



General Assembly

Amendment

January Session, 2011

LCO No. 8184

SB0001108184SD0

Offered by:

SEN. CRISCO, 17th Dist.

SEN. LOONEY, 11th Dist.

REP. MEGNA, 97th Dist.

To: Subst. Senate Bill No. 11

File No. 203

Cal. No. 157

"AN ACT CONCERNING THE RATE APPROVAL PROCESS FOR CERTAIN HEALTH INSURANCE POLICIES."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Section 38a-481 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective January 1, 2012*):

5 (a) No individual health insurance policy shall be delivered or
6 issued for delivery to any person in this state, nor shall any
7 application, rider or endorsement be used in connection with such
8 policy, until a copy of the form thereof and of the classification of risks
9 and the premium rates have been filed with the commissioner. The
10 commissioner shall adopt regulations, in accordance with chapter 54,
11 to establish a procedure for reviewing such policies. The commissioner
12 shall disapprove the use of such form at any time if it does not comply
13 with the requirements of law, or if it contains a provision or provisions

14 [which] that are unfair or deceptive or [which] that encourage
15 misrepresentation of the policy. The commissioner shall notify, in
16 writing, the insurer [which] that has filed any such form of the
17 commissioner's disapproval, specifying the reasons for disapproval,
18 and ordering that no such insurer shall deliver or issue for delivery to
19 any person in this state a policy on or containing such form. The
20 provisions of section 38a-19 shall apply to such orders.

21 (b) (1) No rate filed under the provisions of subsection (a) of this
22 section shall be effective [until the expiration of thirty days after it has
23 been filed or] unless [sooner] approved by the commissioner. [in
24 accordance with regulations adopted pursuant to this subsection.] The
25 commissioner shall adopt regulations, in accordance with chapter 54,
26 to prescribe standards to ensure that such rates shall not be excessive,
27 inadequate or unfairly discriminatory, as described in section 6 of this
28 act. [The] Except as specified in subdivision (2) of this subsection, the
29 commissioner may disapprove such rate within thirty days after it has
30 been filed if it fails to comply with such standards. [, except that no
31 rate filed under the provisions of subsection (a) of this section for any
32 Medicare supplement policy shall be effective unless approved in
33 accordance with section 38a-474.]

34 (2) Any rate filed under the provisions of subsection (a) of this
35 section for health insurance that provides coverage of the type
36 specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469
37 shall be approved in accordance with section 6 of this act.

38 (c) (1) No rate filed under the provisions of subsection (a) of this
39 section for any Medicare supplement policy shall be effective unless
40 approved in accordance with section 38a-474.

41 (2) No insurance company, fraternal benefit society, hospital service
42 corporation, medical service corporation, health care center or other
43 entity [which] that delivers or issues for delivery in this state any
44 Medicare supplement policies or certificates shall incorporate in its
45 rates or determinations to grant coverage for Medicare supplement

46 insurance policies or certificates any factors or values based on the age,
47 gender, previous claims history or the medical condition of any person
48 covered by such policy or certificate. [, except for plans "H" to "J",
49 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,
50 previous claims history and the medical condition of the applicant may
51 be used in determinations to grant coverage under Medicare
52 supplement policies and certificates issued prior to January 1, 2006.]

53 [(d) Rates on a particular policy form will not be deemed excessive
54 if the insurer has filed a loss ratio guarantee with the Insurance
55 Commissioner which meets the requirements of subsection (e) of this
56 section provided (1) the form of such loss ratio guarantee has been
57 explicitly approved by the Insurance Commissioner, and (2) the
58 current expected lifetime loss ratio is not more than five per cent less
59 than the filed lifetime loss ratio as certified by an actuary. The insurer
60 shall withdraw the policy form if the commissioner determines that
61 the lifetime loss ratio will not be met. Rates also will not be deemed
62 excessive if the insurer complies with the terms of the loss ratio
63 guarantee. The Insurance Commissioner may adopt regulations, in
64 accordance with chapter 54, to assure that the use of a loss ratio
65 guarantee does not constitute an unfair practice.

