State of Connecticut
Regulation of
Insurance Department
Concerning
Health Insurance Rate and Form Filings

Section 38a-481-1 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-481-1. Definitions

As used in Sections 38a-481-1 to 38a-481-[4] 9, inclusive, of the Regulations of Connecticut State Agencies:

[(a)**]**(1) ''Commissioner'' means the Insurance Commissioner of the State of Connecticut.

(2) "Department" means the Connecticut Insurance Department

(3) "Excessive Rate" means the rate is unreasonably high for the insurance provided.

(4) "Experience period" means the most recent twelve-month period from which the insurer accumulates the data to support a filing.

[(b)**]**(5) ''Form'' means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, or application, rider or endorsement used in connection therewith.

(6) "Inadequate Rate" means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer.

[(c)**]**(7) ''Insurer'' means an insurance company licensed by the Commissioner to write accident and health insurance.

(8) "Loss ratio" means the ratio of incurred claims to earned premiums.

(9) "PPACA" means Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

[(d)**]**(10) "SERFF" means National Association of Insurance Commissioners System for Electronic Rate and Form Filing.

(11) "Unfairly Discriminatory" situations could include, but are not limited to:

(a) Negotiation or bidding of price;

(b) Discounts not provided to all qualifying risks; or

(c) Rating factors not applied consistently in plans.

(12) "Utilization data" means the number of services used by a fixed number of "covered persons" over a fixed length of time.

The Regulations of Connecticut State Agencies are amended by adding sections 38a-481-5 to 38a-481-9, inclusive, as follows:

(NEW) Sec. 38a-481-5. Timing for Rate Filings

(a) Rate filings shall be made by no later than ninety (90) days prior to the date an insurer intends to market such plans.

(b) For plans subject to the requirements of the PPACA, rate filings shall be filed annually no later than a date prescribed by the Commissioner. The Commissioner shall provide notice to insurers

no less than thirty (30) days prior to the prescribed date each year.

(NEW) Sec. 38a-481-6. Transparency

(a) The information supplied to the Department to fulfill its statutory rate review requirement is not confidential. Complete filings including all correspondence and documentation are available through SERFF and may be posted on the Department website for review and comment by the public. All public comments will be reviewed by the Department and considered as an additional element of the review determination.

(NEW) Sec. 38a-481-7. Process

(a) All rate filings must be submitted via SERFF.
(b) For filings subject to the requirements of the PPACA, all fields in SERFF added for reporting requirements to the federal Department of Health and Human Services in accordance with PPACA must be populated.
(c) All rate filings shall be made in accordance with Department guidance.
(d) Incomplete submissions may be rejected.
(e) No rate filing shall be approved if it is excessive, inadequate or unfairly discriminatory.
(f) Rates will not be approved unless the policy forms to which they apply are approved.
(g) No rate may be marketed until the rates are approved. The Commissioner may grant conditional approval to enhance the fairness and efficiency of the marketplace.

(NEW) Sec. 38a-481-8. Minimum Filing Requirements

(a) All rate filings shall include, at a minimum, the following:
(1) A cover letter describing all policy forms affected by the requested rates or rate changes as well as the effective date of the requested rates or rate changes.
(2) The detailed development for the initial rate or rate increase.
(3) Historical experience from inception-to-date including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios.
(A) Both state specific and nationwide experience shall be provided.
(B) Annual experience shall be provided for all years.
(4) A certification by a member of the American Academy of Actuaries that the rate filing is in compliance with this section. Such certification shall include a statement by a member of the American Academy of Actuaries that the rates are reasonable in relation to the benefits provided, and that they are not excessive, inadequate or unfairly discriminatory.
(5) Claim lag triangles.
(6) Cost for each newly mandated benefit that applies to this type of insurance.
(7) Any additional information the Commissioner deems necessary to review the rate filing.
(b) Any changes submitted after the initial filing shall include a red-lined version as well as a clean copy to facilitate the review.
(c) When the information in section (a) of this provision is received, actuarial review will commence. The filings will be reviewed in the order received.

