

**304.17A-0952 Premium rate guidelines for individual, small group, and association plans.**

Premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

- (1) The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal, on or after January 1, 2003.
- (2) Notwithstanding the thirty-five percent (35%) variance limitation in subsection (1) of this section, insurers offering an individual health benefit plan that is state-elected under sec. 35(e)(1)F of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201, may vary from the index rate by more than thirty-five percent (35%) for individuals who are eligible for the health coverage tax credit under the following conditions:
  - (a) The insurer certifies that the individual does not meet the insurer's underwriting guidelines for issuance of an individual policy;
  - (b) The policy meets the requirements for state-elected coverage under the Trade Act of 2002; and
  - (c) The premium rate is actuarially justified and has been approved by the Department of Insurance pursuant to KRS 304.17A-095.
- (3) The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:
  - (a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;
  - (b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and
  - (c) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business.
- (4) The premium rates charged during a rating period to a small group or to an association member with similar case characteristics for the same coverage, or the rates that could be charged to that small group or that association member under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

- (5) The percentage increase in the premium rate charged to a small group or to an association member for a new rating period shall not exceed the sum of the following:
- (a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;
  - (b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the employee, association member, or dependents as determined from the insurer's rate manual for the class of business; and
  - (c) Any adjustment due to change in coverage or change in the case characteristics of the small group or association member as determined from the insurer's rate manual for the class of business.
- (6) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.
- (7) Adjustments in rates for claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, health status, and duration of coverage shall not be charged to an individual group member or the member's dependents. Any adjustment shall be applied uniformly to the rates charged for all individuals and dependents of the small group.
- (8) The commissioner may approve establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the additional class would enhance the efficiency and fairness for the applicable market segment.
- (a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business in that market segment by more than ten percent (10%).
  - (b) An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative cost related to the following reasons:
    - 1. The insurer uses more than one (1) type of system for the marketing and sale of the health benefit plans;
    - 2. The insurer has acquired a class of business from another insurer; or
    - 3. The insurer is offering a state-elected plan under the provisions of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201.
  - (c) Notwithstanding any other provision of this subsection, beginning January 1, 2001, a GAP participating insurer may establish a separate class of business for the purpose of separating guaranteed acceptance program qualified

individuals from other individuals enrolled in their plan prior to January 1, 2001. The index rate for the separate class created under this paragraph shall be established taking into consideration expected claims experience and administrative costs of the new class of business and the previous class of business.

- (9) For the purpose of this section, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if utilization of the restricted provider network results in substantial differences in claims costs.
- (10) Notwithstanding any other provision of this section, an insurer shall not be required to utilize the experience of those individuals with high-cost conditions who enrolled in its plans between July 15, 1995, and April 10, 1998, to develop the insurer's index rate for its individual policies.
- (11) Nothing in this section shall be construed to prevent an insurer from offering incentives to participate in a program of disease prevention or health improvement.

**Effective:** July 15, 2010

**History:** Amended 2010 Ky. Acts ch. 24, sec. 1213, effective July 15, 2010. -- Amended 2004 Ky. Acts ch. 168, sec. 1, effective April 21, 2004. -- Amended 2002 Ky. Acts ch. 351, sec. 15, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 476, sec. 19, effective January 1, 2001. -- Created 1998 Ky. Acts ch. 496, sec. 10, effective April 10, 1998.

**2010-2012 Budget Reference.** See State/Executive Branch Budget, 2010 (1st Extra. Sess.) Ky. Acts ch. 1, Pt. XII, Sec. 12 at 156.