benefits;
 - i. Coverage with Long Term Care, Nursing Home Care, Home Health Care, Community-Based Care benefits or any combination of these;

- j. Coverage only for specific diseases;
 - k. Hospital indemnity coverage or any other kind of indemnity insurance;
 - l. Medicare Complementary Coverage as defined in Section 1882(g)(1) of the Social Security Act, supplementary coverage provided under Section 1071-1110a of federal law and any other similar group coverage, and
 - m. Any other similar coverage in which medical care benefits are secondary or incidental to the benefits from other coverage;
11. Rates for any other medical plan where the issuer is not under the jurisdiction of the OCI.

This ruling letter is not intended to invalidate any of the provisions of the Puerto Rico Insurance Code. Therefore, the requirement to file rates with the OCI, as set forth in Section 19.080(2)(a) of the Puerto Rico Insurance Code, 26 L.P.R.A., sec. 1908(2)(a) must be complied with by all health service organizations.

If you have any questions or concerns regarding this ruling letter, please contact the Actuarial Division, at 787-304-8686 ext. 4100.

Strict compliance with this letter is required.

Very truly yours,

SIGNED

Ramón L. Cruz-Colón, CPCU, ARe, AU
Commissioner of Insurance

INSTRUCTIONS FOR COMPLETING PRELIMINARY JUSTIFICATION

- I. This document contains the instructions for completing the Preliminary Justification that all insurers or health service organizations should include in the rate increase filing with the OCI, where there is an increase of ten percent (10%) or more over the current rate. This Preliminary Justification also should be submitted to the Centers for Medicare & Medicaid Services ("CMS") on the same date of filing with the OCI.

The Preliminary Justification is comprised of two parts and must be completed for any rate increase that requires filing with the OCI:

1. A summary of the rate increase
2. A written explanation of the rate increase

If the rate increase is ten percent (10%) or more for several products, the insurer or health service organization may submit a single Preliminary Justification for all of those products, provided that the following conditions are complied with:

- a. the experience of all of the products has been pooled to calculate the rate increase and
- b. the rate increase is the same for all of the combined products.

Separate Preliminary Justifications will be filed for products that do not fulfill these two requirements.

II. Instructions for completing Part 1 of the Preliminary Justification

A. General Information

Insurers and health service organizations will use a standard Excel worksheet (version 2010 or earlier), included in Appendix B, for completing Part 1 of the Preliminary Justification (Summary of the rate increase).

Insurers and health service organizations are required to provide historical (Base Period) and claim (Projection Period) information in Sections A and B:

- **Base Period Data:** The base period data are the data for the rate projections that are calculated in the worksheet. This section should be completed using the same data that were used to develop the rate increase and/or prepare any other rate filing required by law.

- **Projection Period Data:** The allowed costs are in two steps, moving from the base period to the projection period.

In Section B1 allowed costs are projected from the base period to the 12-month period immediately preceding the effective date of the proposed rate change based on updated pricing assumptions.

In Section B2 allowed costs are projected from the projection period for the current rate to the projection period representing the effective dates of the proposed rates. The projection periods are 12-month periods immediately before and after the effective date of the proposed rate increase.

Trends are calculated using an overall medical trend factor based on information on claims in the base period. Insurers and health service organizations must enter an overall medical trend factor for claims in each of the service category provided on the worksheet. The overall medical trend factor should reflect all of an insurer's or health service organization's cost, utilization, changes in covered benefits and other trend assumptions for the projection periods.

Insurers and health service organizations will use the following definitions for information included by service category on the worksheet:

- **Inpatients:** Includes non-capitated facility charges for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other inpatient facilities.
- **Outpatients:** Includes non-capitated facility charges for surgery, emergency room, lab, radiology, observation and other outpatient facilities.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of radiology, and other professional services.
- **Prescription Drugs:** Includes drugs dispensed by a pharmacy.
- **Other:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, and other services.
- **Capitation:** Includes payment per person per month for laboratory, professional, mental health and other capitated services.