(NEW) Sec. 38a-481-9. Additional Filing Requirements for Medical Health Insurance

(a) All rate filings for health insurance as defined in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) shall include:
(1) A demonstration that the experience data submitted is consistent with the most recent financial

statement filed with the Department pursuant to section 38a-53a of the Connecticut General Statutes.

(2) Utilization trend by broad service category, including utilization data.

(3) Impact of cost sharing leverage on trend.

(4) Medical technology trend.

(5) Benefit buy-down analysis and impact on trend.

(6) Cost of each new benefit mandate or requirement due to change in law, separately identified, from the experience period to the rating period. This includes requirements of both state and federal law.

(7) Unit cost trend by broad service category, including actual unit cost data and impact of provider contract changes from experience period to rating period (medical and prescription drug separately).

(8) An annual certification of compliance with mental health. For plans that have a copayment for a mental health office visit set at the specialist level, a demonstration that the copayment is in compliance with mental health parity shall also be filed.

(9) A certification and demonstration that any substitution of a non-dollar limit on an essential health benefit as permitted by PPACA is actuarially justified.

(10) A comparison of the proposed retention charge in the filing to the most recently filed statutory financial statement for the regulated entity for which this filing is being made.

(11) Claim lag triangles.

(12) Monthly historical experience including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios shall be provided for the most recent two (2) years.

(13) The current capital and surplus for the regulated entity for which this filing is being made.

(14) For filings subject to PPACA, a demonstration that the increase requested in this rate filing will generate an expected medical loss ratio, for rebate purposes, that is consistent with the 80% prescribed by the federal law for individual health insurance and small group, or 85% for large group, whichever applies to the rate filing.

(15) For rates filings subject to PPACA, the Uniform Rate Review Template (URRT), the Part III Actuarial Memorandum and the I-lIOS rate tables in a PDF format. Insurers shall also provide a summary of benefits for each plan design along with the Actuarial Value calculator output that confirms compliance with the corresponding metal tier. Indicate the HIOS plan ID and the corresponding plan name on the summary of benefits for each plan.

(b) Every rate filing submission that includes an increase to previously approved rates shall include a summary of the rate increases requested and shall be clearly marked as Appendix A. The appendix shall include but not be limited to the following:

(1) The requested increase for each product contained within the rate filing and the effective date of those proposed rate increases. The requested increase for each product shall be identified as a specific percent increase or if appropriate a range of percent increases with an explanation of what the variance is that produces the range.

(2) Number of covered individuals for each product; number of covered policyholders; minimum current premium on a per member per month (pmpm) basis; minimum proposed premium on a pmpm basis; maximum current premium on a pmpm basis; maximum proposed premium on a pmpm basis and the percentage change.

(3) Each component of the increase including trend, experience adjustments and any other factors that are a component of the requested increase. These may be identified as a specific percent, or if appropriate, a percent range.

(4) A footnote listing any other factors that can have an impact on premium rates that have not been specifically identified in the appendix, including, but not limited to, age bands, gender,

geographic area, and smoking.

Statement of Purpose: CGS § 38a-481(a) and CGS §38a-481(b) require that regulations pertaining to filing procedures for individual health insurance rates shall be adopted by the Commissioner and that the Commissioner shall adopt a regulation to prescribe standards to ensure that rates are not excessive, inadequate, or unfairly discriminatory. All amendments reflect updates to existing regulations to conform to the current statutes and requirements.

The revisions are being made as a result of the requirements in CGS § 38a-481(a) and CGS §38a-481(b). All updates to existing regulations contained herein are to conform to the current state and federal statutes, including the Affordable Care Act. The updates include changes to codify the Department's rate review process in regulation for individual health insurance to ensure that rates are not excessive, inadequate or unfairly discriminatory. The updates provide definitions for rate filing and provide requirements for filing of individual health insurance rates. As required by Conn. Gen. Stat. § 4-l68a, the Insurance Department considered the impact of the proposed amended regulations on small business, and in doing so, determined that the preparation of a regulatory flexibility analysis, as contemplated by this statute, was not needed. The amendments reflect activities to be undertaken by insurance companies offering health insurance products which are not small businesses.