66 (e) Premium rates shall be deemed approved upon filing with the
67 Insurance Commissioner if the filing is accompanied by a loss ratio
68 guarantee. The loss ratio guarantee shall be in writing, signed by an
69 officer of the insurer, and shall contain as a minimum the following:

70 (1) A recitation of the anticipated lifetime and durational target loss
71 ratios contained in the original actuarial memorandum filed with the
72 policy form when it was originally approved;

73 (2) A guarantee that the actual Connecticut loss ratios for the
74 experience period in which the new rates take effect and for each
75 experience period thereafter until any new rates are filed will meet or
76 exceed the loss ratios referred to in subdivision (1) of this subsection. If
77 the annual earned premium volume in Connecticut under the

78 particular policy form is less than one million dollars and therefore not
79 actuarially credible, the loss ratio guarantee will be based on the actual
80 nation-wide loss ratio for the policy form. If the aggregate earned
81 premium for all states is less than one million dollars, the experience
82 period will be extended until the end of the calendar year in which one
83 million dollars of earned premium is attained;

84 (3) A guarantee that the actual Connecticut or nation-wide loss ratio
85 results, as the case may be, for the experience period at issue will be
86 independently audited by a certified public accountant or a member of
87 the American Academy of Actuaries at the insurer's expense. The audit
88 shall be done in the second quarter of the year following the end of the
89 experience period and the audited results must be reported to the
90 Insurance Commissioner not later than June thirtieth following the end
91 of the experience period;

92 (4) A guarantee that affected Connecticut policyholders will be
93 issued a proportional refund, which will be based on the premiums
94 earned, of the amount necessary to bring the actual loss ratio up to the
95 anticipated loss ratio referred to in subdivision (1) of this subsection. If
96 nation-wide loss ratios are used, the total amount refunded in
97 Connecticut shall equal the dollar amount necessary to achieve the loss
98 ratio standards multiplied by the total premium earned from all
99 Connecticut policyholders who will receive refunds and divided by
100 the total premium earned in all states on the policy form. The refund
101 shall be made to all Connecticut policyholders who are insured under
102 the applicable policy form as of the last day of the experience period
103 and whose refund would equal two dollars or more. The refund shall
104 include interest, at six per cent, from the end of the experience period
105 until the date of payment. Payment shall be made during the third
106 quarter of the year following the experience period for which a refund
107 is determined to be due;

108 (5) A guarantee that refunds less than two dollars will be
109 aggregated by the insurer. The insurer shall deposit such amount in a
110 separate interest-bearing account in which all such amounts shall be

111 deposited. At the end of each calendar year each such insurer shall
112 donate such amount to The University of Connecticut Health Center;

113 (6) A guarantee that the insurer, if directed by the Insurance
114 Commissioner, shall withdraw the policy form and cease the issuance
115 of new policies under the form in this state if the applicable loss ratio
116 exceeds the durational target loss ratio for the experience period by
117 more than twenty per cent, provided the calculations are based on at
118 least two thousand policyholder-years of experience either in
119 Connecticut or nation-wide.

120 (f) For the purposes of this section:

121 (1) "Loss ratio" means the ratio of incurred claims to earned
122 premiums by the number of years of policy duration for all combined
123 durations; and

124 (2) "Experience period" means the calendar year for which a loss
125 ratio guarantee is calculated.]

126 [(g)] (d) Nothing in this chapter shall preclude the issuance of an
127 individual health insurance policy [which] that includes an optional
128 life insurance rider, provided the optional life insurance rider [must]
129 shall be filed with and approved by the Insurance Commissioner
130 pursuant to section 38a-430. Any company offering such policies for
131 sale in this state shall be licensed to sell life insurance in this state
132 pursuant to the provisions of section 38a-41.

