General Assembly

Raised Bill No. 194

February Session, 2010

LCO No. **985**

00985_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING RATE APPROVALS FOR INDIVIDUAL HEALTH INSURANCE POLICIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-481 of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions **[**which**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer **[**which**]** that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval,

and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) **[**No rate filed under the provisions of subsection (a) of this section shall be effective until the expiration of thirty days after it has been filed or unless sooner approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to insure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.**]** Except as set forth in subdivision (1) of subsection (c) of this section, any rate filed on or after January 1, 2011, under the provisions of subsection (a) of this section shall be filed not later than one hundred eighty calendar days prior to the proposed effective date of such rate. The commissioner shall review and issue a decision regarding such rate filing in accordance with the provisions of sections 2 to 4, inclusive, of this act.

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

(2) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate. **[**, except for plans "H" to "J",

inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.**]**

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

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

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

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned

premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

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

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

(5) A guarantee that refunds less than two dollars will be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center;

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

(f) For the purposes of this section:

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

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

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

[(h)**]** (e) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state shall: (1) Move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole; or (3) use an

individual's history of taking a prescription drug for anxiety for six months or less as a factor in its underwriting unless such history arises directly from a medical diagnosis of an underlying condition.

Sec. 2. (NEW) (*Effective January 1, 2011*) (a) (1) For any (A) rate filing submitted to the Insurance Commissioner pursuant to section 38a-481 of the general statutes, as amended by this act, (B) schedule of amounts filed by a health care center pursuant to section 38a-183 of the general statutes, as amended by this act, (C) schedule of rates filed by a hospital service corporation pursuant to section 38a-208 of the general statutes, as amended by this act, or (D) schedule of rates filed by a medical service corporation pursuant to section 38a-218 of the general statutes, as amended by this act, the commissioner shall, not later than five business days after the receipt of such filing, set a hearing date and post the date, place and time of the hearing and the filing in a conspicuous place on the Internet web site of the Insurance Department. The posting shall include all supplemental information that is part of the filing and shall be updated to include any correspondence between the department and the filer.

(2) Such hearing shall be (A) held not later than one hundred twenty calendar days prior to the proposed effective date of such rate or amount, at a place and time that is convenient to the public, and (B) conducted in accordance with chapter 54 of the general statutes, this section and section 3 of this act.

(3) Upon setting the date, place and time of the hearing on the proposed rate or amount, the commissioner shall immediately notify the filer of the date, place and time of the hearing. Not later than ten business days after receipt of such notice, the filer shall clearly and conspicuously disclose by first class mail to its insureds or subscribers: (A) The proposed rate or amount for each insured's or subscriber's specific policy or agreement, including any increase because of the policyholder's or subscriber's age or change in age rating classification and the percentage increase or decrease of the proposed rate from the

current rate; (B) a statement that the proposed rate is subject to Insurance Department review and approval; and (C) the date, place and time of the hearing on such proposed rate or amount.

(b) Not later than thirty calendar days after the hearing, the commissioner shall issue a decision approving, disapproving or modifying the rate or amount filing. The commissioner shall only approve a proposed rate or amount under this section if such rate or amount is reasonable. As used in this subsection, "reasonable" means a rate or amount that provides a fair rate of return to the filer, taking into consideration the average rate of return of the five previous calendar years in the filer's industry and the filer's average net income for the five previous calendar years. In determining a fair rate of return, the commissioner shall review all expenses of the filer including the adequacy of reserves in light of anticipated medical expenses and transfers of funds to the parent company of the filer.

(c) Any insurance company, health care center, hospital service corporation, medical service corporation or other entity subject to the provisions of this section shall disclose in writing to a prospective customer of a policy, agreement or contract that may be affected by a rate or amount filing made pursuant to this section, (1) that the rate or amount of such policy, agreement or contract is under review by the Insurance Department, and (2) the proposed increase or decrease in the rate or amount of such policy, agreement or contract.

Sec. 3. (NEW) (*Effective January 1, 2011*) (a) Notwithstanding sections 4-176 and 4-177a of the general statutes, the Healthcare Advocate or the Attorney General or both may be a party to any hearing held pursuant to section 2 of this act.

(b) Subject to the provisions of section 4-181 of the general statutes, (1) the Healthcare Advocate or the Attorney General or both shall have access to the records of the Insurance Department regarding a rate or amount filing made pursuant to section 2 of this act, and (2) attorneys, actuaries, accountants and other experts who are part of the Insurance

Commissioner's staff and who review or assist in the determination of such filing shall cooperate with the Healthcare Advocate or Attorney General or both to carry out the provisions of this section.

(c) The Healthcare Advocate or the Attorney General or both may (1) summon and examine under oath, such witnesses as the Healthcare Advocate or the Attorney General deems necessary to the review of a rate or amount filing made pursuant to section 2 of this act, and (2) require the filer or any holding or parent company or subsidiary of such filer to produce books, vouchers, memoranda, papers, letters, contracts and other documents, regardless of the format in which such materials are stored. Such books, vouchers, memoranda, papers, letters, contracts and other documents shall be limited to such information or transactions between the filer and the holding or parent company or subsidiary that are reasonably related to the subject matter of the filing.

(d) The Healthcare Advocate or the Attorney General or both may engage the services of attorneys, actuaries, accountants and other experts not otherwise part of the commissioner's staff as may be necessary to assist the Healthcare Advocate or the Attorney General or both in the review of the rate or amount filing made pursuant to section 2 of this act. The cost of such services shall be borne by the filer and paid in such manner as directed by the Insurance Commissioner, provided the cost of such attorneys, actuaries, accountants and other experts shall not exceed (1) two hundred thousand dollars for the Office of the Healthcare Advocate or two hundred thousand dollars for the office of the Attorney General if the filer has more than ten thousand policyholders or subscribers affected by the rate or amount filing, or (2) fifty thousand dollars for the Office of the Healthcare Advocate or fifty thousand dollars for the office of the Attorney General if the filer has ten thousand or less policyholders or subscribers affected by the rate or amount filing. Such costs shall be recognized by the Insurance Department as proper business expenses of the filer.

