STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-81
OCTOBER 7, 2010

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

The purpose of this bulletin is to identify requirements for all rate filing submissions made to the Insurance Department whether the filing is made via paper or SERFF. These requirements apply to all rate filing submissions made pursuant to sections 38a-183, 38a-208, 38a-218 and 38a-481 of the Connecticut General Statutes. In addition, these requirements will also apply to rate filings that must be submitted with the filing of unreasonable premium increases pursuant to the Patient Protection and Affordable Care Act. A rate filing must accompany the form approved by the Department of Health and Human Services to report unreasonable rate increases and will serve as the basis to determine if the unreasonable rates are justified. 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 increase as well as the effective date of the requested increase.
- 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.
- 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 the health care reform bill 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
- 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.

In addition, 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. 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.
- Each component of the increase including trend, experience adjustments and any other factors that make up 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.

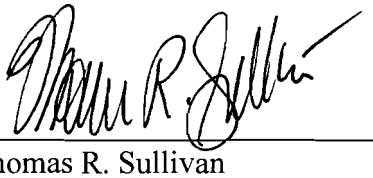
Transparency

It has been the practice for insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers to claim trade secret exemptions under the Connecticut Freedom of Information Act ("FOIA") and request that the Department hold all rate and subscriber fee filings as confidential information not available to the public. Pursuant to Conn. Gen. Stat. §1-210(b)(5)(B), FOIA does not provide for an exemption for commercial or financial information which 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. As soon as the technical revisions to the Department website are completed, all filings will be posted on the Department website and available for review by the public. In addition, all communications between the filing entity and the Department will be documented and included in the website postings.

The technical revisions to the website will also include capabilities for the public to comment on the rate and subscriber fee requests. Those public comments will be reviewed by the Department and considered as an additional element of the prior review determination.

Questions

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



Thomas R. Sullivan
Insurance Commissioner