133 [(h)] (e) No insurance company, fraternal benefit society, hospital
134 service corporation, medical service corporation, health care center or
135 other entity that delivers, issues for delivery, amends, renews or
136 continues an individual health insurance policy in this state shall: (1)
137 Move an insured individual from a standard underwriting
138 classification to a substandard underwriting classification after the
139 policy is issued; (2) increase premium rates due to the claim experience
140 or health status of an individual who is insured under the policy,
141 except that the entity may increase premium rates for all individuals in

142 an underwriting classification due to the claim experience or health
143 status of the underwriting classification as a whole; or (3) use an
144 individual's history of taking a prescription drug for anxiety for six
145 months or less as a factor in its underwriting unless such history arises
146 directly from a medical diagnosis of an underlying condition.

147 Sec. 2. Section 38a-513 of the general statutes is repealed and the
148 following is substituted in lieu thereof (*Effective January 1, 2012*):

149 (a) No group health insurance policy, as defined by the
150 commissioner, or certificate shall be [issued or] delivered or issued for
151 delivery in this state unless a copy of the form for such policy or
152 certificate has been submitted to and approved by the commissioner
153 [under the regulations adopted pursuant to this section] and, with
154 respect to a small employer group health insurance policy, as "small
155 employer" is defined in section 38a-564, the classification of risks and
156 the premium rates have been filed with the commissioner. The
157 commissioner shall adopt regulations, in accordance with chapter 54,
158 concerning the provisions [.] and submission [and approval] of such
159 policies and certificates and establishing a procedure for reviewing
160 such policies and certificates. If the commissioner issues an order
161 disapproving the use of such form, the provisions of section 38a-19
162 shall apply to such order.

163 (b) (1) No rate filed under the provisions of subsection (a) of this
164 section shall be effective unless approved by the commissioner. The
165 commissioner shall adopt regulations, in accordance with chapter 54,
166 to prescribe standards to ensure that such rates shall not be excessive,
167 inadequate or unfairly discriminatory, as described in section 6 of this
168 act. Except as specified in subdivision (2) of this subsection, the
169 commissioner may disapprove such rate within thirty days after it has
170 been filed if it fails to comply with such standards.

171 (2) Any rate filed under the provisions of subsection (a) of this
172 section for a small employer group health insurance policy that
173 provides coverage of the type specified in subdivisions (1), (2), (4), (7),

174 (11) and (12) of section 38-469 shall be approved in accordance with
175 section 6 of this act.

176 [(b)] (c) No insurance company, fraternal benefit society, hospital
177 service corporation, medical service corporation, health care center or
178 other entity which delivers or issues for delivery in this state any
179 Medicare supplement policies or certificates shall incorporate in its
180 rates or determinations to grant coverage for Medicare supplement
181 insurance policies or certificates any factors or values based on the age,
182 gender, previous claims history or the medical condition of any person
183 covered by such policy or certificate. [, except for plans "H" to "J",
184 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,
185 previous claims history and the medical condition of the applicant may
186 be used in determinations to grant coverage under Medicare
187 supplement policies and certificates issued prior to January 1, 2006.]

188 [(c)] (d) Nothing in this chapter shall preclude the issuance of a
189 group health insurance policy [which] that includes an optional life
190 insurance rider, provided the optional life insurance rider must be
191 filed with and approved by the Insurance Commissioner pursuant to
192 section 38a-430. Any company offering such policies for sale in this
193 state shall be licensed to sell life insurance in this state pursuant to the
194 provisions of section 38a-41.

195 [(d)] (e) Not later than January 1, 2009, the commissioner shall adopt
196 regulations, in accordance with chapter 54, to establish minimum
197 standards for benefits in group specified disease policies, certificates,
198 riders, endorsements and benefits.