(e) After exhausting all administrative remedies available within the Insurance Department, the Healthcare Advocate or the Attorney General or both may appeal the commissioner's decision approving, disapproving or modifying the rate or amount filing to the Superior Court in accordance with the provisions of section 4-183 of the general statutes.

Sec. 4. (NEW) (*Effective January 1, 2011*) (a) If the Insurance Commissioner issues a decision to approve or modify a rate or amount filing made pursuant to section 2 of this act and such decision is no longer subject to any appeal, the filer shall provide written notice to each policyholder or subscriber by first class mail that states (1) the approved rate or amount for the policyholder's policy or subscriber's agreement or contract, (2) any increase in the rate or amount due to the policyholder's or subscriber's age or change in age rating classification, and (3) the percentage increase or decrease of the approved rate from the current rate of the policyholder or subscriber.

(b) No such rate or amount shall be effective until thirty calendar days after the notice has been sent by the filer as set forth in subsection (a) of this section.

Sec. 5. Subsection (a) of section 38a-183 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) A health care center governed by sections 38a-175 to 38a-192, inclusive, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval **[**thereof**]** as set forth in sections 2 and 4 of this act. The commissioner **[**may refuse**]** shall issue such approval only if **[**he**]** the commissioner finds such amounts to be **[**excessive, inadequate or discriminatory**]** reasonable, as set forth in section 2 of this act. Each such health care center shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a

copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any **[**request for an approval of the amounts to be paid, any**]** agreement or any form, notify the health care center of **[**either his**]** said commissioner's approval or disapproval thereof.

Sec. 6. Section 38a-208 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

No such corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscribers and has obtained said commissioner's approval **[**thereof**]** as set forth in sections 2 and 4 of this act. The commissioner **[**may refuse**]** shall issue such approval only if **[**he**]** the commissioner finds such rates to be **[**excessive, inadequate or discriminatory**]** reasonable, as set forth in section 2 of this act. No hospital service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either of his**]** of said commissioner's approval or disapproval thereof.

Sec. 7. Section 38a-218 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

No such medical service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval **[**thereof**]** as set forth in sections 2 and 4 of this act. The commissioner **[**may refuse**]** shall issue such approval only if **[**he**]** the commissioner finds such rates are **[**excessive, inadequate or discriminatory**]** reasonable, as set forth in

section 2 of this act. No such medical service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either of his**]** of said commissioner's approval or disapproval thereof.

Sec. 8. Section 11-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) The State Librarian shall, in the performance of his duties pursuant to section 11-8, consult with the Attorney General, the Probate Court Administrator and the chief executive officers of the Connecticut Town Clerks Association and the Municipal Finance Officers Association of Connecticut, or their duly appointed representatives.

(b) The State Librarian may require each such state agency, or each political subdivision of the state, including each probate district, to inventory all books, records, papers and documents under its jurisdiction and to submit to him for approval retention schedules for all such books, records, papers and documents, or he may undertake such inventories and establish such retention schedules, based on the administrative need of retaining such books, records, papers and documents within agency offices or in suitable records centers. Each agency head, and each local official concerned, shall notify the State Librarian of any changes in the administrative requirements for the retention of any book, record, paper or document subsequent to the approval of retention schedules by the State Librarian.

(c) If the Public Records Administrator and the State Archivist determine that certain books, records, papers and documents which have no further administrative, fiscal or legal usefulness are of historical value to the state, the State Librarian shall direct that they be

transferred to the State Library. If the State Librarian determines that such books, records, papers and documents are of no administrative, fiscal, or legal value, and the Public Records Administrator and State Archivist determine that they are of no historical value to the state, the State Librarian shall approve their disposal, whereupon the head of the state agency or political subdivision shall dispose of them as directed by the State Librarian.

(d) The State Librarian may establish and carry out a program of inventorying, repairing and microcopying for the security of those records of political subdivisions of the state which he determines to have permanent value; and he may provide safe storage for the security of such microcopies of such records.

(e) The State Library Board may transfer any of the books, records, documents, papers, files and reports turned over to the State Librarian pursuant to the provisions of this section and section 11-4c. The State Library Board shall have sole authority to authorize any such transfers. The State Library Board shall adopt regulations pursuant to chapter 54 to carry out the provisions of this subsection.

(f) Each state agency shall cooperate with the State Librarian to carry out the provisions of this section and shall designate an agency employee to serve as the records management liaison officer for this purpose.

(g) Notwithstanding subsections (b) and (c) of this section, the Insurance Department shall retain all records of any rate or amount filings made pursuant to section 2 of this act for not less than seven years after the date such filing was approved, disapproved or modified.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2011*	38a-481

Sec. 2	*January 1, 2011*	New section
Sec. 3	*January 1, 2011*	New section
Sec. 4	*January 1, 2011*	New section
Sec. 5	*January 1, 2011*	38a-183(a)
Sec. 6	*January 1, 2011*	38a-208
Sec. 7	*January 1, 2011*	38a-218
Sec. 8	*January 1, 2011*	11-8a

Statement of Purpose:

To establish procedures for a hearing prior to any rate approval for individual health insurance policies, to authorize the Healthcare Advocate or the Attorney General or both to be a party to any such hearing and to specify the amount of time the Insurance Department is required to retain certain records.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]