Senate

General Assembly

File No. 203

January Session, 2011

Substitute Senate Bill No. 11

Senate, March 24, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

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 Section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):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

(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 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.

(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 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 July 1, 2011*):

(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 July 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**]** 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 July 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**]** 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 July 1, 2011*) (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 July 1, 2011, 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) information on the insured's right to submit public comment as set forth in this section; 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 defined 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 hearing 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) If a rate, schedule of amounts or schedule of rates filed pursuant to subdivision (1) of subsection (a) of this section is for more than a ten per cent increase in such rate or amount, not later than five business days after such rate or amount filing has been posted on the Internet web site of the Insurance Department, the commissioner shall set a hearing date on such rate or amount filing and post the date, place and time of the hearing in a conspicuous place on the Internet web site of the department.

(2) Such hearing shall be (A) 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, and (B) conducted in accordance with chapter 54 of the general statutes, this section and section 7 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.

(4) Not later than thirty calendar days after the hearing, 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.

(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.

(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.

Sec. 7. (NEW) (*Effective July 1, 2011*) (a) Notwithstanding the provisions of sections 4-176 and 4-177a of the general statutes, the Healthcare Advocate or the Attorney General, or both, may be parties to any hearing held pursuant to section 6 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 6 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 6 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.

Sec. 8. Section 11-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 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 the provisions of subsections (b) and (c) of this section, the Insurance Department shall retain all records of any rate or amount filing made pursuant to section 6 of this act for not less than seven years after such filing was approved, disapproved or modified.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2011*	38a-481
Sec. 2	*July 1, 2011*	38a-513
Sec. 3	*July 1, 2011*	38a-183(a)
Sec. 4	*July 1, 2011*	38a-208
Sec. 5	*July 1, 2011*	38a-218
Sec. 6	*July 1, 2011*	New section
Sec. 7	*July 1, 2011*	New section
Sec. 8	*July 1, 2011*	11-8a

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
Insurance Dept.	IF - Cost	2,245,000	2,245,000

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

This bill is estimated to result in costs of approximately $2.245 million annually associated with establishing a new rate approval process for certain health insurance policies. This will result in additional annual cost for staffing, outside hearing officers, and transcription expenses. The extent of these costs will be dependent upon the number of additional reviews that must be performed by the Insurance Department, as well as the number of public hearings that must be held.

The total additional staff necessary to implement this bill is 7.5 full time equivalent positions, at a cost of $1.03 million, including fringe benefits[1]. This assumes 30 additional rate reviews annually, as well as 102 public hearings, as detailed in the footnote. The estimate of 102 hearings is based on the average number of rate filings in 2009 and 2010 that exceeded the 10% rate increase trigger (72), plus an additional 30 new filings that are required by the bill.

In addition to the two additional staff assumed above for internal hearing offices, it is estimated that 40 of the 102 hearings will require the contracting of outside counsel. Assuming a total of 60 hours per hearing at a contracted rate of $400 per hour, this will result in an additional $960,000 annually.

The Department of Insurance will also incur an additional cost per hearing for transcription services. Assuming a cost of $2,500 per hearing, this will result in costs of $255,000 annually.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

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	FTE	Annual Sal.	Subtotal	Fringe %	Totals
Actuarial Rate Review - Estimated 30 additional rate reviews, at 15 hours per rate review, for Group Indemnity Authority	0.25	99,559	$ 24,890	* 1.60	$ 39,824
Actuarial Rate Hearing Activities -Estimated 102 hearings, hearing prep, hearing, post hearing activities	0.75	99,559	$ 74,669	* 1.60	$ 119,471
Legal Rate Hearing Activities - Estimated 102 Hearings, Counsel to Hearing Officer, Counsel to Commissioner and Actuarial Staff; hearing prep, hearing, post hearing activities	3.00	77,057	$ 231,171	* 1.60	$ 369,874
Internal Hearing Officers - Estimated 62 Hearings, will use outside staff below in Section II for an estimated 40 Hearings, Pre and Post Hearing Activities, preside at hearing	2.00	99,559	$ 199,118	* 1.60	$ 318,589
IT Support - Technology support for hearing	0.50	72,022	$ 36,011	* 1.60	$ 57,618
Consumer Affairs - handle increased consumer complaints following public notice	1.00	77,796	$ 77,796	* 1.60	$ 124,474