199 Sec. 3. Subsection (a) of section 38a-183 of the general statutes is
200 repealed and the following is substituted in lieu thereof (*Effective*
201 *January 1, 2012*):

202 (a) A health care center governed by sections 38a-175 to 38a-192,
203 inclusive, as amended by this act, shall not enter into any agreement
204 with subscribers unless and until it has filed with the commissioner a
205 full schedule of the amounts to be paid by the subscribers and has

206 obtained the commissioner's approval [thereof] in accordance with
207 section 6 of this act. The commissioner [may refuse such approval if he
208 finds such amounts to] shall adopt regulations, in accordance with
209 chapter 54, to prescribe standards to ensure that such amounts shall
210 not be excessive, inadequate or discriminatory, as described in section
211 6 of this act. Each such health care center shall not enter into any
212 agreement with subscribers unless and until it has filed with the
213 commissioner a copy of such agreement or agreements, including all
214 riders and endorsements thereon, and until the commissioner's
215 approval thereof has been obtained. The commissioner shall, within a
216 reasonable time after the filing of any request for an approval of [the
217 amounts to be paid,] any agreement or any form, notify the health care
218 center of [either his] said commissioner's approval or disapproval
219 thereof.

220 Sec. 4. Section 38a-208 of the general statutes is repealed and the
221 following is substituted in lieu thereof (*Effective January 1, 2012*):

222 No such corporation shall enter into any contract with subscribers
223 unless and until it has filed with the Insurance Commissioner a full
224 schedule of the rates to be paid by the subscribers and has obtained
225 said commissioner's approval [thereof] in accordance with section 6 of
226 this act. The commissioner [may refuse such approval if he finds such
227 rates to] shall adopt regulations, in accordance with chapter 54, to
228 prescribe standards to ensure that such amounts shall not be excessive,
229 inadequate or discriminatory, as described in section 6 of this act. No
230 hospital service corporation shall enter into any contract with
231 subscribers unless and until it has filed with the Insurance
232 Commissioner a copy of such contract, including all riders and
233 endorsements thereof, and until said commissioner's approval thereof
234 has been obtained. The Insurance Commissioner shall, within a
235 reasonable time after the filing of any such form, notify such
236 corporation [either of his] of said commissioner's approval or
237 disapproval thereof.

238 Sec. 5. Section 38a-218 of the general statutes is repealed and the

239 following is substituted in lieu thereof (*Effective January 1, 2012*):

240 No such medical service corporation shall enter into any contract
241 with subscribers unless and until it has filed with the Insurance
242 Commissioner a full schedule of the rates to be paid by the subscriber
243 and has obtained said commissioner's approval [thereof] in accordance
244 with section 6 of this act. The commissioner [may refuse such approval
245 if he finds such rates are] shall adopt regulations, in accordance with
246 chapter 54, to prescribe standards to ensure that such amounts shall
247 not be excessive, inadequate or discriminatory, as described in section
248 6 of this act. No such medical service corporation shall enter into any
249 contract with subscribers unless and until it has filed with the
250 Insurance Commissioner a copy of such contract, including all riders
251 and endorsements thereof, and until said commissioner's approval
252 thereof has been obtained. The Insurance Commissioner shall, within a
253 reasonable time after the filing of any such form, notify such
254 corporation [either of his] of said commissioner's approval or
255 disapproval thereof.

256 Sec. 6. (NEW) (*Effective January 1, 2012*) (a) (1) With respect to a
257 health insurance policy, agreement or contract that provides coverage
258 of the type specified in subdivisions (1), (2), (4), (7), (11) and (12) of
259 section 38a-469 of the general statutes, any (A) rate filed for such policy
260 pursuant to section 38a-481 of the general statutes, as amended by this
261 act, (B) rate filed for such policy pursuant to section 38a-513 of the
262 general statutes, as amended by this act, (C) schedule of amounts filed
263 for such agreement pursuant to section 38a-183 of the general statutes,
264 as amended by this act, (D) schedule of rates filed for such contract
265 pursuant to section 38a-208 of the general statutes, as amended by this
266 act, or (E) schedule of rates filed for such contract pursuant to section
267 38a-218 of the general statutes, as amended by this act, on or after
268 January 1, 2012, shall be filed not later than ninety calendar days prior
269 to the proposed effective date of such rates or amounts.

