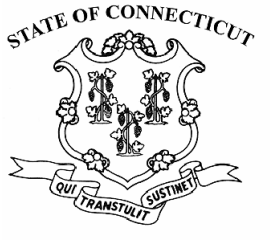

Substitute Senate Bill No. 11

Public Act No. 11-170

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

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

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 Section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(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) (1) 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 ensure that such rates shall not be excessive, inadequate or unfairly discriminatory, as described in section 6 of this act. **[**The**]** Except as specified in subdivision (2) of this subsection, 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.**]**

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

(c) (1) 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.

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 Section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

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

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

(2) Any rate filed under the provisions of subsection (a) of this

section for a small employer group health insurance policy that provides coverage of the type specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38-469 shall be approved in accordance with section 6 of this act.

[(b)**]** (c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which 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.**]**

[(c)**]** (d) Nothing in this chapter shall preclude the issuance of a group 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.

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

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

(a) A health care center governed by sections 38a-175 to 38a-192, inclusive, as amended by this act, 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**]** in accordance with section 6 of this act. The commissioner **[**may refuse such approval if he finds such amounts to**]** shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such amounts shall not be excessive, inadequate or discriminatory, as described in section 6 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. 4. Section 38a-208 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

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**]** in accordance with section 6 of this act. The commissioner **[**may refuse such approval if he finds such rates to**]** shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such amounts shall not be excessive, inadequate or discriminatory, as described in section 6 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. 5. Section 38a-218 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

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**]** in accordance with section 6 of this act. The commissioner **[**may refuse such approval if he finds such rates are**]** shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such amounts shall not be excessive, inadequate or discriminatory, as described in section 6 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. 6. (NEW) (*Effective January 1, 2012*) (a) (1) With respect to a health insurance policy, agreement or contract that provides coverage of the type specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469 of the general statutes, any (A) rate filed for such policy pursuant to section 38a-481 of the general statutes, as amended by this act, (B) rate filed for such policy pursuant to section 38a-513 of the general statutes, as amended by this act, (C) schedule of amounts filed for such agreement pursuant to section 38a-183 of the general statutes,

as amended by this act, (D) schedule of rates filed for such contract pursuant to section 38a-208 of the general statutes, as amended by this act, or (E) schedule of rates filed for such contract pursuant to section 38a-218 of the general statutes, as amended by this act, on or after January 1, 2012, shall be filed not later than one hundred twenty calendar days prior to the proposed effective date of such rates or amounts.

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

(A) On the date the filer submits such rate or amount filing to the Insurance Commissioner, clearly and conspicuously disclose to its insureds or subscribers, in writing and in such form as the commissioner may prescribe: (i) The proposed general rate or amount increase and the dollar amount by which an insured's or subscriber's policy or agreement will increase, including any increase because of the insured's or subscriber's age or change in age rating classification and the percentage increase or decrease of the proposed rate or amount from the current rate or amount; (ii) a statement that the proposed rate or amount is subject to Insurance Department review and approval; and (iii) detailed information on the insured's right to submit public comment to the Insurance Department, including the Internet web site, mailing address and phone number of said department and instructions on how to submit comments to the department; and

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

(3) (A) Notwithstanding the provisions of section 38a-69a of the

general statutes, the Insurance Department shall post on its Internet web site all documents, materials and other information provided to or requested by the department in relation to a rate or amount filing made pursuant to this subsection, including, but not limited to, financial reports, financial statements, actuarial reports and actuarial memoranda. The rate or amount filing and the documents, materials and other information shall be posted not later than three business days after the department receives such filing, and such posting shall be updated to include any correspondence between the department and the filer.

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

(b) Except where a symposium is required under subsection (d) of this section, the commissioner shall issue a written decision approving, disapproving or modifying a rate or amount filing not later than forty-five days after such filing was made. Such decision shall specify all factors used to reach such decision and shall be posted on the Internet web site of the Insurance Department not later than two business days after the commissioner issues such decision.

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

(1) A rate or amount is excessive if it is unreasonably high for the

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

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

(3) A rate or amount 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.

(d) (1) (A) With respect to a health insurance policy, agreement or contract that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, if a rate, schedule of amounts or schedule of rates filed pursuant to subdivision (1) of subsection (a) of this section (i) is for more than a ten per cent increase in such rate or amount, and (ii) the Healthcare Advocate or the Attorney General requests, not later than five business days after such rate or amount filing has been posted on the Internet web site of the Insurance Department, a symposium on such rate or amount filing, the commissioner shall, not later than five business days after the receipt of such request, set a symposium date and post the date, place and time of the symposium in a conspicuous place on the Internet web site of said department. The commissioner shall not be required to hold more than ten symposiums pursuant to this subparagraph in a calendar year.

