RULES
OF
THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE
INSURANCE DIVISION

CHAPTER 0780-01-93
RULES RELATED TO FORM AND RATE FILINGS FOR HEALTH INSURANCE COVERAGE SUBJECT TO THE AUTHORITY OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

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0780-01-93-.01 DEFINITIONS.

As used in this Chapter:

(1) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer; it does not include excepted benefits. For purposes of this Chapter, health insurance coverage shall have the same meaning as that given “major medical health insurance” in T.C.A. § 56-26-102 (d).

(2) "Health insurance issuer" means an entity, including a small employer carrier, subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation.

(3) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(4) “Small employer” has the same meaning given in Title 56, Chapter 7, Section 2203.

Authority: *T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2203, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History:*** *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.02 APPLICATION OF CHAPTER.

(1) The provisions of this Chapter shall apply to health insurance coverage issued to any individual or small employer. The provisions of this Chapter are severable. If any provision of this Chapter or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Chapter which can be given effect without the invalid provision or application.

(Rule 0780-01-93-.02, continued)

(2) This Chapter does not apply to any policy as described by Section 2791(c) of the Public Health Service Act, compiled in 42 U.S.C. § 300gg-91(c).

Authority: *T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2203, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History:*** *Emergency rule filed August 28, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.03 GENERAL FILING REQUIREMENTS.

(1) All initial premium rates and forms for new policies and revised premium rates on any previously approved policies must be filed for approval for all health insurance coverage as specified in T.C.A. §56-26-102(a).

(2) Each form shall be listed in a cover letter or in an attached list or in the general filing information of an electronic filing system.

(3) The marketing method to be used (e.g., individual sales, franchise, blanket, direct mail, group, exchanges) shall be identified.

(4) All filings must be submitted by the company concerned. If the filing is submitted through a third party, the filing should be accompanied by a letter of authorization signed by an officer of the insurance company.

(5) All blank spaces in each policy form, except an application, must be filed in and completed with hypothetical data to indicate the purpose and use of the form. If the form includes a range of numerical variables, these variables must be in the actual form.

(6) When submitting a policy form to which a copy of the application must be attached when issued, a copy of the appropriate application shall be attached to the policy form. If the application has already been approved, the form number and date of approval shall be stated in the transmittal letter.

Authority: *T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History:*** *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.04 ACTUARIAL MEMORANDUM.

Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio hereinafter called ‘‘anticipated medical loss ratio’’, of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary’s knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of this state and that the benefits are reasonable in relation to premiums.

Authority: *T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History:*** *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.05 PREVIOUSLY APPROVED FORMS.

The filing of revised premium rates on any previously approved policy, endorsement, rider, certificate or application shall also include the following:

(1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated medical loss ratio for the form;

(2) A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons it applies only to new or only to in-force business;

(3) A history of the experience under existing rates, including at least the data indicated in Rule 0780-1-93-.07. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data should include: substitution of actual claim run-offs for claim reserves and liabilities; determination of medical loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data;

(4) The date and magnitude of each previous rate change, if any;

(5) Data and documentation in connection with the following must be provided to the extent applicable to the filing under review, with an explanation as to how each item has or has not impacted the premium rate. If the item is not applicable to the filing under review, provide an explanation as to why the item has not impacted the premium rate:

(a) Medical trend changes by major service categories;

(b) Utilization changes by major service categories;

(c) Cost-sharing changes by major service categories;

(d) Benefit changes;

(e) Changes in enrollee risk profile;

(f) Any overestimate or underestimate of medical trend for prior year periods related to the rate increase;

(g) Changes in reserve needs;

(h) Changes in administrative costs related to programs that improve health care quality;

(i) Changes in other administrative costs;

(j) Changes in applicable taxes, licensing, or regulatory fees;

(k) Medical loss ratio;

(l) Health insurance issuer's capital and surplus; and

(m) Other information the Commissioner determines is necessary to review the rates for approval, the requirements will be posted in SERFF;

(6) Filing of Preliminary Justification – In the case of a rate increase of ten percent (10%) or more, or above the State-specific threshold as defined by the Secretary of the U.S. Department of Health and Human Services ("HHS"), pursuant to the HHS final regulation at 45 C.F.R. part 154, Subpart B, Section 200, a health insurance issuer must file with the Tennessee Department of Commerce and Insurance and HHS a Preliminary Justification. The Preliminary Justification must be prepared in accordance with the standards set forth in HHS final regulations at 45 C.F.R. part 154, Subpart B, Section 215, and must contain the following:

(a) Rate Increase Summary (Part I), which must be consistent with the requirements set forth in 45 C.F.R. § 154.215(e); and

(b) A written description justifying the rate increase (Part II), which must be consistent with the requirements set forth in 45 C.F.R. § 154.215(f); and

(7) The review process will include an examination of the following:

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

(b) The health insurance issuer's data related to past projections and actual experience.

