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ResearchReport

Connecticut's Health Insurance Rate Review Requirements

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Issue

Describe Connecticut's statutory rate review requirements for individual and group health insurance policies. What factors does the Connecticut Insurance Department use to approve an insurer's proposed rate increase? (This report replaces OLR Report 2010-R-0507.)

Summary

State law requires insurance companies and health care centers (also known as health maintenance organizations or HMOs) to file rates for certain fully insured commercial insurance products offered in Connecticut with the Connecticut Insurance Department for review and approval. The department reviews insurer and HMO rate filings for (1) individual health plans and (2) small employer health plans (covering up to 50 employees). Additionally, the department reviews HMO rate filings for plans offered to large employers (those covering more than 50 employees). However, the department does not have authority over employer groups that self-fund their health plans and, therefore, it lacks jurisdiction to review rates associated with those plans. (The U.S. departments of Labor, Health and Human Services, and Treasury regulate self-funded plans.)

Rate Review Factors

The Connecticut Insurance Department's authority to review health insurance rates is defined by statute, which limits the review to three factors: whether the rates are excessive, inadequate, or unfairly discriminatory. There is no authority for the department to consider other factors, including affordability.

Two states, Vermont and Rhode Island, do take affordability into account during the rate review process. For a discussion of their rate review standards, see OLR Reports 2017-R-0185 and 2016-R-0146.

The Connecticut Insurance Department reviews a rate filing based on actuarial science and applicable statutes, which provide that health insurance rates may not be excessive, inadequate, or unfairly discriminatory. While state law does not require a public hearing on a health insurance rate filing, the insurance commissioner may hold one at her discretion.

The department's actuarial staff reviews detailed information from the insurer or HMO about projected medical claim trends and claim history for the policy form for which the rate is requested. The department will approve a rate filing if the insurer or HMO can show that the new rate meets the statutory requirements. If the company's data does not support a requested rate, the department will deny it or, if warranted, approve a modified rate.

For more information about the health insurance rate review process in Connecticut, see the following documents on the department's website:

- Frequently Asked Questions (FAQ) on Rate Filing, Rate Reviews and Approval of Health Insurance Rates in Connecticut and
- Bulletin No. HC-81-18 (issued January 31, 2018) on Health Insurance Rate Filing Submission Guidelines.

Rate Review Requirements

Individual Health Plans

State law requires HMOs and insurance companies to file rates with the insurance commissioner for health insurance plans offered to individuals (CGS §§ 38a-183 & 38a-481). No rate is effective until the commissioner has approved it. Rates may vary based on age, geographic area, and tobacco use, as well as by actuarially justified differences in plan design, provider network, and administrative expenses.

Small Employer Health Plans

The law requires HMOs and insurance companies to file rates with the insurance commissioner for health insurance plans offered to small employers (up to 50 employees) (CGS §§ 38a-183, 38a-513, & 38a-567). As with individual health plans, no rate is effective until the commissioner has approved it.

In general, rates for small employer health plans may vary based on age and geographic area, as well as by actuarially justified differences in plan design, provider network, and administrative expenses. Grandfathered plans—those in existence before March 23, 2010 that have not changed since in ways that substantially reduced benefits or increased costs for consumers—may also vary rates based on other factors, including gender, industry, and family composition.

Large Employer Health Plans

The law also requires HMOs to file rates with the insurance commissioner for health insurance plans offered to large employer groups (more than 50 employees) (CGS § 38a-183). No rate is effective until the commissioner has approved it. (The department does not have statutory authority to review insurance company rates for health plans offered to large groups.)

Rate Review Factors

By law, the Insurance Department's authority to review health insurance rates is limited to three factors: whether the rates are excessive, inadequate, or unfairly discriminatory. According to the department's FAQ document, these terms are generally understood to mean the following:

1. "excessive rate" is a rate that is unreasonably high in relation to the benefits provided and underlying risks;

2. "inadequate rate" is a rate that is unreasonably low in relation to the benefits provided and underlying risks, and continued use of it would endanger the insurer's solvency; and

3. "unfairly discriminatory rate" is a rate that is not actuarially sound and is not applied in a consistent manner so the resulting rate is not reasonable in relation to the benefits and underlying risk.

Actuarial Analysis

Upon receipt of a rate filing from an HMO or insurance company, the Insurance Department performs an actuarial analysis to determine whether a requested rate is warranted based on the rate review factors. As part of the analysis, the department reviews, among other things, the following information:

1. historical claim experience by month for the previous three years by broad service category (e.g., inpatient, outpatient, physician, pharmaceutical);

2. "claim lag triangles," which analyze incurred claims by month with paid claims that extend three months past the last incurral date;

3. loss ratios from inception-to-date on a calendar year basis (i.e., the ratio of earned premium to incurred claims); and

4. the company's expenses using the most recent financial statement.

If Connecticut experience is not statistically significant (i.e., credible), the department requests the above information on a nationwide basis if available.

The department tests the validity of the assumptions the HMO or insurer used in the filing by analyzing the information, along with any additional information included in the company's actuarial memorandum. It reviews any other adjustments to the pricing that the company proposes and determines whether the rate increase requested is excessive, inadequate, or unfairly discriminatory in relation to the benefits provided. If the rate meets these statutory standards, the department approves the requested rate. If it does not meet the standards, the department disapproves the requested rate or, if warranted, approves a modified rate.

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