(B) With respect to a health insurance policy, agreement or contract that provides coverage of the type specified in subdivision (7) of section 38a-469 of the general statutes, if the Healthcare Advocate or the Attorney General requests, not later than five business days after a rate, schedule of amounts or schedule of rates filed pursuant to subdivision (1) of subsection (a) of this section has been posted on the Internet web site of the Insurance Department, a symposium on such rate or amount filing, the commissioner shall, not later than five business days after the receipt of such request, set a symposium date and post the date, place and time of the symposium in a conspicuous place on the Internet web site of said department. The commissioner shall not be required to hold more than five symposiums pursuant to this subparagraph in a calendar year.

(2) (A) Such symposium shall be held not later than ninety calendar days prior to the proposed effective date of such rate or amount, at a place and time that is convenient to the public.

(B) Such symposium shall be conducted in accordance with section 7 of this act and shall not be deemed to be a contested case for purposes of chapter 54 of the general statutes.

(3) Upon setting the date, place and time of the symposium on the proposed rate or amount, the commissioner shall immediately notify the filer of the date, place and time of the symposium.

(4) Not later than thirty calendar days after the symposium, the commissioner shall issue a written decision approving, disapproving or modifying the rate or amount filing. Such decision shall specify all factors used to reach such decision and shall be posted on the Internet web site of the Insurance Department not later than two business days after the commissioner issues such decision.

(5) The provisions of this subsection shall be effective on and after

January 1, 2012, and until December 31, 2013.

(e) (1) If the Insurance Commissioner issues a decision to approve or modify a rate or amount filing made pursuant to subsection (a) of this section, the filer shall provide written notice to each insured or subscriber by first class mail that states (A) the approved rate or amount for the insured's or subscriber's policy or agreement, (B) any increase in the rate or amount due to the insured's or subscriber's age or change in age rating classification, and (C) the percentage increase or decrease of the approved rate from the current rate of the insured or subscriber.

(2) 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 subdivision (1) of this subsection or the effective date proposed under subdivision (1) of subsection (a) of this section, whichever is later.

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

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

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

Sec. 7. (NEW) (*Effective January 1, 2012*) (a) Each symposium held pursuant to section 6 of this act shall include an opportunity for public participation. The Healthcare Advocate or the Attorney General, or both, shall be allowed to present evidence and information at such symposium and each shall be allowed to present a closing argument in support of his or her position.

(b) The Insurance Commissioner shall assist the Healthcare Advocate or the Attorney General, or both, to obtain from the Insurance Department or the filer documents or materials related to the subject matter of the filing that are not readily available from the Insurance Department's Internet web site, provided such documents or materials are not confidential or prohibited to be disclosed by law.

(c) In making a decision to approve, disapprove or modify a rate or amount filing made pursuant to subsection (a) of this section, the commissioner shall consider any oral and written comments made or submitted at such symposium and any written public comments submitted pursuant to subparagraph (B) of subdivision (3) of subsection (a) of section 6 of this act.

(d) The provisions of this section shall be effective on and after January 1, 2012, and until December 31, 2013.

Sec. 8. (NEW) (*Effective January 1, 2012*) Not later than January thirty-first, annually, the Insurance Department shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance that lists all rates filed pursuant to section 38a-481 or 38a-513 of the general statutes, as amended by this act, schedule of amounts filed pursuant to section

38a-183 of the general statutes, as amended by this act, and schedule of rates filed pursuant to section 38a-208 or 38a-218 of the general statutes, as amended by this act, for health insurance policies, agreements or contracts that provide coverage of the type specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469 of the general statutes, in the calendar year immediately preceding. Such report shall include the name of the filer, the per cent increase or decrease of such rate of amount filing, the per cent increase or decrease approved by the Insurance Department, the market segment and the product type.

Sec. 9. Section 7 of public act 11-6 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The following sums are appropriated from the INSURANCE FUND for the annual periods indicated for the purposes described.

	2011-2012	2012-2013
GENERAL GOVERNMENT		
OFFICE OF POLICY AND MANAGEMENT		
Personal Services	$219,888	$212,322
Other Expenses	500	500
Equipment	2,250	0
Fringe Benefits	147,018	146,503
AGENCY TOTAL	369,656	359,325
REGULATION AND PROTECTION		
INSURANCE DEPARTMENT		
Personal Services	**[**13,445,665**]** 13,543,665	**[**12,996,951**]** 13,094,951
Other Expenses	**[**2,022,453**]** 2,047,453	**[**2,022,453**]** 2,047,453
Equipment	40,060	40,060

Fringe Benefits	[8,715,295] 8,774,095	[8,699,254] 8,758,054
Indirect Overhead	58,043	59,842
AGENCY TOTAL	[24,281,516] 24,463,316	[23,818,560] 24,000,360
OFFICE OF THE HEALTHCARE ADVOCATE		
Personal Services	746,398	725,540
Other Expenses	136,373	136,374
Equipment	1,400	700
Fringe Benefits	493,954	495,294
Indirect Overhead	117,320	120,957
AGENCY TOTAL	1,495,445	1,478,865
HUMAN SERVICES		
DEPARTMENT OF SOCIAL SERVICES		
Other Expenses	475,000	475,000
TOTAL - INSURANCE FUND	[26,621,617] 26,803,417	[26,131,750] 26,313,550

Vetoed July 1, 2011