

OFFICE OF LEGISLATIVE RESEARCH  
PUBLIC ACT SUMMARY



**PA 11-170—sSB 11 (VETOED)**

*Insurance and Real Estate Committee  
Appropriations Committee*

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

**SUMMARY:** This act imposes new requirements on health insurers and the Insurance Department with regard to rates. It requires that rates charged for small employer group health insurance be approved by the insurance commissioner and modifies the rate approval process for individual policies. The act:

1. requires small employer group health insurers to file risk classifications and premium rates with the insurance commissioner;
2. generally increases the amount of time required before a new rate can go into effect;
3. requires the Insurance Department to post certain rate filings on its website and provide a 30-day public comment period;
4. from January 1, 2012 to December 31, 2013, requires a symposium on these proposed rate filings if specified criteria are met and the healthcare advocate and attorney general request it;
5. establishes disclosure and record retention requirements for these rate filings; and
6. increases the amount appropriated to the Insurance Department in FYs 12 and 13.

The act also makes minor, technical, and conforming changes.

EFFECTIVE DATE: January 1, 2012

**INSURANCE DEPARTMENT REQUIREMENTS**

*Individual Health Insurance Policies*

By law, rates for individual health insurance policies are subject to Insurance Department review and approval. The act eliminates the provision that allows rates (other than those for Medicare supplement policies) to go into effect automatically 30 days after they are filed. It instead provides a new rate approval process, which is described below.

By law, the Insurance Department must adopt regulations to ensure that the rates charged for such policies are not excessive, inadequate, or unfairly discriminatory. The act defines these terms.

Under the act, a rate is “excessive” if it is unreasonably high for the insurance in relation to the underlying risks and costs after due consideration to:

1. the filer’s experience;
2. the filer’s past and projected costs, including amounts paid and to be paid for commissions;

## OLR PUBLIC ACT SUMMARY

3. any transfers of funds to the filer's holding or parent company, subsidiary; or affiliate;
4. the filer's rate of return on assets or profitability, as compared to similar filers;
5. a reasonable margin for profit and contingencies;
6. any public comments received related to the filing; and
7. other factors the commissioner deems relevant.

A rate is "inadequate" if it is unreasonably low in relation to the underlying risks and costs and continued use of the rate would endanger the filer's solvency. It is "unfairly discriminatory" if the premium charged for any classification is not reasonably related to the underlying risks and costs, such that different premiums result for insureds with similar risks and costs.

The act deletes a provision that deemed rates "not excessive" if the insurer filed a loss ratio guarantee that the insurance commissioner approved. For this purpose, "loss ratio" meant the ratio of incurred claims to earned premiums.

### *Group Health Insurance Policies*

By law, the insurance commissioner must review and approve the form for group health insurance policies. The act eliminates a requirement that the commissioner adopt regulations concerning the approval of the policies themselves.

The act requires that, for small employer group health insurance policies, the insurer submit the premium rates and classification of risks to the insurance commissioner. Under the act, a "small employer" is a person, firm, corporation, limited liability company, partnership, or association actively engaged in business or self-employed for at least three consecutive months that, on at least 50% of its working days during the preceding 12 months, employed 50 or fewer employees most of whom are in Connecticut. When counting the number of employees, companies that are affiliates under state law or eligible to file a combined tax return are considered one employer.

The act prohibits these rates from going into effect until the commissioner approves them. It requires the commissioner to adopt regulations setting standards to ensure that the rates are not excessive, inadequate, or unfairly discriminatory, as described above.

Except for specified types of policies, the commissioner may disapprove a rate within 30 days if it does not meet the standards. These specified policies include those covering (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) hospital or medical services, or (5) long-term care. The rate approval process for these policies is described below.

### *Policies Provided by HMOs and Hospital and Medical Service Corporations*

Prior law barred HMOs from entering any agreement with subscribers until the commissioner approved the amount the subscribers would pay. It similarly barred hospital and medical service corporations from entering into contracts with subscribers until the commissioner approved the subscribers' rates. Under prior law, the commissioner could refuse to approve these amounts and rates if he

## OLR PUBLIC ACT SUMMARY

found them to be excessive, inadequate, or discriminatory. The act instead requires the commissioner to adopt regulations to ensure that the amounts and rates are not excessive, inadequate, or discriminatory. It also requires the commissioner to follow the procedures established by the act (described below) in approving the amounts and rates. These procedures apply to specific types of policies. It is unclear whether the commissioner must follow these procedures in approving amounts and rates for other types of policies.

### RATE APPROVAL PROCESS FOR SPECIFIED TYPES OF POLICIES

#### *Applicability*

The act establishes a rate approval process that applies to any rate filed by an HMO, hospital or medical service corporation, or an individual or small employer group health insurer that issues policies that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) hospital or medical services, or (5) long-term care.

#### *Process and Timeline*

The act requires the above entities to file rates with the department within 120 days before their proposed effective date. The department must post the filing and supporting documents on its website within three business days of receiving it and update the file to include any correspondence between the department and the entity that filed it.

The department must provide a 30-day public comment period once the filing is posted on the website. The website posting must include the day the public comment period ends and how to submit written comments to the department.

