Agency

Insurance Department

Subject

Approval of Individual Accident and Health Policy Forms

Inclusive Sections

§§ 38a-481-1—38a-481-13

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Approval of Individual Accident and Health Policy Forms

Sec. 38a-481-1. Definitions

As used in Sections 38a-481-1 to 38a-481-13, inclusive, of the Regulations of Connecticut State Agencies, unless the context otherwise requires:

(1) "Commissioner" means the Insurance Commissioner of the State of Connecticut.

(2) "Department" means the Connecticut Insurance Department.

(3) "Excessive rate" means the rate is unreasonably high for the insurance provided.

(4) "Experience period" means the most recent twelve (12) month period from which the insurer accumulates the data to support a rate filing.

(5) "Form" means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, or application, rider or endorsement used in connection therewith.

(6) "Formulary" means a list of prescription drugs that are covered by a specific health insurance plan.

(7) "Inadequate rate" means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer.

(8) "Insurer" means a health care center, as defined in Section 38a-175 of the Connecticut General Statutes, or an insurance company licensed by the Commissioner to write accident and health insurance.

(9) "Loss ratio" has the same meaning as provided in Section 38a-481(a) of the Connecticut General Statutes.

(10) "Pharmaceutical and therapeutics committee" or "P&T committee" means a group of members that may include physicians, pharmacists, administrators, quality improvement managers, other health care professionals and staff appointed by an insurer to establish policies regarding the use of drugs, therapies and drug-related products, identifying those that are most medically appropriate.

(11) "PPACA" means Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(12) "Prescription drug tier" means a subset of the drugs covered in a formulary that are covered and subject to a specified level of cost share.

(13) "SERFF" means the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing.

(14) "Specialty drug" means a unique prescription drug that may require special handling, close monitoring or may only be available from limited pharmacies.

(15) "Unfairly discriminatory" means rating practices that reflect differences based on age, disability, race, ethnicity, gender, sexual orientation or health status that are not actuarially justified or otherwise prohibited by law.

(16) "Utilization data" means the number of services used by a fixed number of covered persons, as defined in Section 38a-591a of the Connecticut General Statutes, over a fixed

length of time.

(Effective September 25, 1992; Amended April 23, 2015; Amended August 2, 2016; Amended December 3, 2018)

Sec. 38a-481-2. Filing procedure

Any insurer required pursuant to Section 38a-481 of the Connecticut General Statutes to file a copy of a form with the Commissioner for approval, shall comply with the following standards:

(a) **Filing**.

(1) Filing shall be done electronically through SERFF or any subsequent corresponding system adopted by the National Association of Insurance Commissioners or the Commissioner. All fields in SERFF shall be filled out appropriately and accurately for each filing.

(2) If one or more elements within a filing vary by member company within a group of companies, the filer shall file separately for each insurer within the group.

(3) The electronic filing shall contain a descriptive caption. The caption shall include a brief description of the type of filing, and any applicable form identification number. All subsequent correspondence to the Insurance Department on the filing shall include the caption in the identical format as it was displayed in the original electronic filing and a reference to the previous filing's State tracking number in addition to the date of the original filing transmittal document and the Department's file number, if known.

(4) All SERFF submissions shall include the following information in the filing description:

(A) A list of the documents submitted therewith;

(B) A brief outline of proposed changes;

(C) The approval sought;

(D) The proposed effective date; and

(E) Whether the form sought to be approved by the Commissioner is subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the Connecticut General Statutes.

(b) Every form filing shall be completed in ''John Doe'' fashion.

(c) (1) Every form filing subject to the requirements of the Insurance Plain Language Act, Chapter 699a of the Connecticut General Statutes, shall be accompanied with a certificate signed by an officer of the insurer, that the form complies with the Insurance Plain Language Act.

