

Health Insurance Rate Filing Requirements – ACA-Compliant Plans

The Government of the District of Columbia Department of Insurance, Securities and Banking (DISB), Actuarial Analysis Division, only accepts Health rate filings via the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filings (SERFF).

Health insurance FORM filings should be filed in SERFF separately from Health Insurance RATE filings.

Health insurance rate filings for ACA-compliant plans should include the following information as pertinent to the nature of the purpose of the filing:

1. Fill out all requested information for the rate filing in SERFF under the tabs labeled "General Information" and "Rate/Rule Schedule"
2. Create a **cover letter** on Company Letterhead that includes the following:
 - a. Company Name
 - b. NAIC Company Code
 - c. Unique Company Filing Number (assigned by Company)
 - d. Date Submitted
 - e. Proposed Effective Date
 - f. Type of Product
 - g. Individual or Group
Group Size
 - h. Scope and Purpose of Filing
 - i. Indication Whether Initial Filing or Change
 - j. Indication if no DC Policyholders
 - k. Overall Premium Impact of Filing on DC Policyholders
 - l. Contact information, Name, Telephone, Fax, e-mail
 - m. Signature and Date
3. If someone other than the insurer is submitting a filing on the insurer's behalf, then the filing must include a letter of authorization from the insurer. This letter must be on the insurer's Letterhead, dated, and signed by a person with authority. Submit this letter in the tab labeled "Supporting Documentation" in the scheduled item called **Certificate of Authority to File**.
4. Effective March 28, 2013, the Uniform Rate Review Template (URRT) replaced the Rate Summary Worksheet (Preliminary justification Part I). The URRT, a market-wide reform, is required to be completed and submitted for ALL individual and small group health insurance rate filings that are not grandfathered health plan coverage or excepted benefits under the Rate Review Regulation, regardless of whether the rate action meets or exceeds the "subject to review" threshold of the Rate Review Regulation. Additionally, the Actuarial Memorandum Part III, is also required to be submitted whenever the URRT is submitted.

The Draft 2025 Letter to Issuers dated November 15, 2023, refers issuers to the 2017 through 2024 Letters to Issuers. Please refer to the Unified Rate Review Instructions for plan year 2025 for more information. That information may be found [here](#). (dated March 2, 2023)

Please download the URRT from the [QHP Certification web page](#), complete the document and attach the Excel version to the URRT Requirement under the “Supporting Documentation” tab within applicable SERFF filings.

Please bypass this requirement on large group filings and/or filings that have grandfathered plans or excepted benefits.

Please refer to the documentation in SERFF's Online Help for instruction on completing the required PPACA fields.

The elements of the Rate Filing are as follows:

- Part I (Unified Rate Review Template)

- a) Worksheet 1 – Market Experience
 - a. Experience Period Data
 - b. Projections (Trend)
 - c. Morbidity & other Adjustments
- b) Worksheet 2 – Plan / Product Info
 - a. General Info
 - b. Experience Period and Current Level Plan Level Info
 - c. Plan Adjustment Factors
 - d. Projected Plan Level Info
- c) Worksheet 3 – Rating Area; the District has only one rating area.

- Part II (Preliminary Justification) (ONLY REQUIRED WHEN A RATE INCREASE IS GREATER THAN THE THRESHOLD FOR RATE REVIEW) – The written description of the rate increase must include a simple and brief narrative describing the data and assumptions used to develop the rate increase, including the following:

- a. Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary
- b. Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios

- Part III (Actuarial Memorandum) – Two versions are required; an unredacted version for regulators and a redacted version for public disclosure. The Actuarial Memorandum should include the following elements:

- a. Company Identifying Information
 - i Company Legal Name
 - ii State
 - iii HIOS Product ID

- b. Effective date
 - c. Company contact information
 - d. Market
 - e. Average rate increase requested
 - f. Reason for rate increase
 - g. Risk Adjustment
 - h. Risk Score
 - i. Reinsurance
 - j. Non-Benefit Expenses
 - i) Administrative Costs of Programs that Improve Health Care Quality
 - ii) Taxes and Licensing or Regulatory Fees
 - k. Projected Loss Ratio
 - l. Index Rate
 - m. Market Adjusted Index Rate
 - n. AV Value
 - o. Benefit/Metal level(s)
 - p. Calibration
 - q. Consumer Adjusted Premium Rate Development
 - r. Past experience
 - s. Rating Factors
 - t. Credibility assumption
 - u. Trend assumption
 - v. Cost-sharing changes
 - w. Benefit changes
 - x. Claim reserve needs
 - y. Reliance
 - z. Actuarial Certification
5. Download and complete the **DISB Actuarial Memorandum Dataset** template (see Appendix L) from SERFF (located on the “Supporting Documents” tab) and upload the completed version.
 6. Download and complete the **District of Columbia Plain Language Summary** template from SERFF (located on the “Supporting Documents” tab) and upload the completed version.
 7. Complete the **Rate Filing Checklist** (see Appendix C)
 8. Complete the CCIIO Risk Adjustment Transfer Elements Extract (RATE ‘E’) report and submit to DISB prior to approval of the rate filings for all QHP rate plans. This report should be submitted either by the set deadline date for QHP submissions, or no later than April 30th of the current year, whichever is first. You should receive the template and instructions for this report directly from CCIIO. You can submit this report in one of two ways (or both):
 - a. The report can be attached to the corresponding rate filing (marked as “confidential” if you would prefer that the report not be available for public viewing);

- b. You can email the report directly to Stephen F. Flick, Health Actuary (stephen.flick@dc.gov).

Please bypass this requirement on large group filings and/or filings that have grandfathered plans or excepted benefits.

9. DISB will require all issuers of Qualified Health Plans (for sale on DC Health Link) to provide a chart containing clear and concise information on the following:
 - a. Any and all components of requested changes in the rates from the prior plan year, listed individually, such as trends, risk adjustment, age calibration, mapping from a different plan, etc. (this is not meant to be an exhaustive list; your list should contain all applicable components);
 - b. A quick summary/explanation of the change associated with each listed component; and
 - c. The actual percentage impact of the change to each component, such that the sum total for all components equals the total percentage change requested for the plan year.

This chart should be submitted along with the rate filing, either within the Actuarial Memorandum or as a separate supporting document.

10. The filing (and all applicable elements) should also be submitted in the Health Insurance Oversight System (HIOS) portal. Refer to the HIOS Portal User Manual published on the CMS [website](#) for detailed instructions on using the portal. Note that the HIOS Product ID must be included in the Actuarial Memorandum submitted with the SERFF filing.

11. The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% (for individual and small group) or 85% (for large group) of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. Starting in 2012, insurance companies were required to provide rebates to their customers if the companies failed to meet these standards.

Insurers must submit a report each year to the Department of Health and Human Services (HHS) showing how much the insurer spent on health care and activities that improve care in the past year. Each year's report is due by July 31 of the following year.

Each insurer's MLR information is provided separately for each state and, within each state, by market (individual, small group and large group markets). It is not provided by a particular plan, product, or policy.

Complete the **MLR Report** and submit the report to CMS by July 31st of the year following the end of an MLR reporting year. Also send either the Excel version, or a PDF version, of the completed MLR Report for the District of Columbia to DISB via email to Stephen F. Flick, Health Actuary (stephen.flick@dc.gov).