a) Current health insurance rate review capacity and process

The Nevada Division of Insurance (Division) is committed to enhancing its health rate review process to better identify unreasonable increases in a manner that is both transparent and more meaningful to the consumer. Limited funding and in-house actuarial expertise has constrained the ability of the Division to challenge rate flings. State statutes requiring the Nevada Insurance Commissioner to keep actuarial supporting data within rate filings confidential have limited public participation in the process.

The Division currently has prior approval authority over individual health insurance rates and all HMO rates. There are no rate filing requirements for either small or large group PPO products. Nonprofit medical corporations must also receive prior approval from the Division before implementing rate changes. Initial rates for all new health benefit plan products must be filed with the Division for prior approval.

Individual health benefit plan rating characteristics are age, sex, occupation, geographic area, composition of the family of the individual and health status. The highest rating factor for health status must not exceed the lowest factor by more than 75 percent. A carrier may establish blocks of business for its individual heath benefit plans. After adjustment for rating characteristics and design of benefits, the rate for any block of business must not exceed the rate for any other block of business by more than 50 percent. After adjustment for rating characteristics and design of benefits, the rate change for a single block of business in a 12-month period cannot exceed the rate change for any other block of business by more than 15 percent.

Small employer health benefit plan rating characteristics are age, sex, industry, geographic area, composition of family, size of group and the amount contributed by the employer to the cost of coverage. The highest rating factor associated with any industry classification may not exceed the lowest rating factor associated with any industry classification by more than 20 percent. A small employer carrier may establish no more than nine separate classes of business, and each class must reflect substantial differences in expected claim experience or administrative costs. The index rate, defined to be the arithmetic average of the base rate and the highest premium rate for small employers with similar characteristics within a class, for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20 percent. The premium charged to a small employer with similar characteristics within a class of business may not vary because of health status-related factors from the index rate by more than 30 percent. This effectively allows carriers to rate for health status with a rating factor limit of 85.7 percent within each class of business. The premium rate charged to a small employer for a new rating period may not increase by a percentage greater than the sum of:

1) The percentage of change in the premium rate for new business for the policy under which the small employer is covered, measured from the first day of the previous rating period to the first day of the new rating period;

2) An adjustment, not to exceed 15 percent annually, adjusted pro rata for rating periods of less than one year, on account of the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

3) Any adjustment on account of change in coverage or change in the characteristics of the small employer as determined from the carrier's rate manual for the class of business.

In addition to the rating restrictions described above, individual health benefit plans are subject to the ratemaking standards and criteria mandated by Nevada Revised Statutes (NRS) Chapter 686B for Rates and Essential Insurance. These statutes require individual health carriers to submit rates to the Division for prior approval. Rates are deemed approved 60 days after the Division determines the filing to be complete if the proposal is not disapproved within that period. Each rate filing is deemed complete unless the Division, within 15 business days after receiving the proposal, determines the proposal is incomplete due to lack of supporting data. A rate filing is generally considered complete if it includes the following:

1) An actuarial memorandum which identifies the carrier's individual blocks of business and demonstrates compliance with the block rating restrictions for health benefit plans;

2) Written and earned premium and paid and incurred claims for each block of business;

3) Earned premium recalculated at current rate level and incurred loss ratios based on premium at current rate level;

4) If Nevada data lacks full credibility, national experience must also be provided. Any credibility weighting of national and Nevada data requires justification using a reasonable credibility model;

5) A minimum of five years of monthly or quarterly state and/or national claim cost and utilization data to support the trend factor used in the filing;

6) A complete rate history; and

7) The number of policies in force.

After the filing is determined to be complete, carrier experience, claim trends and assumptions are analyzed to determine if the proposed rate change is actuarially justified. Statutory standards require that rates must not be inadequate, excessive, or unfairly discriminatory. In determining whether rates for individual health benefit plans comply with these standards, due consideration shall be given to past and prospective loss and expense experience within and outside of this state; catastrophe hazards and contingencies; trends within and outside of this state; loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members, or subscribers; and to all other relevant factors, including the judgment of technical personnel. If the analyst determines within 60 days the rate request is unreasonable or is out of compliance with the rating restrictions for individual health benefit plan blocks of business, the filing is disapproved by notifying the carrier in writing of the specific objections. The carrier may modify its proposal or request a hearing to challenge the validity of the determination of the analyst. The hearing must be held within 30 days after the request is submitted. During the hearing, the carrier has the burden of demonstrating compliance with the applicable statutory standards for rates. The rate proposal is deemed approved if the Division fails to issue an order within 45 days after the hearing is held.