(2) The certificate required by subdivision (1) of this subsection shall be in the following form:

(NAME OF COMPANY)

(COMPANY ADDRESS)

This is to certify that the forms listed below are in compliance with Chapter 699a of the Connecticut General Statutes.

A. Option Selected
_____1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.
_____2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below:
Form Form Number Flesch Score
B. Test Option Selected
_____1. Test was applied to entire form(s).
_____2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.
C. Standards for Certification
A checked block indicates the standard has been achieved.
_____1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
_____2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
_____3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
_____4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
_____5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
_____6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsement or riders.
_____7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)
(COMPANY NAME)
_____ By: _____
(Date) (Title)

(d) Each form filing other than those involving group accident and health insurance, shall be filed separately in coordination with the classification of risks and the premium rates, or in the case of cooperatives or assessment companies, the estimated cost that will be used in connection with such form.

(e) When an insurer makes reference to another document in its filing, it shall include a copy or provide the tracking number for the referenced document.

(f) The Insurance Department is obligated to collect, pursuant to Section 12-211 of the Connecticut General Statutes, form filing fees from foreign or alien insurers, if the state in which they are domiciled imposes such and larger fees upon Connecticut's domestic insurers. Accordingly, each insurer domiciled in any other state or jurisdiction which

requires such fees shall remit the equivalent filing fee (in the form of a check made payable to the Treasurer, State of Connecticut or electronically through SERFF) together with each such filing submitted. The insurer shall also represent and certify that the fee payment remitted is the same amount required by its domiciliary state or jurisdiction.

(Effective September 25, 1992; Amended April 23, 2015; Amended April 4, 2017)

Sec. 38a-481-3. Policy form approval

(a) Each filing shall be state specific. Only filings with state specific language will be approved.

(b) Unless otherwise provided by law, the Insurance Department shall review all forms filed with the Insurance Commissioner for approval pursuant to Section 38a-481 of the Connecticut General Statutes in the order in which they are received by the Department; provided, however, that in appropriate circumstances the Commissioner may waive this requirement and direct the immediate review of a form filing. The Department shall employ a chronological logging system to facilitate the chronological review.

(c) Within ninety (90) days after a form is accepted for review, the Insurance Department shall review the form and either approve it or disapprove it. If, upon such review of the form, the Insurance Department determines that additional information from the insurer is necessary in order to ascertain whether the form is contrary to law or is unfair, deceptive or may encourage misrepresentation of the policy, the Department shall make such request to the insurer. The insurer will then have ten (10) days from the date of the request to provide the Department with the additional information; provided that during such time, the insurer may request in writing that the period for responding to the request for information be extended for an additional period of time, not to exceed thirty (30) days. The request for extension shall be considered granted upon its receipt by the Insurance Department. During the pendency of the Insurance department's request for information, the ninety (90) day period for Department action shall be tolled. If the insurer fails to comply with such request within the allotted time, such applicant shall be deemed to have voluntarily withdrawn its filing and the Department shall close its file without further action.

(d) The Commissioner shall issue a decision disapproving the use of any such form if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. Any such order shall specify the reason for disapproval of the form.

(e) Forms that are approved by the Commissioner shall have the form labeled ''Approved,'' together with the name and signature of the staff member who acted upon the filing and the date of the approval.

(Effective September 25, 1992; Amended April 23, 2015)

Sec. 38a-481-3a. Electronic filing

Filings shall be considered received by the Commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on

the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002; Amended April 23, 2015)

Sec. 38a-481-4. Severability

If any provision of this regulation or application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(Effective September 25, 1992)

Sec. 38a-481-5. Timing for rate filings

(a) Rate filings shall be made no later than ninety (90) days prior to the date an insurer intends to market such plans.

(b) For plans subject to the requirements of the PPACA, rate filings shall be filed annually no later than a date prescribed by the Commissioner. The Commissioner shall provide notice to insurers no later than thirty (30) days prior to the prescribed date each year.

