RULES OF

Department of Commerce and Insurance

Division 400—Life, Annuities and Health

Chapter 13—Health Insurance Rates

TITLE 20 — DEPARTMENT OF COMMERCE AND INSURANCE
Division 400 — Life, Annuities and Health
Chapter 13 — Health Insurance Rates

20 CSR 400-13.100 Health Insurance Rates

PURPOSE: This rule prescribes the form and content of the rate information required to be submitted to the Missouri Department of Commerce and Insurance and sets forth the standards of review applicable to such filings.

(1) Scope. This rule is applicable to rates for health benefit plans that are subject to section 376.465.7, RSMo.

(2) Definitions. As used in this rule, the following terms mean —

(A) "Director" means the Director of the Department of Commerce and Insurance or the director's designee;

(B) "Health benefit plan" means those health benefit plans described under section 376.465.7, RSMo, and shall include student health plans;

(C) "Rate" means the amount of money a health carrier charges as a condition of providing coverage under a health benefit plan;

(D) "Rate filing" means a submission through SERFF that contains rates and rate filing justifications as well as other documents required by this rule and that assist the director in making determinations consistent with 45 CFR 154.215 and section 376.465, RSMo;

(E) "Rate filing justification" means actuarial data and other related information provided by a health carrier that supports the use of the proposed rate;

(F) "Student health plan" means a type of health coverage maintained pursuant to an agreement between an institution of higher education and a health carrier under which coverage is provided in connection with enrollment as a student at that institution of higher education, regardless of how the coverage is underwritten or issued;

(G) "System for Electronic Rate and Form Filing" or "SERFF" means the web-based interface system used for the submission of rate filings and form filings.

(3) All rates, rate filings, rate filing justifications, and any communication or notices filed under this rule shall be submitted through SERFF.

(4) All rate filings must conform to the requirements of 20 CSR 100-9.100.

(5) All proposed rates and rate filings for health benefit plans to be delivered, issued for delivery, continued, or renewed on or after January 1, 2018, shall contain the following:

(A) Rates for each health benefit plan including all variations based on age, rating area, and tobacco use, in an Excel spreadsheet, or other format as allowed by the director;

(B) Identification of all policy forms to which the rate filing will apply, including SERFF tracking number, policy form number, and plan identification number. A rate filing shall be made separately and apart from a policy form filing;

(C) The total number of in-force policies or certificates to which the rate filing will apply;

(D) The rate filing justification as described in section (6) of this rule;

(E) All proposed rates and rate filings for health benefit plans to be delivered, issued for delivery, continued, or renewed on or after January 1, 2025, shall also include an actuarial value and cost-sharing factor spreadsheet that contains —

1. The plan identification number included in the spreadsheet specified in subsection (5)(A);

2. The component factors of the actuarial value and cost-sharing design of plan field in the spreadsheet specified in subsection (5)(A), which shall not include adjustments that account for the morbidity of the population expected to enroll in the plan. Such component factors shall include at a minimum the following:

A. The actuarial value used in the pricing of the plan;

B. Induced demand factors for each metal level;

C. For individual silver plans sold on the exchange, a cost-sharing reduction adjustment factor that accounts for the average costs attributable to cost-sharing reductions (CSRs), to the extent that health carriers are not otherwise being reimbursed for those costs. A cost-sharing reduction adjustment factor shall not be applied to any other plans sold on the exchange. If health carriers are being reimbursed for the CSRs consistent with 42 U.S.C. section 18071, then the cost-sharing adjustment factor does not apply; and

D. For purposes of subparagraphs (5)(E)2.B. and C., the director shall determine the methodology used to establish the induced demand factor and the cost-sharing reduction adjustment factor on an annual basis. In determining the methodology, the director shall consider, at a minimum, actuarial best practices, guidance from the National Association of Insurance Commissioners, and guidance from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services;

3. The actuarial value and cost-sharing design of plan specified in the spreadsheet identified in subsection (5)(A). This value must equal the product of the component factors from paragraph (5)(E)2. and shall reflect the benefit differences and utilization differences due to differences in cost-sharing, including benefits and utilization differences attributable to CSRs, to the extent that health carriers are not otherwise being reimbursed for those costs.