270 (2) Each filer making a rate or amount filing pursuant to this
271 subsection shall:

272 (A) On the date the filer submits such rate or amount filing to the
273 Insurance Commissioner, clearly and conspicuously disclose to its
274 insureds or subscribers, or in the case of a small employer group health
275 insurance policy specified in subdivision (2) of subsection (b) of section
276 38a-513 of the general statutes, as amended by this act, to the
277 policyholder for distribution to such policyholder's covered certificate
278 holders, in writing and in such form as the commissioner may
279 prescribe: (i) The proposed general rate or amount increase and the
280 dollar amount by which an insured's, subscriber's or policyholder's
281 policy or agreement will increase, including any increase because of
282 the insured's, subscriber's or certificate holder's age or change in age
283 rating classification and the percentage increase or decrease of the
284 proposed rate or amount from the current rate or amount; (ii) a
285 statement that the proposed rate or amount is subject to Insurance
286 Department review and approval; and (iii) detailed information on the
287 insured's, subscriber's or policyholder's right to submit public
288 comment to the Insurance Department, including the Internet web site,
289 mailing address and phone number of said department and
290 instructions on how to submit comments to the department; and

291 (B) Include with its rate or amount filing an actuarial memorandum,
292 certified by a qualified actuary, as defined in section 38a-78 of the
293 general statutes, that to the best of such actuary's knowledge, (i) such
294 rate or amount filing is in compliance with law, and (ii) the rate or
295 amount filing is not excessive, as described in this section.

296 (3) (A) Notwithstanding the provisions of section 38a-69a of the
297 general statutes, the Insurance Department shall post on its Internet
298 web site all documents, materials and other information provided to or
299 requested by the department in relation to a rate or amount filing
300 made pursuant to this subsection. The posting shall include all
301 documents required by the commissioner to support such rate or
302 amount filing, including, but not limited to, any information
303 designated by the United States Department of Health and Human
304 Services as necessary to ensure an effective rate review process.

305 (B) The rate or amount filing and the documents, materials and
306 other information shall be posted not later than three business days
307 after the department receives such filing, and such posting shall be
308 updated to include any correspondence between the department and
309 the filer.

310 (C) The department shall provide for a written public comment
311 period of thirty calendar days following the posting of such filing. The
312 department shall include in such posting the date the public comment
313 period closes and instructions on how to submit comments to the
314 department.

315 (b) The commissioner shall issue a written decision approving,
316 disapproving or modifying a rate or amount filing not later than forty-
317 five days after such filing was made. Such decision shall specify all
318 factors used to reach such decision and shall be posted on the Internet
319 web site of the Insurance Department not later than two business days
320 after the commissioner issues such decision.

321 (c) The commissioner shall not approve a rate or amount filing
322 made under this section if it is excessive, inadequate or unfairly
323 discriminatory. The commissioner shall conduct an actuarial review to
324 determine if the methodology and assumptions used to develop the
325 rate or amount filing are actuarially sound and in compliance with the
326 Actuarial Standards of Practice issued by the Actuarial Standards
327 Board.

328 (1) A rate or amount is excessive if it is unreasonably high for the
329 insurance provided in relation to the underlying risks and costs after
330 due consideration to (A) the experience of the filer, (B) the past and
331 projected costs of the filer including amounts paid and to be paid for
332 commissions, (C) any transfers of funds to the holding or parent
333 company, subsidiary or affiliate of the filer, (D) the filer's rate of return
334 on assets or profitability, as compared to similar filers, (E) a reasonable
335 margin for profit and contingencies, (F) any public comments received
336 on such filing, and (G) other factors the commissioner deems relevant.