Under prior law, individual health insurance rates were deemed approved if not otherwise disapproved within 30 days of being filed with the department. For HMOs and hospital and medical service corporations, the commissioner had to approve or disapprove rates within a reasonable time. The law did not specify a time frame for approval of individual long-term care health insurance rates.

The act instead requires the commissioner to issue a written decision approving, modifying, or disapproving a rate filing within 45 days after receiving it, unless a symposium is required on the filing (see below). The decision must specify all factors used to reach it and be posted on the department's website within two business days after being issued.

#### *Disclosure to Insureds or Subscribers*

The act requires each entity to disclose to its insureds or subscribers, on the date it submits a rate filing to the department, clearly and conspicuously, in writing, and in a form the commissioner prescribes:

1. the proposed general rate increase and the dollar amount by which a person's policy or agreement will increase, including any increase because of the person's age or change in age rating classification and the percentage increase or decrease in the proposed rate from the current rate;

## OLR PUBLIC ACT SUMMARY

2. a statement that the proposed rate or amount is subject to department review and approval; and
3. detailed information on the person's right to submit public comment to the Insurance Department, including the department's website, mailing address, phone number, and instructions on how to submit comments.

The entity must disclose in writing to a prospective customer the (1) fact that the department is reviewing the policy rates and (2) proposed rate increase or decrease.

If the insurance commissioner approves or modifies a rate filing, the entity must provide written notice to each insured or subscriber by first class mail that states:

1. the approved rate for the person's policy or agreement,
2. any increase in the rate due to the person's age or change in age rating classification, and
3. the percentage increase or decrease in the approved rate from the person's current rate.

The act prohibits a new rate from taking effect until 30 days after the notice has been sent or the effective date proposed in the rate filing, whichever is later.

### *Actuarial Memorandum*

The entity's rate filing must include an actuarial memorandum certified by a qualified actuary (i.e., a member in good standing with the American Academy of Actuaries who meets regulatory requirements in regulations that the commissioner may prescribe). The actuary must certify that, to the best of his or her knowledge, the rate filing complies with law and is not excessive.

### *Rate Filing Review Requirements*

The act requires the insurance commissioner, when reviewing a rate filing to determine that it is not excessive, inadequate, or unfairly discriminatory, to conduct his own actuarial review to determine if the methodology and assumptions used to develop the rate filing are actuarially sound and comply with the Actuarial Standards of Practice issued by the Actuarial Standards Board.

### *Public Symposium Required for Certain Rate Filings*

Under the act, from January 1, 2012 to December 31, 2013, the commissioner must hold a symposium when (1) any entity files a rate increase of more than 10% and (2) the healthcare advocate or attorney general requests it within five business days after the filing is posted on the department's website. (The 10% rate increase criterion does not apply to long-term care policies.) The commissioner must, within five business days of receiving a request, set a symposium date and conspicuously post on the department's website the date, place, and time of the symposium. The act requires the symposium to be held (1) within 90 days before the proposed effective date of the rate filing at a place and time convenient for the public and (2) in accordance with the act. The commissioner must immediately notify the filer of the symposium date, place, and time.

The commissioner must, within 30 days after the symposium, issue a written

## OLR PUBLIC ACT SUMMARY

decision approving, modifying, or disapproving the rate filing. The decision must specify all factors used to reach it and be posted on the department's website within two business days from being issued.

The commissioner is not required to hold, in any year, more than (1) 10 symposiums for individual and small employer group health insurance rates and (2) five symposiums for long-term care rates. The act specifies that the symposium is not deemed a contested case under the Uniform Administrative Procedures Act and thus cannot be appealed to Superior Court.

### *Healthcare Advocate and Attorney General*

The act authorizes the healthcare advocate, the attorney general, or both, to present evidence, information, and a closing argument at any rate filing symposium held. It requires the insurance commissioner to help these officials obtain the department's rate filing records that are not readily available from its website, provided they are not confidential or prohibited by law from disclosure. In making his decision to approve, disapprove, or modify a rate filing, the commissioner must consider any oral or written comments made or submitted at each symposium and written comments submitted directly to the department.

### *Report*

The act requires the Insurance Department to report annually by January 31 to the Insurance and Real Estate Committee all rates, amounts, and rate schedules filed in the immediately preceding calendar year by the above individual, small group employer, and long-term care entities. The report must include the (1) filer's name, (2) percent rate increase or decrease filed and approved by the department, and (3) market segment and product type.

### *Record Retention*

The act requires each insurer, HMO, or hospital or medical service corporation to retain records of earned premiums and incurred benefits by calendar year for each policy or agreement for which a rate filing was made under the act. The records must be kept for at least seven years after the filing was made and must include records for any rider or endorsement used in connection with the policy or agreement.

The act requires the Insurance Department to retain rate filing records for at least seven years from the date it approved, modified, or disapproved the filing.

### *Insurance Fund*

The act amends PA 11-6 (the biennial budget act) to adjust amounts appropriated to the Insurance Department from the Insurance Fund for personnel, fringe benefits, and other expenses. Specifically, it increases the appropriations in each year for personal services, other expenses, and fringe benefits by \$98,000, \$25,000, and \$58,000 respectively.

OLR PUBLIC ACT SUMMARY

OLR Tracking: ND:KM:JL:df