A. For plan year 2025, health carriers shall assume that at least eighty percent (80%) of enrollees in silver plans select one (1) of the ninety-four percent (94%) or eighty-seven percent (87%) actuarial value designs, as described in 45 CFR section 156.420(a)(1) and (a)(2).

B. For plan year 2026, health carriers shall assume that at least eighty-eight percent (88%) of enrollees in silver plans select one (1) of the ninety-four percent (94%) or eighty-seven percent (87%) actuarial value designs, as described in 45 CFR section 156.420(a)(1) and (a)(2).

C. For plan year 2027, and all subsequent plan years, health carriers shall assume that at least ninety-five percent (95%) of enrollees in silver plans select one (1) of the ninety-four percent (94%) or eighty-seven percent (87%) actuarial value designs, as described in 45 CFR section 156.420(a)(1) and (a)(2); and

4. Student health plans and transitional plans are exempt from the requirements of subsection (5)(E); and

(F) Any other data or information that provides a sufficient basis for the director to determine if the proposed rates are reasonable and to complete the review under the standards outlined in 45 CFR Part 154.

(6) A health carrier shall submit a rate filing justification as follows:

(A) Part 1 of the rate filing justification shall be submitted on a form and in the manner prescribed by 45 CFR 154.215(d). Part

1 shall include the following data and information:

1. Historical and projected claims experience;

2. Trend projections related to utilization and service or unit cost;

3. Any claims assumptions related to benefit changes;

4. Allocation of the overall rates to claims and non-claims costs;

5. Per enrollee per month allocation of current and projected premium; and

6. Three- (3-) year history of rates for the product associated with the rate filing;

(B) Part 2 of the rate filing justification shall contain a brief, non-technical, consumer-oriented explanation of the proposed rates contained in Part 1 and any modifications contained therein. This explanation shall include a simple and brief narrative describing the data, information, and assumptions the health carrier used to develop the rate. Part 2 shall include, but not be limited to, the following:

1. An explanation of the most significant factors underlying a rate increase or decrease, where applicable, including a brief description of the relevant claims and non-claims expense increases reported in Part 1; and

2. A brief description of the overall experience of the policy, including historical and projected expenses and loss ratios;

(C) Part 3 of the rate justification shall contain an actuarial memorandum that contains the reasoning and assumptions supporting the data and information contained in Part 1 of the rate justification. The actuarial memorandum shall be submitted by a qualified actuary who represents the health carrier and who is a member of the American Academy of Actuaries.

1. A health carrier may submit a public version of Part 3 that redacts properly designated trade secrets or proprietary information. This redacted document shall be clearly denoted as the Part 3 Public Version. The health carrier may only redact information that is trade secret or proprietary under Missouri law. The Part 3 Public Version shall be submitted in SERFF as a document separate from other rate information.

2. If a health carrier submits a Part 3 Public Version, the health carrier must also submit an un-redacted version. This un-redacted version shall contain all of the required data and information with no redactions. The un-redacted version shall be clearly denoted as the Part 3 Confidential Version and submitted in SERFF as a document separate from other rate information.

(7) Any trade secret information included as a part of the rate filing justification must be designated as such by the health carrier and shall be subject to the provisions of sections 417.450-417.467, RSMo, and 20 CSR 10-2.400. All data and information contained within a rate filing or rate filing justification that is not clearly designated as either trade secret or proprietary under Missouri law, filed under this rule, will be open to the public.

(8) A health carrier shall submit rates and rate filing justifications, as outlined in this rule, to the Centers for Medicare & Medicaid Services on the same date it submits the information to the director, consistent with the requirements of 45 CFR Part 154.

(9) The director shall designate annual filing deadlines and posting dates, not inconsistent with the requirements of 45 CFR Part 154. The designation of annual filing deadlines may be announced through a bulletin or other electronic means as determined by the director.

(10) All proposed rates shall be posted at a uniform time on the department's website. All final rates shall be posted at a uniform time on the department's website.

(11) The department shall allow the submission of public comments regarding proposed rates in written form, submitted to the department by mail or in an electronic format. The comment period shall be open for at least thirty (30) days from the date the proposed rates are posted. Comments received on rate filings shall be accessible to the public through the department's website.

(12) A rate shall be determined to be unreasonable if the rate is excessive, inadequate, unfairly discriminatory, or unjustified.