OLR Bill Analysis

sSB 11

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

SUMMARY:

This bill establishes a new rate approval process for individual and group health insurance companies, HMOs, and hospital and medical service corporations. The bill:

1. requires group health insurers to file risk classifications and premium rates with the insurance commissioner;

2. increases the amount of time required before a new rate can go into effect;

3. requires the Insurance Department to post rate filings on its website and provide a 30-day public comment period;

4. requires a public hearing on a proposed rate filing if specified criteria are met and allows the healthcare advocate and attorney general to be parties to such a hearing;

5. establishes disclosure and record retention requirements for rate filings; and

6. requires the insurance commissioner to adopt regulations to prescribe standards to ensure that group, HMO, and hospital and medical service corporation rates are not excessive, inadequate, or discriminatory (he must currently do this for individual health insurance rates).

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

EFFECTIVE DATE: July 1, 2011

RATE APPROVAL PROCESS

Applicability

The bill applies to any rate filed by an HMO, hospital or medical service corporation, or an individual or group health insurer that issues policies covering (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, (4) hospital or medical services, or (5) long-term care.

Current law does not require group health insurers to obtain rate approval from the insurance commissioner (see BACKGROUND).

Process

Starting July 1, 2011, the bill 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.

Unless a hearing is required on the filing (see below), the commissioner must issue a written decision approving, modifying, or disapproving a rate filing within 45 days after receiving it. 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 bill 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 of the proposed rate from the current rate;

2. a statement that the proposed rate or amount is subject to department review and approval; and

3. information on the person's right to submit public comment.

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 of the approved rate from the person's current rate.

The bill prohibits a new rate from taking effect until 30 days after the notice has been sent.

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 bill 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.

Excessive, Inadequate, Unfairly Discriminatory

By law, rates may not be excessive, inadequate, or unfairly discriminatory and the commissioner must adopt regulations to prescribe standards to ensure that individual health insurance rates comply with this requirement. The bill deletes a provision of current law 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.

Instead the bill defines an "excessive" rate as one that 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;
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 bill expands the regulatory authority to include standards for group, HMO, and hospital and medical service corporation rates.

Public Hearing Required for Certain Rate Filings

Under the bill, the commissioner must hold a public hearing when any entity files a rate increase of more than 10%. The commissioner must, within five days of the rate filing's posting on the department's website, set a hearing date and conspicuously post on the department's website the date, place, and time of the hearing. The bill requires the hearing 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 law. The commissioner must immediately notify the filer of the hearing date, place, and time.

The commissioner must, within 30 days after the hearing, issue a written 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 after issuance.

Healthcare Advocate and Attorney General

The bill authorizes the healthcare advocate, the attorney general, or both, to be a party to any rate filing hearing.

It grants these officials access to the department's rate filing records. Department attorneys, actuaries, accountants, and other experts who review or assist in the determination of a rate filing must cooperate with the officials.

The officials may (1) summon and examine under oath witnesses either deems necessary to the rate filing review and (2) require the

filer, or any holding or parent company or subsidiary, to produce books, vouchers, memoranda, papers, letters, contracts, and other documents. Such material must be limited to information or transactions between the filer and the holding or parent company or subsidiary that are reasonably related to the filing.

Record Retention

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

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

BACKGROUND

Rate Approval Process

The law requires individual health insurers (including those providing long-term care coverage), HMOs, and hospital and medical service corporations to file proposed premium rates with the insurance commissioner for review and approval. Rates may not be excessive, inadequate, or unfairly discriminatory. For individual health insurance, rates are 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 has to approve or disapprove rates within a reasonable time. The law does not specify a time frame by which the commissioner has to approve individual long-term care insurance rates, but does require such insurance policies to maintain a 60% minimum loss ratio.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 10 Nay 7 (03/10/2011)