# STATE OF CONNECTICUT

*INSURANCE DEPARTMENT*

**BULLETIN NO. HC-81-25**
**April 29, 2025**

**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**

This Bulletin 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. Carriers must file all rate filings, including small group indemnity rate filings, with the Department in accordance with 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 be accompanied by the forms approved by HHS, the information contained in such forms will serve as the basis to determine if any unreasonable rates are justified. In accordance with the HHS final regulations at 45 CFR, Part 154, each carrier 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.

**Enhanced federal subsidies under the 2021 American Rescue Plan Act ("ARPA")**

Under ARPA, the premium subsidies as well as the income levels eligible for subsidies in the individual ON-Exchange plans under the PPACA were increased. These enhancements are set to expire at the end of 2025. For Individual plans that participate on the State Based Exchange (Access Health CT), carriers must submit their filings for 2026 Rates with the assumption that the subsidies will be extended through 2026. Due to the uncertainty of the enhancements extension, carriers must also provide an adjustment factor to be applied to experience claims that would be appropriate if the enhancements are not extended. This adjustment, the full actuarial justification, as well as the impact of this change on premium shall be provided within the Actuarial Memorandum.

## Office of Health Strategy – Cost Growth Benchmark

The Office of Health Strategy created a per annum rate-of-growth Cost Growth Benchmark ("Benchmark") for health care spending for calendar years 2021 through 2025, which uses a weighting of the growth in Connecticut Potential Gross State Product and the growth in Connecticut Median Income. The updates on the Benchmark for calendar years 2026-2030 is currently underway. The Department will consider the Benchmark along with all other factors when performing its review of rate filings submitted in accordance with this Bulletin.

## Filing Requirements

While carriers may file multiple market segments (i.e., individual, small group and large group) in one rate filing submission, carriers must include separate filings for each market segment that include the following 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 for each filing. This includes earned premium, paid claims, incurred claims, members, actual loss ratios and expected loss ratios (annual experience for all years; monthly experience for the most recent two years).

- A demonstration that the experience data submitted is consistent with the carrier's 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 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 carrier's most recently filed statutory financial statement.

- Claim lag triangles (separate triangles for medical vs. prescription drug).

- The current capital and surplus for the carrier.

- 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).

Carriers shall also provide any additional information the Commissioner deems necessary for the review of rates.

In addition, for carriers filing individual and small group rates subject to PPACA, such carriers shall provide the following to assist the Department in its actuarial review:

- Identification of all known estimates of the risk adjustment transfer amount (paid or received) for the previous rating year. This shall include the date of all estimates received, the source of those estimates, and the details for all of the components included in company's filing including risk adjustment transfer, high-cost risk pool, etc. in per member per month ("PMPM") amounts. Carriers must explain any difference between the known estimates of risk adjustment and what is used as the projection for the pricing period.

    - Note: The Department will consider the 2025 Centers for Medicare & Medicaid Services ("CMS") report on Benefit Year 2024 in its review. In addition, the Department may consider the most recent CMS determined Risk Adjustment Data Validation in the 2026 Risk Adjustment estimate. Please note the risk adjustments in the Center for Consumer Information and Insurance Oversight report have already been reduced by the administrative expense of 14%.

- A one-page rate buildup that starts with the experience period claims and show all adjustments that lead to the proposed year's premium. Include a clear statement on whether the baseline experience is on the allowed basis or the paid basis. Include a clear statement on how any pharmacy rebate is determined for the projection period. For all adjustments, provide detailed actuarial justification in the Actuarial Memorandum or in the supporting documents. Show the prior year's premium, and the ratio of proposed to prior should be equal to the average increase requested or an explanation provided. For small group filings, show all quarters and annual average for both prior and proposed. If some supporting exhibits in the carrier's memorandum contain some of the build-up steps by plan, please provide the overall total so the Department can reconcile to the one-page rate buildup.

- Calendar year historical data for at least three years (i.e. 2022, 2023 and 2024) and the most recent 2025 YTD data in the trend template. Include a clear statement on the paid through date and whether the projection trend is on the allowed basis or the paid basis.

- Projection trend with splits by cost type (unit cost, utilization, allowed and paid) and type of service (inpatient, outpatient, professional, medical subtotal, pharmacy and total).

- Justification of the difference between the projection trend and the historical trend.

- COVID – 19 impact in the historical trend as well as in projection trend.

- Impact of pharmacy rebate on trend, including the actual pharmacy rebate data and the projection.

- For individual ON-Exchange filings, state the CSR Silver loading percentage and justification as well as the impact on the rate increase driven by the change from the prior year.

- For Individual ON-Exchange filing, provide supporting document on the calculation of Covered CT Adjustment by component.

- 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. If area factors have changed, provide an actuarial justification for the changes. This should include, ideally, more than one year of experience and a unit cost analysis by region.

- For Small Group, a clear statement on whether Connecticut Small Employer Health Reinsurance Pool is included in the projection. Provide supporting document on the calculation as needed.

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. Carriers shall submit all materials, including but not limited to, the Uniform Rate Review Template ("URRT"), the Part III Actuarial Memorandum and the Health Insurance Oversight System ("HIOS") rate tables, in a PDF format, which is necessary for upload to our public website. In addition, the URRT, the HIOS rate tables and the Trend Template shall be submitted in excel format. The URRT PDF version shall also be submitted as a standalone document within the URRT tab of the filing.

For filings subject to PPACA, carriers shall 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 shall 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 shall be filed with the form filing in one submission using the Filing Type FORM/RATE. Policies subject to PPACA shall be filed using separate submissions for form and rate filings for new products or amendments. Rate increases shall be filed as a separate rate filing submission for all products.

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

- For small group filings, the overall requested increase shall 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 shall be identified as a specific percentage.

- Number of covered individuals for each product; number of covered policyholders; minimum current premium on a 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 major component of the requested increase. These can be identified as a specific percent or, if appropriate, a 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**

Carriers must provide a demonstration of compliance with mental health parity for each plan that uses varying copays within a service category as allowed in Bulletin HC-124.[1] The Final Rules under the Mental Health Parity and Addiction Equity Act of 2008 (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.

[1] https://portal.ct.gov/cid/-/media/cid/bulletinhc-124-maxcopay.pdf?rev=337336f7c1d348f5b552ab9ea40841b8&hash=A21F66F1AFDD1D03DFF6EE58C7E12760

Carriers must include demonstrations that each plan with 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.

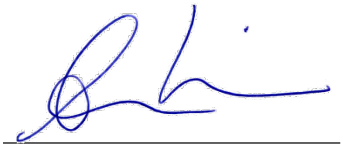
**Transparency**

The Connecticut Freedom of Information Act does not provide for an exemption for commercial or financial information that is required by statute.[2] The information identified above enables the Department to fulfill its statutory rate review requirement and as such is information required by statute. Therefore, the Department will not grant any requests to treat 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 Department's Life and Health Division at cid.lh@ct.gov with any questions.



Andrew N. Mais
Insurance Commissioner

[2] Section 1-210(b)(5)(B) of the Connecticut General Statutes provides that "[n]othing in the Freedom of Information Act shall be construed to require disclosure of:… (B) Commercial or financial information given in confidence, not required by statute…" (Emphasis added.)