(A) A rate is excessive if it is unreasonably high for the coverage provided under the health benefit plan.

(B) A rate is inadequate if it is unreasonably low for the coverage provided under the health benefit plan or the use of such rates endangers the solvency of the health carrier using the rate.

(C) A rate is unfairly discriminatory when a health carrier makes or permits differences in rates between individuals of the same class or of essentially the same risk when such differences are not permissible pursuant to section 375.936, RSMo, or when differences in rates do not reasonably correspond to differences in expected costs.

(D) A rate is unjustified if the heath carrier provides a rate justification that is incomplete or otherwise does not provide a sufficient basis upon which the reasonableness of a rate can be determined.

(13) The director's review of rates shall, at a minimum, consider the following:

(A) The reasonableness of the assumptions used by the health carrier to develop the proposed rate increase and the validity of the historical data underlying the assumptions;

(B) The health carrier's data related to past projections and actual experience;

(C) The reasonableness of assumptions used by the health carrier to estimate the rate impact of the federal risk adjustment program under 42 U.S.C. Section 18063; and

(D) The health carrier's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values, and other market standards or rules established under state or federal law.

(14) The director's review of rates may consider the following, to the extent the director believes any to be applicable to the rate filing under review:

(A) Medical cost trend changes by major service categories;

(B) Impact of changes in utilization of services by major service categories;

(C) Impact of cost-sharing changes by major service categories, including actuarial values;

(D) Impact of changes in benefits, including essential health benefits and non-essential health benefits;

(E) Impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under 42 U.S.C. Section 300gg;

(F) Impact of over- and under-estimation of medical trends in the previous three (3) years on the current premium rate;

(G) Impact of changes in reserve needs;

(H) Impact of changes in administrative costs related to programs that improve health care quality;
(I) Impact of changes in other administrative costs;
(J) Impact of changes in applicable taxes and licensing or regulatory fees;
(K) Medical loss ratio;
(L) The health carrier's capital and surplus;
(M) The impacts of geographic factors and variations;
(N) The impact of changes within a single risk pool to all products or plans within the risk pool; and
(O) The impact of risk adjustment payments and charges.

(15) Pursuant to section 376.465.10(4), RSMo, written notice of the director's determination that proposed rates are reasonable or unreasonable shall be provided within sixty (60) days after a complete rate submission to the director. This sixty- (60-) day time frame may be extended pursuant to a mutual agreement between the director and the health carrier.
(A) Proposed rates that are determined to be reasonable will be considered final and the filing will be closed upon the same date as the director's notice.
(B) Proposed rates that are determined to be unreasonable will be considered open for amendment by the carrier pursuant to section (16) of this rule.

(16) Pursuant to section 376.465.11, RSMo, after receiving written notice from the director that a proposed rate is unreasonable, if a health carrier elects to amend proposed rates or request reconsideration of the director's determination, the carrier shall notify the director and submit any amendments or additions to the rate filing or rate filing justification within thirty (30) days after the date the carrier receives written notice of the director's determination. The thirty- (30-) day time frame may be extended pursuant to a mutual agreement between the director and the health carrier.
(A) If a health carrier chooses to file an amended rate, it shall file the amended rate and a rate filing justification supporting the amended rate.
(B) If a health carrier chooses to request reconsideration, it shall notify the director, in writing, of its request for reconsideration and may submit any additional rate filing justification that it believes further supports the proposed rate. The director shall review such information and make a determination as to whether the proposed rate is reasonable or unreasonable.

(17) When a health carrier receives written notice that a proposed rate is unreasonable and the health carrier decides to implement the proposed rate notwithstanding the director's determination, the health carrier shall notify the director of its decision to use the rate within thirty (30) days after receiving notice of the director's determination. The director shall make the determination that the rate is unreasonable publicly available on the department's website at the same time as final rates are posted on the department's website.

AUTHORITY: sections 374.045 and 376.465, RSMo 2016. Original rule filed Oct. 3, 2016, effective March 30, 2017. Non-substantive change filed Sept. 11, 2019, published Oct. 31, 2019. Amended: Filed Jan. 16, 2024, effective July 30, 2024.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995, 2008, and 376.465, RSMo 2016.*