B. Description of Worksheet Data Elements

Section A: Base Period Data

- **Base Period Data - Start and End Dates:** enter the beginning and end dates of the base period in "MM/DD/YYYY" format."
- **Member Months:** enter the total member months for the base period data for each service category.
- **Total Allowed Cost:** enter claims dollars for the base period by service category on an allowable basis including estimates of unpaid claims. Total allowed costs are summed automatically.
- **Member's Cost Sharing:** Calculated automatically by service category excluding capitation from total allowed dollars and net claims (dollars).
- **Net Claims:** enter incurred claims or the base period by service category including estimates of unpaid claims and net of member cost sharing. Total net claims (dollars) are summed automatically.
- **Member Cost Share Per Member Per Month (PMPM):** Calculated automatically by service category and in total based on member's cost sharing and member months.
- **Net PMPM:** Calculated automatically by service category and in total based on net claims and member months.
- **Allowed PMPM:** Calculated automatically by service category and in total based on allowed dollars and member months.

Section B: Claims Projections

B1. Adjustment to the Current Rate

This section projects allowed costs from the base period to the projection period for the current rate based on updated pricing assumptions.

- **Start and End Dates:** enter the starting date of the projection period for the current rate, which is 12 months prior to the effective date of the proposed rate increase. Enter the ending date of the projection period for the current

rate, which is one day prior to the effective date of the proposed rate change. Dates should be entered in "MM/DD/YYYY."

- Overall Medical Trend: enter the overall medical trend factor for each service category in the format "1.xxx".
- Projected Allowed Claims PMPM: Calculated automatically by service category as the product of the base period allowed PMPM, and the overall medical claims trend in this section (projection period for current rate).
- Member's Cost Share: enter the average of all member's cost share for the projection period for the current rate (for example, deductibles, co-pays, and coinsurance) by service category in the format ".xxx". This factor is used to calculate net claims PMPM from projected allowed PMPM.

The total member cost share factor is calculated automatically as 1 minus the ratio of net claims PMPM to total projected allowed PMPM.

- Net Claims PMPM: Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

B2. Claim Projection for the Future Rate

This section projects the claims experience from the midpoint of the projection period for the current rate to the midpoint of projection period for the future rate.

- Projection Period for Future Rate- enter the effective date of the proposed rates, for example, 1/1/2012. The end date should be exactly one year after the start date.
- Overall Medical Trend: enter the overall medical trend factor for each service category in the format "/.xxx".
- Projected Allowed PMPM: Calculated automatically by service category as the product of the current rate allowed PMPM, and the overall medical claims trend in this section (projection period for the future rate).
- Member's Cost Share: enter the average of all member's cost share for the projection period for the future rate (for example, deductibles, copays, and coinsurance) by service category in the format ".xxx". This factor is used to calculate net claims PMPM from projected allowed PMPM.

The total member's cost share factor is calculated automatically as 1 minus the ratio of total net claims PMPM to total projected allowed PMPM.

- Net Claims PMPM: Calculated automatically by service category based on projected allowed PMPM and member's cost sharing PMPM. Total net claims PMPM is summed automatically.

B3. Medical Trend Breakout

For the impact of medical trend, estimate the proportions of trend attributable to each of (1) unit cost changes, (2) utilization changes, and (3) all other components of trend combined. These fields should sum to one.

Section C: Components of Current and Future Rates

This section collects information on the net claims, administrative, and underwriting gain/loss components of the current and future rates. The administrative and underwriting gain/loss components should be reported in a manner consistent with how these terms are determined for state rate filings and financial reporting.

Future Rates

- Line 1 -Projected Net Claims: Completed based on net claims amount in Section B2.
- Line 2 - Administrative Cost: enter estimated administrative costs for the future rate.
- Line 3 - Underwriting Gain/Loss"): enter the gain loss estimate for the future rate.
- Line 4 - Total Rate: Calculated automatically as the sum of lines 1 through 3.
- Line 5 -Overall Rate Increase: Calculated automatically.
- Percentage of Rate (Line 1-4): Calculated automatically.

Prior Estimate of Current Rate

Complete these fields with the net claims PMPM and projected non-claim expenses PMPM based on the pricing assumptions in an earlier rate filing for the current rate.

- Line 1 - Projected Net Claims: enter prior estimate of net claims from prior rate filing.
- Lines 2 - Administrative Costs: enter prior estimate of estimated administrative costs for the current rate from the prior rate filing.
- Line 3 - Underwriting Gain/Loss: enter prior estimate of the underwriting gain/loss for the current rate period.
- Line 4 - Total Rate: Calculated automatically as the sum of lines 1 through 3.
- Percentage of Rate (Lines 1-4): Calculated automatically.

Difference

These fields are calculated automatically.

Section D: Components of Medical Claims Changes

This section shows the difference between the projected rate and the current rate as reflected in medical claims.