Authority**: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107, Public Law 111-148 as amended by Public Law 111-152 (2010), and 45 C.F.R. part 154, Subpart B, Section 200.* ***Administrative History: *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.06 ELECTRONIC FILING.

Beginning January 1, 2012, all filings submitted pursuant to this Chapter shall be filed electronically. All electronic filings shall be made via the System for Electronic Rate and Form Filing (SERFF).

Authority:** T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, and 56-32-107.* ***Administrative History: *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.07 EXPERIENCE RECORDS.

Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

Authority:** T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107, and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History: *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.08 REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM.

(1) New Forms and Rate Revisions

(a) New forms and filings of new premium rates on a previously approved policy, endorsement rider, or certificate benefits will be presumed to be reasonable in relation to premiums provided the anticipated medical loss ratio is at least 80% in the individual and small group markets for all health insurance; however, failure to meet the anticipated medical loss ratio alone will not constitute an unreasonable rate.

(b) The medical loss ratio shall be calculated pursuant to the standards set forth by the U.S. Department of Health and Human Services interim final regulation at 45 C.F.R. part 158 or the corresponding section of any future HHS regulation. For the purposes of this Rule, "small group market" shall mean products sold to employers who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

Authority: *T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-117, 56-32-107, Public Law 111-148 as amended by Public Law 111-152 (2010), and 45 C.F.R. part 158.* ***Administrative History:*** *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.09 CLAIM FORMS FOR REPORTING BY HEALTH CARE PROVIDERS.

(1) No later than July 1, 1994, all insurance companies offering for sale health care policies in this state shall require all policyholders and third party claimants to utilize the following standardized forms when making a claim against any health care insurance policy in effect in this state:

(a) Centers for Medicare and Medicaid (CMS) Form 1500 for health care practitioner claims other than dental. Health care practitioners who bill patients directly shall provide a properly completed CMS Form 1500 in addition to any other form used to bill the patient when requested by the patient.

(b) Form UB04 for hospital and other institutional care claims. Institutional care practitioners who bill patients directly shall provide a properly completed UB04 in addition to any other form used to bill the patient when requested by the patient.

(c) American Dental Association Claim Form for dental health care claims. Dentists who bill patients directly shall provide a properly completed Claim Form in addition to any other form used to bill the patient when requested by the patient.

(d) The National Council for Prescription Drug Programs (NCPDP) Universal Claim Form for pharmacy claims. Pharmacists who bill patients directly shall provide a properly completed Universal Claim Form in addition to any other form used to bill the patient when requested by the patient.

(Rule 0780-01-93-.09, continued)

(e) The ANSI X12N standard format for the health care transaction sets for claims submission (837) and claims payment (835) for all issuers and health care providers who receive claims or sent payment by electronic means.

(2) All forms required by this Rule shall be updated to meet the requirements of federal law or state laws implementing federal or state health care reimbursement programs.

Authority: *T.C.A. §§ 4-5-208, 56-1-212, 56-2-201, 56-2-301, 56-7-1008, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-116, 56-29-117, 56-32-107 and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History:*** *Emergency rule filed August 29, 2011; effective through February 25, 2012. Original rule filed November 22, 2011; effective February 20, 2012.*

0780-01-93-.10 RESERVED.

Authority: *T.C.A. §§ 4-5-208, 56-1-212, 56-2-201, 56-2-301, 56-7-2802, 56-26-102, 56-26-103, 56-26-114, 56-26-202, 56-27-112, 56-28-106, 56-29-116, 56-29-117, 56-32-107, and Public Law 111-148 as amended by Public Law 111-152 (2010).* ***Administrative History:*** *Emergency rule filed August 29, 2011; effective through February 25, 2012. Emergency rule filed August 29, 2011 expired effective February 26, 2012; rule reverted to a reserved status.*