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Revised Filing Guidance Notice 2010-A
Health Care Access Bureau

TO: Health Maintenance Organizations Offering or Renewing Insured Managed Care Plans in Massachusetts and Blue Cross and Blue Shield of Massachusetts, Inc.

FROM: Kevin Beagan, Deputy Commissioner and Director of the Health Care Access Bureau

DATE: February 24, 2010 [Revision Date – March 5, 2010]

RE: Filing Rates and Changes to Rating Factors under 211 CMR 43.00

This notice provides guidance to health maintenance organizations and other affected carriers (collectively "Health Plans") on the filing of increases to rates or the filing of proposed changes to rating factors with the Massachusetts Division of Insurance ("Division") in connection with amendments to 211 CMR 43.00, *Health Maintenance Organizations (HMOs)* and related Division Bulletin 2010-05. This regulation and bulletin require Health Plans to submit, with all proposed health insurance rates, detailed rate filing material in support of their filings that is sufficient for the Division to review the proposed rates. Health Plans seeking to increase their small group rates or to change their small group rating factors are required to file the requested changes with the Division at least 30 days in advance of the effective dates.

Health Plans Must File via SERFF
All filings must be submitted to the Division via SERFF. SERFF requires a $150.00 fee for each filing. Multiple submissions may be consolidated into one filing. For further information on SERFF filings, see Division Bulletin 2008-08.

Rate Filings Generally
The Division shall check all filings for completeness, but no filing shall be reviewed until it is deemed complete. The Division will contact a Health Plan if it requires additional information in order to deem the filing complete. Health Plans are requested to include the following in their submissions in order to deem them complete so that the Division can complete its review:

A) In the actuarial memorandum required under 211 CMR 43.08 and Division Bulletin 2010-05, Health Plans should explain the way that the items in 1-10 are used to derive the final rates;
B) Health Plans should include member months to supplement the historic utilization and claims information; and
C) Health Plans should provide a history of base premiums for the past three years.

Requested Increases
Requested rate increases or changes to rating factors that are not disapproved cannot be implemented until 30 days after the date the filing is deemed complete. Health Plans must file *any* increases to rates that will affect renewals in advance of the policy renewal date. For example, a Health Plan that has a group renewing on April 1st must make a rate filing if that group will receive any increase above that group's April 1st rate from the previous year. Health Plans may either (1) include trend information for future months in a rate filing or (2) file rates every month in which the rates increase prior to implementation.

Disapproval
Health Plans may immediately re-file if a filing is disapproved, but the filing will be subject to at least another 30 days for review. Health Plans may **not** increase a rate from the prior year if the filing is disapproved. For example, if a group policy is renewing on April 1st, and the March 1st filing for April rates is disapproved, the prior April's rates must stay in effect until such time, if any, that the Health Plan's filing is deemed not disapproved. Health Plans must notify the affected policyholder if a filing is disapproved by the Division.

If you have any questions regarding this Filing Guidance Notice, please contact Kevin Beagan, Deputy Commissioner of the Health Care Access Bureau and Director of the State Rating Bureau at 617-521-7323 or Chester Lewandowski, Health Actuary of the Health Care Access Bureau at 617-521-7467.