

Form and Rate Filings for Health Insurance in Connecticut

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Form Filing Authority

- All life and health policy forms are required to be filed for prior approval
- Products should not be marketed until forms and rates (if applicable) are approved
- We encourage amendatory riders or endorsements for new mandates to facilitate the review process
- All statutes, regulations and bulletins that govern filings are on the Department website at www.ct.gov/cid

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Rate Filing Authority

- Life and annuity rates are not required to be filed
- Most group health rates are not required to be filed
 - Rates for health care centers (HMOs) must be filed for prior approval
 - Long term care rates must be filed and are subject to disapproval authority
- All individual health rates are required to be filed
 - Long term care rates are subject to prior approval
 - Rates for health care centers (HMOs) are subject to prior approval
 - Medicare supplement rate increases are subject to a rate hearing process and prior approval
 - Most other products are subject to a 30 day deemer
- CT has no statutory loss ratio requirements except for long term care and Medicare supplement products
- The statutory standard for rate approval is that rates shall not be excessive, inadequate, or unfairly discriminatory

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Life and Health Division

- The Life and Health Division reviews all forms for life and health products
- There are 5 examiners, one actuary and a program manager with oversight for managed care
- The current backlog runs approximately 1 ½ months for life and 2 ½ months for health products
- Priority is given to domiciled companies

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Types of Health Insurance

C.G.S. §38a-469 defines health insurance as:

1. Basic hospital expense coverage
2. Basic medical-surgical expense coverage
3. Hospital confinement indemnity coverage
4. Major medical expense coverage
5. Disability income protection coverage
6. Accident only coverage
7. Long term care coverage
8. Specified accident coverage
9. Medicare supplement coverage
10. Limited benefit health coverage
11. Hospital or medical service plan contract
12. Hospital and medical coverage provided by a health care center
13. Specified disease coverage
14. TriCare supplement coverage

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Types of Health Insurance continued

- Forms filed must fit into one of the categories
- Combination health policies may be filed, but must meet the minimum requirements of each type of health insurance
- Combination life and health policies are also permitted providing all requirements of each type of coverage are met
- Two new categories of health insurance were added in recent implementer legislation
 - Travel Insurance
 - Single service ancillary health coverage including but not limited to dental, vision, prescription drug coverage

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Mandates

INDIVIDUAL	GROUP	SUBJECT	COV TYPE (*)
38a-476	38a-476	Pre-Existing Condition Waiver	1,2,4,11 & 12
38a-477b	38a-477b	Post-claims underwriting	1,2,4,6,10,11 & 12
38a-482a	38a-513c	Medical necessity	1,2,4,6,10,11 & 12
38a-482b	38a-513d	Regulating limited benefit medical plans	1,2,4,11 & 12
38a-483c	38a-513b	Experimental Treatments	All
38a-486a	38a-514	Benefits for Mental Stress	1,2,4,11 & 12
38a-486b	38a-514b	Coverage for Autism Spectrum Disorder	1,2,4,11 & 12
38a-489	38a-515	Continuation for Mentally or Physically Handicapped Children	1,2,4,6,11,12 & 10 for 1
38a-490	38a-516	Newborn Infants	1,2,4,6,11,12 & 10 for 1
38a-490a	38a-516a	Birth-To-Three Program (Early Intervention Services)	1,2,4,11 & 13
38a-490b	38a-516b	Hearing Aids for Children 12 and Younger	1,2,4,11 & 12
38a-490c	38a-516c	Craniofacial Disorders	1,2,4,11 & 12
38a-491a	38a-517a	Coverage for In-patient Dental	1,2,4,11 & 12

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Mandates continued

38a-492	38a-518	Accidental Ingestion of a Controlled Drug	1,2,4,6,11 & 10 for 1
38a-492a	38a-518a	Coverage for Hypodermic Needles and Syringes	1,2,4,6,10,11 & 12
38a-492b	38a-518b	Cancer Drugs Not to be Excluded	All
38a-492c	38a-518c	Coverage for Prescription Foods/Formulas	1,2,4,6,11 & 12
38a-492d	38a-518d	Coverage for Diabetes	1,2,4, 11 & 12
38a-492e	38a-518e	Diabetes Outpatient Self Management Training	1,2,4, 11 & 12
38a-492f	38a-518f	Screening for Prostate Cancer	1,2,4, 11 & 12
38a-492h	38a-518h	Lyme Disease Treatment	1,2,4, 11 & 12
38a-492i	38a-518i	Pain Management	1,2,4,10, 11 & 12
38a-492j	38a-518j	Cosmetic Appliances and Supplies	1,2,4, 11 & 12
38a-492k	38a-518k	Colorectal Cancer Screening	1,2,4,11 & 12
38a-492l	38a-518l	Developmental Needs of Children & Youth with Cancer	1,2,4,11 & 12
38a-493	38a-520	Home Health Care	1,2,4,6,11,12 & 10 for 1
38a-497	38a-554	Definition Of dependent child to 26	1,2,4,6,11,12 & 10 for 1