During the past two years, few individual health benefit plan rate filings have been disapproved. Most carriers have been submitting rate filings proposing increases at or below medical trend. Generally, the Division has not considered rate requests at trend to be excessive. The rate filing activity during the past two years for carriers actively marketing individual health benefit plans in Nevada is listed below:

Carrier	Submission Date	Request	Amount Approved	Effective Date
Aetna	1/21/2009	15%	15%	8/1/2009
	1/19/2010	17%	pending	
Anthem	10/20/2008	18%	18%	4/1/2009
	11/30/2009	18.5%	12.8%	6/1/2010
Celtic	6/10/2008	12.6%	12.6%	1/1/2009
HPN	6/19/2009	9.5%	9.5%	11/1/2009
Humana	7/25/2008	12.4%	12.4%	10/1/2009
	1/21/2010	5.4%	5.4%	7/1/2010
John Alden	1/12/2009	14.7%	14.7%	3/1/2010
Sierra	6/19/2009	3.8%	3.8%	11/1/2009
Time	1/12/2009	14.7%	14.7%	3/1/2010

An individual health benefit plan rate filing is more likely to be disapproved for failing to comply with the rating restrictions for individual blocks of business. This is particularly the case with carriers that file revised rates for different blocks of business at different points in time. An example of this is the most recent filing from Anthem requesting an 18.5 percent overall increase. This filing was disapproved because its request did not comply with the block rating restriction that limits the rate increase for a block of business in a 12-month period to not more

than 15 percent above the rate increase for any other block of business. The Division earlier this year approved an Anthem rate filing which resulted in a 1 percent decrease to an individual health benefit plan block of business. As a result, the Division reduced Anthem's request to a 12.8 percent overall increase consisting of a 1 percent decrease for one block of business, and a 14 percent increase for all other blocks of business.

Other than HMOs, small employer carriers are not required to file rates with the Division, but many choose to do so. Additionally, each small employer carrier must annually submit an actuarial memorandum certifying and demonstrating compliance with Nevada's small group rating restrictions. Failure to submit this certification or failure to reasonably demonstrate compliance may trigger a retrospective review of a carrier's small group rates. In 2005, this was the case for a major writer of small group business in Nevada. The Division determined that the index rates for several of this carrier's classes of business were more than 20 percent higher than its most preferred class. This carrier was required to reduce its index rates for its least preferred classes to within 20 percent of its index rate of its most preferred class.

The rates for all HMO products are filed for prior approval and are subject to the ratemaking standards NRS Chapter 686B: rates must not be excessive, inadequate, or unfairly discriminatory. Individual and small group HMO products must comply with all individual and small group market rating restrictions in Nevada. Only HMOs are required to file rates for large group products. The large group market in Nevada has been very competitive, and large group HMO rate filings are rarely disapproved.

Most carriers utilize the System for Electronic Rate and Form Filing (SERFF) to submit filings. However, several carriers with significant market share in Nevada continue to submit paper rate filings. On January 1, 2011, all carriers will be required to file rates and forms through SERFF. The Division has not created any databases outside of SERFF to track rates for health benefit plans. This has made it difficult for the Division to analyze health benefit plan rating data for products submitted through paper filings. The Division intends to use funds from this grant to create and maintain a separate database to capture rate filing supporting data for each carrier.

Currently Ms. Kim Everett and Mr. Glenn Shippey review all rate filings required to be filed for health benefit plans in Nevada. Mr. Shippey has academic degrees in mathematics and statistics and is working toward an Associate credential in the Casualty Actuarial Society. He has been reviewing rate filings for the Nevada Division of Insurance for more than six years. Ms. Everett has 16 years experience working for health insurers and ten years experience reviewing rate filings for the Division. The total Division budget for the fiscal year ending June 30, 2010 is $9,197,743 and $89,879 is allocated to fund the salary and benefits for the individual responsible for health benefit plan rates. In 2008, The Division received 26 individual and 40 group health benefit plan rate filings. In 2009, The Division received 41 individual and 56 group health benefit plan rate filings. The average amount of time to complete the rate review process for an individual health benefit plan rate filing has been approximately 16 hours and for a group health benefit plan rate filing has been about 10 hours.

The Division is required to keep supporting actuarial data included in individual and small group rate filings confidential. The public may only inspect filed and approved rates and rating factors,

and a summary of the approved changes. Health carriers are required to provide notice to the insured of any alteration in terms at least 60 days prior to renewal date. A consumer aggrieved by an act of the Commissioner may request a hearing. Such a hearing was granted and held on June 29, 2010, for an Anthem consumer who received notice of a 13.3 percent increase.

