



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

**BULLETIN NO. HC-81-20A
MAY 11, 2020**

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: HEALTH INSURANCE RATE FILING SUBMISSION GUIDELINES

[NOTE – This Bulletin is being issued (repealing and replacing Bulletin No. HC-81-20) to remove the demonstration of compliance with non-quantitative treatment limitations (NQTLs). Such demonstration of compliance was a new requirement for rate filing submissions made to the Insurance Department and has been removed due to the public health emergency posed by COVID-19. In addition, pursuant to PA 19-159 (Conn. Gen. Stat. §38a-477ee) information concerning NQTLs is required to be provided to the Department not later than March 1, 2021, and annually thereafter and requiring this information as part of the rate filing process was deemed duplicative.]

This notice sets forth the requirements for all rate filing submissions made to the Insurance Department (Department) pursuant to sections 38a-183, 38a-208, 38a-218 and 38a-481 of the Connecticut General Statutes. All rate filings, including small group indemnity rate filings, must be filed with the Department pursuant to the requirements of the rate review regulations promulgated by the US Department of Health and Human Services (HHS) pursuant to the Patient and Protection Act, P.L. 111-148, as amended (PPACA). A rate filing must accompany the forms approved by HHS to report unreasonable rate increases and will serve as the basis to determine if the unreasonable rates are justified. In accordance with the HHS final regulations at 45 CFR, Part 154, the company must provide a preliminary justification that consists of a Rate Increase Summary (Part I) and a written description justifying the rate increase (Part II) that is consistent with 45 CFR §154.215.

Filing Requirements

While multiple market segments can be filed in one rate filing submission, the Department requests that the carrier include separate filings for each market segment (individual, small group and large group) that comply with the following information to assist the Department in its actuarial review:

- A cover letter describing all policy forms affected by the requested rate change as well as the effective date of the requested rate change.

- Historical experience from inception-to-date, this includes earned premium, paid claims, incurred claims, members, actual loss ratios and expected loss ratios (annual experience is appropriate for all years; monthly experience for the most recent two years).
- A demonstration that the experience data submitted is consistent with the most recent financial statement filed with the Department pursuant to section 38a-53a of the Connecticut General Statutes.
- Unit cost trend by broad service category, including actual unit cost data and impact of provider contract changes from experience period to rating period (medical and prescription drug separately).
- Utilization trend by broad service category, including actual utilization data.
- Impact of cost sharing leverage on trend.
- Medical technology trend.
- Benefit buy-down analysis and impact on trend.
- Cost of each new benefit mandate or requirement due to change in law, separately identified, from the experience period to the rating period. This includes requirements of both state and federal law.
- A comparison of the proposed retention charge in the filing to the most recently filed statutory financial statement for the regulated entity for which this filing is being made.
- Claim lag triangles (separate triangles for medical vs. Rx)
- The current capital and surplus for the regulated entity for which this filing is being made.
- A demonstration that the increase requested in this rate filing will generate an expected medical loss ratio, for rebate purposes, that is consistent with the 80% prescribed by the federal law for individual health insurance and small group or 85% for large group, whichever applies to this rate filing.
- Actuarial certification signed by a Member of the American Academy of Actuaries (MAAA).
- Any additional information the Commissioner deems necessary for the review of rates.

Carriers filing individual or small group rates must identify all estimates of which they are aware, of the risk adjustment transfer amount (paid or received) for the previous rating year. This should include the date of all estimates received, the source of those estimates, and the actual pmpm amounts. In addition, provide the risk adjustment transfer amounts by market segment scheduled to be published by the Center for Consumer Information & Insurance Oversight (CCIIO) in June of each year, as well as the most recent Risk Adjustment Data Validation (RADV) transfer amounts. Explain any difference between the risk adjustment used in pricing and the latest published from CCIIO. Please note the risk adjustments in the CCIIO report have already been reduced by the administrative expense of 14%.

All rate filings must be submitted via the National Association of Insurance Commissioners System for Electronic Rate and Form Filings (SERFF). All fields in SERFF added for reporting requirements to HHS in accordance with PPACA must be populated. Incomplete submissions may be rejected. In addition, carriers should submit the Uniform Rate Review Template (URRT), the Part III Actuarial Memorandum and the HIOS rate tables in a PDF format.

Carriers should also provide a summary of benefits for each plan design along with the Actuarial Value calculator output that confirms compliance with the corresponding metal tier. Indicate the HIOS plan ID and the corresponding plan name on the summary of benefits for each plan.

Any changes submitted after the initial filing should include a red-lined version as well as a clean copy to facilitate the review.

For new products other than policies subject to the requirements of PPACA, the rates should be filed with the form filing in one submission using the Filing Type FORM/RATE. Policies subject to PPACA should file separate submissions for form and rate filings for new products or amendments. Rate increases should be filed as a separate rate filing submission for all products.

Every rate filing submission that includes an increase of previously approved rates shall include a summary of the rate increases requested and should be clearly marked as Appendix A. The appendix should include the following, but not be limited to:

- For Small Group Filings, the overall requested increase should be stated as the average annual increase across all quarters of the new rate year and not limited to the annual increase from Quarter 1 of the previous rate year to Quarter 1 of the new rate year.
- The requested increase for each plan contained within the rate filing and the effective date of those proposed rate increases. The requested increase for each plan should be identified as a specific percent increase.
- Number of covered individuals for each product; number of covered policyholders; minimum current premium on a per member per month (pmpm) basis; minimum proposed premium on a pmpm basis; maximum current premium on a pmpm basis; maximum proposed premium on a pmpm basis and the percentage change.
- Each component of the increase including trend, experience adjustments and any other factors that are a component of the requested increase. These can be identified as a specific percent or if appropriate a percent range.
- A footnote listing any other factors that can have an impact on premium rates that have not been specifically identified in the appendix, including but not limited to age bands, gender, geographic area, smoking, etc.
- A summary statement on age bands, geographic area factors and/or smoking factors; specifically if they have changed or remain the same since the last approved filing.

Annual Certifications to be Included as Part of the Rate Filing

Carriers must provide a demonstration of compliance with mental health parity for each plan that utilizes varying copays within a service category as allowed in Bulletin HC-124. The Final Rules under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (45 CFR Part 146 and 147) provide tests for determining "substantially all" and "predominant" medical/surgical benefits for reviewing the financial requirements and quantitative treatment limitations. Carriers must include demonstrations that each plan utilizing varying copays meets the substantially all and predominant tests. Such demonstration must also include a certification of compliance with mental health parity signed by a member of the American Academy of Actuaries. After the initial approval, such demonstration and certification must be made annually.

Any carrier that substitutes a non-dollar limit on an essential health benefit as permitted by PPACA must file a certification and demonstration that such substitution is actuarially justified.

Transparency

Pursuant to Conn. Gen. Stat. §1-210(b)(5)(B), the Connecticut Freedom of Information Act does not provide for an exemption for commercial or financial information that is required by statute. The information identified above as being required to enable the Department to fulfill its statutory rate review requirement is considered to be information required by statute and therefore, the Department will not grant any requests to hold these filings as confidential. Complete filings including all correspondence and documentation will be posted on the Department website and available for review and comment by the public. All public comments will be reviewed by the Department.

Questions

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any questions.



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Insurance Commissioner