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Mandates continued

38a-497	38a-554	Definition Of dependent child to 26	1,2,4,6,11,12 & 10 for 1
38a-498	38a-525	Ambulance Service	1,2,4,11,12 & 6, 10 for 1
38a-498b	38a-525b	Extend isolation & emergency services to mobile field hospitals	All
38a-498c	38a-525c	Health Care Services to Residents with Elevated Blood Alcohol Levels	1,2,4,11,12 & 6, 10 for 1
38a-503	38a-530	Mammography/Breast Cancer Screening	1,2,4,11,12 & 6, 10 for 1
38a-503a	38a-530a	Maternity Care & Postpartum Care (48/96 hours)	1,2,4,6,10,11 & 12
38a-503b	38a-530b	Maximectomy or Lymph Node Dissection (48 hours)	1,2,4,10,11 & 12
38a-503c	38a-530c	Prescription Birth Control	1,2,4,11 & 12
38a-503d	38a-530d	Preventive Pediatric Care	1,2,4,6,11 & 12
38a-490d	38a-535(b)	Blood screening added to preventive pediatric	1,2,4,11 & 12
38a-537		Notice of Cancellation of Group Coverage	All
38a-541		Policy to Allow Spouse Coverage as Both Dependent and Employee	All
38a-504	38a-542	Tumor and Lymphatic/Breast Implant Removal & Reconstruction	1,2,4,11,12 & 10 for 1

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Mandates continued

38a-504a-q	38a-542a-q	Cancer Clinical Trials	1, 2, 4, 11 & 12
38a-504d	38a-542d	ODN facility during treatment in a clinical trials	1, 2, 4, 11 & 12
	38a-543	Age Discrimination-Small Group less than 20 Employees	1, 2, 4, 11 & 12
	38a-546	Continuation of Coverage	1, 2, 3, 4, 11 & 12
38a-508	38a-549	Coverage for Prospective Adoptive Children	1, 2, 4, 6, 10, 11 & 12
38a-509	38a-536	Infertility Treatment & Procedures	1, 2, 4, 11 & 12
38a-510	38a-544	Prescription Drug- mail order prohibition	All
38a-511	38a-550	Access to Imaging Services	All
	38a-544	Continuation, Extension & Conversion Rights	1, 2, 3, 4, 11 & 12
	38a-513(d)	Group specified disease benefit	1, 2, 4, 11, 12 & 13
PA02-42	PA02-42	Communication of mammographic breast density information to patients	1, 2, 4, 11 & 12, 6 & 10 for Ind.
PA02-45	PA02-45	Adverse determinations of external appeals	All
PA02-01	PA02-01	Requiring coverage for wound care for individuals with epidermolysis bullosa	1, 2, 4, 11 & 12
PA02-511		Revision of autism spectrum disorder benefits	1, 2, 4, 11 & 12

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Content of Rate Filings

- The statutory language requires that "rates" be filed
- Rather than file actual rates for each product, base rates and factor tables may be filed
- The Department requires supporting documentation to be filed so an actuarial analysis can be completed:
 - Detailed development of revenue requirements including cost and utilization assumptions
 - Identification of all demographic adjustments and all factors used in rating
 - Trend assumptions and development
 - Past claims experience (state specific and nationwide)
 - Enrollment data
 - Experience rating methodology where allowed and used
 - Development of administrative expense load

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Rate Filings Documents

- Rate filings including any factors needed to match rates are available for public inspection
- To be exempt from the Freedom of Information Act, the information must be considered trade secret, must not be required to be filed and must be marked as confidential
- Since the pricing assumptions (cost, utilization, etc.) are not required by statute, carriers have been allowed to mark these documents as confidential
- Carriers file a separate public copy that removes the confidential information

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Recent legislation

- New mandates:
Effective 1/1/09:
 - Expanded coverage for autism spectrum disorder
 - Coverage for wound care for individuals with epidermolysis bullosa
 - Prohibition to deny refills of eye drops within 30 days
- Effective from passage:
 - Coverage for step children
 - Increased benefit levels for coverage in the Birth to Three program
- Carriers are prohibited from using the history of prescription drugs for anxiety for six months or less as an underwriting tool unless the history is based on a diagnosis of an underlying condition
- Employers may stop health insurance coverage 72 hours after an employee terminates employment if notice is provided to the insurance carrier; the carrier must provide a pro-rata refund and the employer is responsible to refund any employee contribution

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Recent legislation continued

- The Insurance Department is required to contract with the University of Connecticut to conduct a review of mandated health benefits
 - The law requires all existing mandates to be reviewed as well as those requested by the legislature
 - The Department is currently working with UCONN to conduct a study on seven mandates that may be introduced by the legislature during the next session
 - The study entails:
 - cost
 - social impact
 - impact on other benefits
 - availability of the service
 - level of public demand
 - expected changes in utilization

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Recent legislation continued

- Public Act 09-49 revises the current external appeals process
 - Adds an expedited appeal process
 - Adopts standards for the selection of contracted entities
- Public Act 09-13 redefines marriage to include same sex couples and transforms same sex civil unions to marriage
- Public Act 09-204 sets standards for access to provider fee information and changes made to provider contracts
- Public Act 09-148 creates the Sustinet Plan
 - The purpose is to create a self-insured universal health care plan
 - 9 member board must make a legislative recommendation by January 1, 2011

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Possible Legislation in 2010

- There are several mandates under consideration that did not make it this year
 - Expanded coverage for ostomy appliances and supplies
 - Coverage for prosthetic devices
 - Expanded coverage for hearing aids to age 18
 - Expanded coverage for wigs for alopecia
 - Coverage for donor match testing for bone marrow transplants
 - Expanded coverage for colonoscopies
 - Mandate for wellness incentives

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Possible legislation continued

- Rate hearings may be required for all rate increase requests for individual health insurance
 - There is a desire to provide a role for the public in the rate review process
 - The statutory standard for rate approval may be modified
 - The Attorney General and the Health Care Advocate want affordability to be a factor in the determination of any rate increase
 - Pricing assumptions may be required to be public information

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