The Division receives numerous inquiries from health benefit plan consumers following approval of a rate increase. However, most of these consumers choose not to file written formal complaints. The Division received written formal complaints regarding health benefit plans from 20 consumers in 2008 and 16 consumers in 2009. The Division has not taken any regulatory action against carriers regarding rates for health benefit plans over the past two years.

b) Proposed rate review enhancements for health insurance

During the 2011 session of the Nevada Legislature, the Division will propose legislation to obtain prior approval rate review authority for small and large group health benefit plans. Group health benefit plans will be subject to the ratemaking standards and criteria specified within NRS 686B. Grant funds will be used to hire additional staff, including a Qualified Health Actuary (Actuary) familiar with the Actuarial Standards of Practice and Guidelines for Professional Conduct, to oversee the regulation of insurance rates for all health benefit plans and to help absorb the additional small and large group rate filing workload. Ten percent of the grant funds will be used for outside independent actuarial reviews of unreasonable rate requests.

The Actuary will define an objective process to identify unreasonable rate increases that will be consistent with HHS guidance. Unreasonable rate requests will be based on one or more of the following:

1) Actuarial supporting data provided is inaccurate or incomplete;

2) The overall average rate request exceeds a defined threshold;

3) The rate request for a class of insureds exceeds a defined threshold;

4) The provision for administrative expenses or profit included in the proposed rates is excessive; or

5) Actuarial supporting data does not justify the rate request.

The Actuary will oversee the collection, analysis, and reporting of data used to support rate filings. Ten percent of the initial grant funds will be used for information technology consulting services intended to improve the Division's IT infrastructure.

The Division is committed to enhancing transparency of the rate review process and will seek legislation to make all health benefit plan rate filings publicly available as soon as they are filed, and plans to post all health benefit plan rate filings on its web site. Consumers will be encouraged to comment in writing directly to the Division regarding rate proposals via electronic mail, fax or USPS. In order to significantly enhance consumer participation in the rate review process, approximately 25 percent of the Cycle I grant funds will be used to create a Consumer Advocate for Health Insurance Customers (Advocate) and an attorney to assist the Advocate. The Commissioner may schedule a public rate hearing shortly after receiving a rate filing

determined by the Division and Advocate to be outside reasonable rate filing thresholds consistent with HHS regulations. Consideration will be given to the magnitude of the request and the market share of the carrier. The Advocate will represent the interests of consumers during the hearing, and may use grant funds to obtain outside actuarial consulting services. The Actuary will be the lead witness on behalf of the Division, and the carrier will have the burden of demonstrating compliance with the ratemaking standards and criteria set forth in NRS 686B. The Division may choose to hold hearings in different areas of Nevada depending on the distribution of a carrier's policyholders within the state and the premium impact of the carrier's proposal by geographic area.

Proposed Timeline

8/1/2010	The Division will begin posting a summary of individual health benefit plan rate filings on its web site;
8/1/2010	The Division will begin soliciting public comment on individual health benefit rate filings posted on its web site;
10/1/2010	The Division will hire additional staff including a Qualified Health Actuary, Consumer Advocate, attorney, compliance investigator, and management analyst;
10/1/2010	The Division will report 2009 aggregate market data to HHS;
10/1/2010	The Division will begin reporting data to HHS for each health benefit plan rate filing received;
11/1/2010	The Actuary will finalize the definition of unreasonable rate filing thresholds consistent with HHS regulations;
11/1/2010	The Division will purchase hardware and/or software to improve its IT infrastructure;
11/1/2010	A database external to SERFF will be created to track and analyze actuarial supporting data submitted in rate filings;

11/1/2010	The Advocate will begin reviewing unreasonable individual health benefit plan rate filings;
12/1/2010	The Division will begin the process of holding public hearings requested by the Actuary and Advocate for unreasonable individual health benefit plan rate filings;
1/1/2011	All carriers will be required to submit rate filings using SERFF;
1/1/2011	The Division will report 2010 aggregate market data to HHS;
2/7/2011	The Division will propose legislation permitting the Division to have prior approval rate review authority for all health benefit plans and making these filings available in their entirety open for public inspection;
7/1/2011	If passed, the proposed legislation referenced above permitting the Division prior approval rate review authority for all health benefit plans and making these filings available in their entirety for public inspection becomes effective;
7/1/2011	The Advocate will begin reviewing unreasonable group health benefit plan rate fillings;
7/1/2011	The Division will begin the process of holding public hearings requested by the Actuary and Advocate for unreasonable group health benefit plan rate filings.

c) Reporting to the Secretary on Rate Increase Patterns

The Division will comply with the reporting requirements to the Secretary of HHS outlined in Section 2794 of the Public Health Service Act. SERFF will be used to collect data and generate required reports for each health benefit plan rate fling received for the individual, small group and large group markets. The Division will create a database external to SERFF to collect data from rate filings necessary to generate the required aggregate reports for the individual, small group and large group markets. The Division will use Cycle I grant funds to hire a management analyst who will be responsible for compiling these reports under the direct supervision of the Actuary.