TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – INSURANCE DIVISION
ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE
EFFECTIVE DATE: FEBRUARY 3, 2025

R20-6-2301. Applicability; Definitions

A. This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:

1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or
3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).

B. In this Article, the following definitions apply:

1. "Department" means the Arizona Department of Insurance and Financial Institutions.
2. "Blanket disability insurance" has the meaning prescribed in A.R.S. § 20-1404(A).
3. "CMS" means the Centers for Medicare & Medicaid Services.
4. "Federal medical loss ratio standard" means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
5. "Health insurance" means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(4) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822.
6. "Health insurer" means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
7. "Individual health insurance" means health insurance that a health insurer issues to either:
   a. An individual, to cover:

    i. The individual, or
    ii. The individual's dependents, or
    iii. The individual and the individual's dependents.
  b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.
8. "PHS Act" means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
9. "Product" means a discrete package of individual health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area that has its own set of rating and pricing methodologies.
10. "Preliminary justification" means a justification that consists of the parts described in R20-6-2302(A).
11. "Rate increase" means an increase of the rates for an individual health insurance plan or plans within a product that:
    a. Results from a change to the underlying rate structure, and
    b. May result in premium changes.
12. "Secretary" means the Secretary of the United States Department of Health and Human Services.
13. "Threshold rate increase" means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
    a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
    b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to

threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.

14. "Threshold rate review" means the review by the Department under this Article of a threshold rate increase.
15. "Unreasonable rate increase" means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
    a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;
    b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;
    c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
    d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
    e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.

R20-6-2305. Threshold Rate Increase Documentation Requirements

A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:

1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
2. The health insurer's data related to past projections and actual experience.

B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:

1. The impact of medical trend changes by major service categories;
2. The impact of utilization changes by major service categories;

3. The impact of cost-sharing changes by major service categories, including actuarial values;
4. The impact of geographic factors and variations;
5. The impact of changes to all plans within the single risk pool product;
6. The impact of reinsurance and risk adjustment payments and changes;
7. The impact of benefit changes;
8. The impact of changes in enrollee risk profile;
9. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
10. The impact of changes in reserve needs;
11. The impact of changes in administrative costs related to programs that improve health care quality;
12. The impact of changes in other administrative costs;
13. The impact of changes in applicable taxes, licensing or regulatory fees;
14. Medical loss ratio;
15. The health insurer's capital and surplus; and
16. Other relevant documentation at the discretion of the Director.

C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:

1. The health insurer submits the preliminary justification required under R20-6-2302, or
2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).