- Line 1- Inpatients: Calculated automatically as the product of the overall trend for inpatients entered in B2 (the projection period for future rate) minus 1 and the inpatient net claims amount in B 1 (the projection period for the current rate).
- Line 2- Outpatients: Calculated automatically as the product of the overall trend for outpatients entered in B2 (the projection period for future rate) minus 1 and the outpatient net claims amount in B1 (the projection period for the current rate).
- Line 3 - Professional: Calculated automatically as the product of the overall trend for professional entered in B2 (the projection period for future rate) minus 1 and the professional net claims amount in B1 (the projection period for the current rate).
- Line 4 - Prescription Drugs: Calculated automatically as the product of the overall trend for prescription drugs entered in B2 (the projection period for future rate) minus 1 and the prescription drugs net claims amount in B1 (the projection period for the current rate).

- Line 5 - Other: Calculated automatically as the product of the overall trend for other entered in B2 (the projection period for future rate) minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- Line 6 - Capitation: Calculated automatically as the product of the overall trend for payment per capita entered in B2 (the projection period for future rate)minus 1 and the other net claims amount in B1 (the projection period for the current rate).
- Line 7 - Cost Share Change: calculated automatically by adding the products of:
 - the difference in cost sharing amounts entered in B2 and B1 (the projection periods for the future and current rate) for each service category, and
 - the net claims amount in B2 for each service category.
- Line 8 - Correction of Prior Net Claims Estimate: calculated automatically based on the difference between Sections 8b and 8a.
 - Line 8a- Prior Net Claims Estimate for Current Rate Period: Enter the projected net claims for the current rate prior estimate in Section C, line 1.
 - Line 8b - Re-Estimate of Net Claims PMPM for Current Rate Period: Enter the total net claims PMPM for the projection period for the current rates in Section B1.
- Line 9- Total: calculated automatically as the sum of lines 1 through 8.

Section E: List of the Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years:

- Enter "yes." "no" or "new." The term "new" means that the product did not exist in the specific year or that the product was in its first year and there was no rate increase.
- Enter the average increase in rates submitted for approval for the product(s).
 - Enter the average increase in rates implemented for this product.

- Enter a zero (0) in all fields in Section E where there have not been any rate increases.

Section F: Range and Scope of Premium Changes Due to Rate Increase

- **Number of Covered Individuals:** enter the number of covered individuals as of the effective date of the increase.
- **Minimum and Maximum Rate Increases:** enter the minimum and maximum of rate increases. A change in the employer contribution will not be considered a rate increase.

III. Instructions for completing Part 2 of the Preliminary Justification

Provide a brief description in simple language of the reasons why the insurer or health service organization is requesting this rate increase. This explanation should also help consumers to interpret the information provided in Part 1 of the Preliminary Justification. In addition, it should identify and explain the key factors for the rate increase, as indicated in Part 1 of the Preliminary Justification. For example, if inpatient costs are reported as the main factor of the rate increase, the written explanation should describe why inpatient costs are increasing.

The explanation should include information on the following components related to the rate increase:

- **Scope and range of the rate increase:** Provide the number of individuals impacted by the rate increase. explain any variation in the increase among affected individuals (e.g., describe how any changes to the rating structure impact premiums).
- **Financial Experience of the Product:** describe the overall financial experience of the product, including historical summary-level information on historical premium revenue, claims expenses and profit. Discuss how the rate increase will affect the projected financial experience of the product.
- **Changes in Medical Services Costs:** Describe how changes in medical service costs are contributing to the overall rate increase. Discuss cost and utilization changes as well as any other relevant trend factors that are impacting overall service costs.
- **Changes in Benefits:** Describe any changes in benefits and explain how benefit changes affect the rate increase. Issuers should explain whether the applicable benefit changes are required by law.

- **Administrative Costs and Anticipated Profits:** Identify the main factors that affect changes in administrative costs. Discuss how changes in anticipated administrative costs and profit are impacting the rate increase.

There is no standardized reporting form for Part II of the Preliminary Justification, but issuers are expected to cover items listed above in their submissions. The written statement must be submitted in Microsoft Word format (version 2010 or earlier).

