Colorado Association of Health Plans

HEALTH LITERACY

Rate Filings 101

Rate Filing and Review

Health insurance carriers must submit all rate changes to the Colorado Department of Insurance (DOI) for review and approval before the rates can be applied to consumers. In the spring, insurance carriers file proposals with the DOI to offer health insurance plans in different regions of the sate on the individual and small group markets for the following calendar year. The DOI reviews the rates and publishes the final approval rates in the fall. The rates and filings are made public and can be found on the DOI's website. The rate filing must include an actuarial memorandum demonstrating the calculation and analysis used to determine the rates submitted.

When carriers submit a rate filing, they are required to provide a projection of each rate as a percent of the premium. In general, the premiums are broken into three factors which must equal 100 percent of the premium:

- **projected medical expenses from claims;**
- **administrative expenses including commissions and taxes;**
- **profit and contingency factors.**

Health plans may only charge more for premiums based on four factors: type of coverage (self-only or family), tobacco use, age, and geographic rating areas. In Colorado, geographic rating allows insurance companies to vary premiums across nine different geographic areas.

The DOI evaluates each of these components to determine whether the requested rate increase or decrease is appropriate. Under Colorado law, rates may not be "excessive, inadequate, or unfairly discriminatory".

Medical Loss Ratios

Medical expenses are the cost of paying for health care services for the insured, and include payments to hospitals, doctors and other providers. The medical loss ratio (MLR), which is the ratio of medical expenses incurred divided by premiums earned and reflects the cost of health care delivery and a key measure of whether premium rates are reasonable. The ACA established the MLR for individual and small group plans is 80% and for large group plans is 85%.

Minimum Actuarial Value Requirements

The ACA established that plans sold on the individual and small group marketplaces must tailor the cost sharing of the plans with one of four metal levels of actuarial value. The actuarial value reflects the relative share of cost sharing that may be imposed. On average, the lower the actuarial value, the greater the cost sharing for enrollees overall. There are four metal plan designs with the following actuarial values required:

Bronze 60% | Silver 70% | Gold 80% | Platinum 90%

Limits on Annual Out-of-Pocket Spending

Plans must comply with federal annual limits on out-of-pocket spending when calculating premiums and plan designs. The limits apply only to in-network coverage for the Essential Health Benefits. For the 2020 plan year, the out-of-pocket limit for a marketplace plan is $7,900 for an individual plan and $15, 800 for a family plan.

Network Adequacy Standards

Under the ACA and Colorado law, health plans must provide consumers with "adequate networks" and provide reasonable access to a sufficient number of in-network primary care and specialty physicians.

Network Access Plans

These standards include limits on appointment wait times, travel distance, and ratios for provider-to-enrollees by specialty and service type. Carriers are also required to file their provider directories with the DOI annually and the directories must be updated monthly.

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2. https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

3. B-4.90 Network Adequacy Standards and Reporting Guidelines for Health Benefit Plans https://drive.google.com/file/d/0BwM-mWVFE3YMsT0F3aURzNWJaWHc/view