337 (2) A rate or amount is inadequate if it is unreasonably low for the
338 insurance provided in relation to the underlying risks and costs and
339 continued use of such rate or amount would endanger solvency of the
340 filer.

341 (3) A rate or amount is unfairly discriminatory if the premium
342 charged for any classification is not reasonably related to the
343 underlying risks and costs, such that different premiums result for
344 insureds with similar risks and costs.

345 (d) (1) (A) If the Insurance Commissioner issues a decision to
346 approve or modify a rate or amount filing made pursuant to
347 subsection (a) of this section, the filer shall provide written notice to
348 each insured or subscriber, or in the case of a small employer group
349 health insurance policy specified in subdivision (2) of subsection (b) of
350 section 38a-513 of the general statutes, as amended by this act, to the
351 policyholder by first class mail that states (i) the approved rate or
352 amount for the insured's, subscriber's or policyholder's policy or
353 agreement, (ii) any increase in the rate or amount due to the insured's,
354 subscriber's or certificate holder's age or change in age rating
355 classification, and (iii) the percentage increase or decrease of the
356 approved rate from the current rate of the insured, subscriber or
357 policyholder.

358 (B) No such rate or amount shall be effective until thirty calendar
359 days after the notice has been sent by the filer as set forth in
360 subdivision (1) of this subsection or the effective date proposed under
361 subdivision (1) of subsection (a) of this section, whichever is later.

362 (2) If the Insurance Commissioner issues a decision to disapprove a
363 rate or amount filing made pursuant to subsection (a) of this section,
364 the filer shall provide written notice to each insured or subscriber by
365 first class mail of such decision.

366 (f) Each insurance company, health care center, hospital service
367 corporation or medical service corporation subject to the provisions of
368 this section shall disclose in writing to a prospective customer of a

369 policy or agreement that may be affected by a rate or amount filing
370 made pursuant to this section, (1) that the rate or amount of such
371 policy or agreement is under review by the Insurance Department, and
372 (2) the proposed increase or decrease in the rate or amount of such
373 policy or agreement.

374 (g) Each insurance company, health care center, hospital service
375 corporation or medical service corporation subject to the provisions of
376 this section shall retain records of all earned premiums and incurred
377 benefits per calendar year for each policy or agreement for which a
378 rate or amount filing is made pursuant to this section. Such records
379 shall be retained for not less than seven years after the date each such
380 filing is made and shall include records for any rider or endorsement
381 used in connection with such policy or agreement.

382 (h) The Insurance Department shall retain all records of any rate or
383 amount filing made pursuant to this section for not less than seven
384 years after such filing was approved, disapproved or modified.

385 Sec. 7. (NEW) (*Effective January 1, 2012*) Not later than January
386 thirty-first, annually, the Insurance Department shall submit a report
387 to the joint standing committee of the General Assembly having
388 cognizance of matters relating to insurance that lists all rates filed
389 pursuant to section 38a-481 or 38a-513 of the general statutes, as
390 amended by this act, schedule of amounts filed pursuant to section
391 38a-183 of the general statutes, as amended by this act, and schedule of
392 rates filed pursuant to section 38a-208 or 38a-218 of the general
393 statutes, as amended by this act, for health insurance policies,
394 agreements or contracts that provide coverage of the type specified in
395 subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469 of the
396 general statutes, in the calendar year immediately preceding. Such
397 report shall include the name of the filer, the per cent increase or
398 decrease of such rate of amount filing, the per cent increase or decrease
399 approved by the Insurance Department, the market segment and the
400 product type."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2012</i>	38a-481
Sec. 2	<i>January 1, 2012</i>	38a-513
Sec. 3	<i>January 1, 2012</i>	38a-183(a)
Sec. 4	<i>January 1, 2012</i>	38a-208
Sec. 5	<i>January 1, 2012</i>	38a-218
Sec. 6	<i>January 1, 2012</i>	New section
Sec. 7	<i>January 1, 2012</i>	New section