Part 2 of the preliminary justification should also include the following information:

1. Description of the kind of policy or contract, benefits, renewability, general marketing methods and issue age limits.
 - a. Name of the insurance company or health service organization
 - b. NAIC company code
 - c. Contact person and title
 - d. Telephone number and email of contact person
 - e. Date of filing
 - f. Proposed effective date
 - g. Form/product number
 - h. Type of market (Individual/Small group)
 - i. Status: Open/closed block
 - j. Brief description:
 - Type of policy or contract
 - Benefits
 - Renewability
 - General marketing method
 - Underwriting method
 - Premium classifications
 - Base age and issue age
2. Scope and reason for the rate increase.
3. Average annual premium per policy or contract, before and after rate increase.
 - a. Brief description previous rate increase
 - b. Description of the proposed increase in dollars
4. Past experience and any other alternative or additional information used.
 - a. Number of policy holders or contracts

- b. Number of lives covered
 - c. Total written premium
 - d. Evaluation period, experience period, projection period
 - e. Past experience, including:
 - Cumulative Loss Ratio (Historical/Past)
 - Any alternative experience data used
 - f. Credibility analysis
 - g. Incurred but not reported claims (IBNR)
 - h. Contract Reserves
5. A description of how the rate increase was determined, including a general description and source of each assumption.
- a. Expenses
 - Profit and contingencies
 - Commissions and producer fees
 - Taxes, licenses, and fees
 - General expenses
 - Other administrative costs
 - Reinsurance
 - b. Impact of statutory changes, including mandatory benefits
 - c. Overall premium impact of the proposed increase:
 - Annual average premium per policy or contract
 - Before and after the rate increase
 - d. Descriptive relationship between the proposed rate scale and the current rate scale.
 - e. Premium basis
 - Brief description of how revised rates were determined, including the following:
 - i. General description
 - ii. Source of each assumption
 - For expenses, include:

- i. Percent of premiums
- ii. Dollar per policy/contract or dollars per unit of benefits or both

- Trend assumptions
- Interest rate assumptions
- Interest rate assumptions compared to other assumptions including morbidity, mortality, and persistence

f. Company financial condition

- Company surplus

6. The cumulative loss ratio and a description of how it was calculated (for individual policies/contracts only).
7. The projected future loss ratio and a description of how it was calculated.
8. The projected lifetime loss ratio for the policies or contracts, combining cumulative and future experience and a description of how it was calculated.

Include an appendix showing details of the loss ratio.

9. The federal standard medical loss ratio ("MLR") in the applicable market for the rate increase, taking into account allowable adjustments under federal law.
10. If the result obtained under above paragraph (7) is less than the standard set forth in paragraph (9), a justification for this outcome must be included.

Rate Summary Worksheet

Per the instructions, health insurance issuers proposing rates increases above 10% in only those cells that are highlighted in GREY. The other cells are auto-populated.

A. Base Period Data

Service Categories	Member Months	Total Allowed	Net Claims	Member's Cost Sharing	Member's Cost Sharing PMPM	Net PMPM	Allowed PMPM
Inpatient							
Outpatient							
Professional							
Prescription Drugs							
Other							
Capitation							
Total							

B. Claim Projections

B.1. Adjustment to the Current Rate

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient				
Outpatient				
Professional				
Prescription Drugs				
Other				
Capitation				
Total				

B.2. Claims Projection for Future Rate

Service Categories	Overall Medical Trend	Projected Allowed PMPM	Net Claims	Member's Cost Sharing
Inpatient				
Outpatient				
Professional				
Prescription Drugs				
Other				
Capitation				
Total				

B.3 Medical Trend Breakout

Factor	Impact
Utilization	
Unit Cost	
Other Factors	

C. Components of Current and Future Rates

1. Projected Net Claims	Future Rate		Prior Estimate of Current Rate		Difference %
	PMPM	%	PMPM	%	
2. Administrative Costs					
3. Underwriting Gains/Losses					
4. Total Rate					
5. Overall Rate Increase					

D. Components of Rate Increase

Claims Components	Impact on Rate	Percent
1. Inpatient		
2. Outpatient		
3. Professional		
4. Prescription Drugs		
5. Other		
6. Capitation		
7. Cost Share Change		
8. Correction of Prior Net Claims Estimate		
9. Total		

E. List of Annual Average Rate Changes Requested and Implemented in the Past Three Calendar Years

Calendar Year	New Form	Requested	Implemented
2010			
2009			
2008			

F. Benefit and Scope of Proposed Increase

Number of Covered Individuals	
Minimum % Increase	Range of Rate Increase
Maximum % Increase	