

**RULES
OF
THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE
INSURANCE DIVISION**

**CHAPTER 0780-01-92
RULES RELATED TO FORM AND RATE FILINGS FOR HEALTH INSURANCE COVERAGE NOT
SUBJECT TO THE AUTHORITY OF
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010**

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0780-01-92-.01 DEFINITIONS.

As used in this Chapter:

- (1) "Accident and health insurance" means insurance against bodily injury, disablement or death, by accident or accidental means, or the expense of bodily injury, disablement or death, against disablement or expense resulting from sickness, and every insurance pertaining thereto; providing for the mental and emotional welfare of an individual and members of the individual's family by defraying the cost of legal services; or providing aggregate or excess stop-loss coverage in connection with employee welfare benefit plans, managed care organizations participating in commercial plans or the TennCare program, or both, health maintenance organizations, long-term care facilities and physician-hospital organizations as defined in T.C.A. § 56-32-102;
- (2) "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 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, 56-26-102, 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.

0780-01-92-.02 APPLICATION OF CHAPTER.

This Chapter shall not apply to health insurance coverage provided to any individual or small employer as regulated by Tenn. Comp. R. & Regs. 0780-01-93. This Chapter shall apply to all other types of accident and health insurance. 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.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 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 chapter filed November 22, 2011; effective February 20, 2012.

0780-01-92-.03 GENERAL FILING REQUIREMENTS.

- (1) All the provisions of this Chapter, Rule 0780-01-92-.01 through Rule 0780-01-92-.08, apply to individual policy forms except as specifically provided in Rule 0780-01-92-.03(8).
- (2) Each form shall be listed in a cover letter or in an attached list and all covering letters and lists shall be in duplicate. Rates and subsequent rate revisions must be filed with all accident and sickness policy forms as specified in T.C.A. §§ 56-26-102 and 56-26-202, and each policy form filing must be accompanied by a schedule of the proposed premium rates, except revised policy forms previously filed, rider and endorsement forms which do not require a change in rates.
- (3) The marketing method to be used (e.g., individual sales, franchise, blanket, direct mail, group) shall be identified. Submission of mass-marketed policies, excluding individually marketed and underwritten policies and group policies as defined in T.C.A. § 56-26-201, shall include a description of the marketing program and state any fees involved.
- (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) If the form being submitted is intended to replace an approved form already on file, a list of the material changes made in the new form must accompany the transmittal letter.
- (6) All blank spaces in each policy form, except an application, must be filled in and completed with hypothetical data to indicate the purpose and use of the form. If there are numerical variables contained within the policy form, the range of variables must be stated in the policy form.
- (7) 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.
- (8) The requirements of this paragraph shall apply solely to group accident and sickness policies and forms except for major medical health insurance coverage as referenced in T.C.A. § 56-26-102(d) and to coverage regulated under Tenn. Comp. R. & Regs. 0780-01-93.
 - (a) As to experience-rated group insurance, premium rates and classifications need not be filed; however, form filings must be accompanied by a statement signed by an authorized person on behalf of the company that:
 1. The policy filing is experience-rated group insurance, and
 2. The premium rates and classification of risks are available for review by the Commissioner of Insurance upon request.
 - (b) As to other than experience-rated group insurance, the applicable premium rates and classifications must accompany the form filing, and the filing must be accompanied by a certification by an authorized person on behalf of the company that the premium rates are not unreasonable in relation to benefits provided, and that actuarial data and experience shall be maintained by the company and available for review by the commissioner upon request.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-26-102, 56-26-103, 56-26-114, 56-26-

(Rule 0780-01-92-.03, continued)

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.

0780-01-92-.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 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, 56-26-102, 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.

0780-01-92-.05 PREVIOUSLY APPROVED FORMS.

Filings of rate revisions for a previously approved policy, rider or endorsement form 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 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;
- (3) A history of the experience under existing rates, including at least the data indicated in Rule 0780-1-92-.06. 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 might include: substitution of actual claim run-offs for claim reserves and liabilities; determination of 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; and
- (4) The date and magnitude of each previous rate change, if any.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 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.

0780-01-92-.06 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.

(Rule 0780-01-92-.06, continued)

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, 56-26-102, 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.

0780-01-92-.07 EVALUATING EXPERIENCE DATA.

In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

- (1) Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency;
- (2) Experienced and projected trends relative to the kind of coverage, e.g. inflation in medical expenses, economic cycles affecting disability income experience;
- (3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations; and
- (4) The mix of business by risk classification.

Authority: T.C.A. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 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 15, 2011; effective February 22, 2012.

0780-01-92-.08 REASONABLENESS OF BENEFITS IN RELATION TO PREMIUMS.

- (1) New Forms

With respect to a new form, benefits may be considered reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

Definitions of Renewal Clause

OR - Optionally Renewable: renewal is at the option of the insurance company.

CR - Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

(Rule 0780-01-92-.08, continued)

GR - Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC - Non-Cancellable: renewal cannot be declined nor can rates be revised by the insurance company.

If satisfactory justification is submitted to the Department of Insurance for a policy form, including riders and endorsements, under which the expected average annual premium per policy is \$100 or more but less than \$200, the company may be permitted to subtract up to 5 percentage points from the numbers in the table above, or if less than \$100, subtract up to 10 percentage points.

The average annual premium per policy and the average anticipated loss ratio shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

(2) Rate Revisions.

With respect to filings of rate revisions for a previously approved form, benefits may be considered reasonable in relation to premiums provided the following standards are met:

(a) With respect to policies issued on and after the effective date of the revision, the standards are the same as in Paragraph (1) of this Rule, except that the average annual premiums shall be determined based on an actual rather than an anticipated distribution of business.

(b) With respect to policies issued prior to the effective date of the revision, both subparagraph (a) above and this subparagraph (b) shall be at least as great as the standards in Paragraph (1) of this Rule:

1. The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage;

2. The ratio of (i) to (ii) where:

(i) is the sum of the accumulated benefits, from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and

(ii) is the sum of the accumulated premiums, from the original effective date of the form to the effective date of the revision, and the present value of the future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

3. Other methods, in addition to those in this Paragraph (2) may be used to calculate rate revisions. However, the minimum anticipated loss ratio thus calculated must be at least as great as the standards in Paragraph (1), with

(Rule 0780-01-92-.08, continued)

consideration given active life reserves, and such methods must be approved by the Insurance Commissioner.

- (3) Anticipated loss ratios different from those indicated in Paragraphs (1) and (2) above will require justification based on the special circumstances that may be applicable.
 - (a) Examples of coverages that may receive special consideration are as follows:
 1. accident only;
 2. short term non-renewable, e.g., airline trip; student accident;
 3. specified peril, e.g., cancer, common carrier; and
 4. other special risks.
 - (b) Examples of other factors that may receive special consideration are as follows:
 1. marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
 2. extraordinary expenses;
 3. high risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage; and
 4. product features such as long elimination periods, high deductibles and high maximum limits.
- (4) 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, 56-26-102, 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.

0780-01-92-.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.

(Rule 0780-01-92-.09, continued)

- (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.
 - (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. §§ 4-5-206, 56-1-212, 56-2-201, 56-2-301, 56-7-1008, 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.