STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-81-14
MARCH 10, 2014

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

SUBJECT: HEALTH INSURANCE RATE FILING SUBMISSION GUIDELINES -2014

The purpose of this bulletin is to identify 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 as well as the rate filings, including small group indemnity rate filings, that 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 Subtitle A, Subchapter B, 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 utilization data.
- Impact of cost sharing leverage on trend.

- Utilization trend by broad service category, including 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 list of each component of PPACA that impacted premium and the actual impact used in pricing for each component
- 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
- 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.

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 (see attached example). Indicate the HIOS plan ID and the corresponding plan name on the summary of benefits for each plan.

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:

- The requested increase for each product contained within the rate filing and the effective date of those proposed rate increases. The requested increase for each product should be identified as a specific percent increase or if appropriate a range of percent increases with an explanation of what the variance is that produces the range.
- 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.

Annual Certifications to be Included as Part of the Rate Filing

Any carrier that files products that have a copay for a mental health office visit set at the specialist copay level must file an annual certification and demonstration of compliance with mental health parity in accordance with Bulletin HC-87 Allowable Office Visit Copayments For Mental Health Services To Comply With Mental Health Parity.

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 and considered as an additional element of the review determination.

Questions

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

Thomas B. Leonardi
Insurance Commissioner

Summary of Benefits Covered

CONNECTICUT

Catastrophic plan

SUMMARY OF FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible Individual Family	 $6,350 $12,700	 $12,700 $25,400
Coinsurance (Member responsibility)	0% ($0 once out-of-pocket max is satisfied)	50% ($0 once out-of-pocket max is satisfied)
Out-of-Pocket Maximum Individual Family	 $6,350 $12,700 (all cost sharing accumulates to the Out-of-Pocket maximum above)	 $15,000 $30,000 (all cost sharing accumulates to the Out-of-Pocket maximum above)
Primary Care Visit to Treat an Injury or Illness (excludes preventive and X-rays	$20 ded waived/visits 1-3 0% after deductible	50% after deductible
Specialist Visit	0% after deductible	50% after deductible
All Inpatient Hospital services (includes Mental/Behavioral Health and Substance Abuse)	0% after deductible	50% after deductible
Emergency Room Services	0% after deductible	Paid as in-network
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	0% after deductible	50% after deductible
Imaging (CT/PET Scans, MRIs)	0% after deductible	50% after deductible
Rehabilitative Speech Therapy	0% after deductible	50% after deductible
Rehabilitative Occupational & Rehabilitative Physical Therapy	0% after deductible	50% after deductible
Preventive Care/Screening/Immunization	0%	50% after deductible
Laboratory Outpatient & Professional Services	0% after deductible	50% after deductible
X-rays and Diagnostic Imaging	0% after deductible	50% after deductible
Skilled Nursing Facility	0% after deductible	50% after deductible
Outpatient Facility Fee (e.g., ambulatory surgery center)	0% after deductible	50% after deductible
Outpatient Surgery Physician/Surgical Services	0% after deductible	50% after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Deductible Individual Family	 Integrated with medical Integrated with medical	 Integrated with medical Integrated with medical
Generics	0% after deductible	50% after deductible
Preferred Brand Drugs	0% after deductible	50% after deductible
Non-Preferred Brand Drugs	0% after deductible	50% after deductible
Specialty Drugs (i.e. high-cost)	0% after deductible	50% after deductible

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
ırate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		$6,350.00			
		100.00%			
		$6,350.00			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$20.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
nary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	60.2%
Metal Tier:	Bronze

This product atisfies the HHS guidelines for a Bronze plan with an Actuarial Value of 60.2%