(Effective August 2, 2016)

Sec. 38a-481-6. Transparency of rate filings

The information supplied to the Department to fulfill its statutory rate review requirement is not confidential. Complete rate filings including all correspondence and documentation are available through SERFF and may be posted on the Department website for review and comment by the public. All public comments shall be reviewed by the Department and considered as an additional element of the review determination.

(Effective August 2, 2016)

Sec. 38a-481-7. Rate filing process

(a) All rate filings shall be submitted via SERFF.

(b) For filings subject to the requirements of the PPACA, all fields in SERFF added for reporting requirements to the federal Department of Health and Human Services in accordance with PPACA shall be populated.

(c) All rate filings shall be made in accordance with Department bulletins, notifications, and other written guidance.

(d) Incomplete submissions may be rejected.

(e) No rate filing shall be approved if the Department determines that it is excessive, inadequate or unfairly discriminatory.

(f) Rates shall not be approved unless the policy forms to which they apply are approved.

(g) No rate may be marketed until the rates are approved. The Commissioner may grant

conditional approval to enhance the fairness and efficiency of the marketplace.

(Effective August 2, 2016)

Sec. 38a-481-8. Minimum rate filing requirements

(a) All rate filings shall include, at a minimum, the following:

(1) A cover letter describing all policy forms affected by the requested rates or rate changes as well as the effective date of the requested rates or rate changes.

(2) The detailed development for the initial rate or rate increase.

(3) Historical experience from inception-to-date including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios.

(A) Both state-specific and nationwide experience shall be provided.

(B) Annual experience shall be provided for all years.

(4) A certification by a member of the American Academy of Actuaries that the rate filing is in compliance with this section. Such certification shall include a statement by a member of the American Academy of Actuaries that the rates are reasonable in relation to the benefits provided, and that they are not excessive, inadequate or unfairly discriminatory.

(5) Claim lag triangles.

(6) Cost for each newly mandated benefit that applies to the type of insurance for which the rate filing has been submitted.

(7) Any additional information the Commissioner deems necessary to review the rate filing.

(b) Any changes submitted after the initial rate filing shall include a version that shows the changes made as well as a clean copy to facilitate the Department's review.

(c) When the information required under subsection (a) of this section is received, actuarial review shall commence. Rate filings shall be reviewed in the order received by the Department.

(Effective August 2, 2016)

Sec. 38a-481-9. Additional rate filing requirements

(a) All rate filings for individual health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) shall include:

(1) A demonstration that the experience data submitted is consistent with the most recent financial statement filed by the insurer with the Department pursuant to section 38a-53a of the Connecticut General Statutes.

(2) Utilization trend by broad service category, including utilization data.

(3) Impact of cost sharing leverage on trend.

(4) Medical technology trend.

(5) Benefit buy-down analysis and impact on trend.

(6) Cost of each new benefit mandate or requirement due to a change in state or federal law, separately identified, from the experience period to the rating period.

(7) 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).

(8) An annual certification of compliance with mental health parity. Any insurer that offers a plan that includes a cost share for medical expense at a lower level than the mental health cost share shall include a demonstration that the copayment is in compliance with mental health parity.

(9) A certification and demonstration that any substitution of a non-dollar limit on an essential health benefit as permitted by the PPACA is actuarially justified.

(10) A comparison of the proposed retention charge in the filing to the most recently filed financial statement for the insurer for which this filing is being made.

(11) Monthly historical experience including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios shall be provided for the most recent two (2) years.

(12) The current capital and surplus for the insurer for which this filing is being made.

(13) For filings subject to the PPACA, a demonstration that the rate increase requested in this filing will generate an expected medical loss ratio, for rebate purposes, that is consistent with the medical loss ratio prescribed by the federal law for individual health insurance.

(14) For filings subject to the PPACA, the Uniform Rate Review Template (URRT), the Part III Actuarial Memorandum, and the Health Insurance Oversight System rate tables. The Health Insurance Oversight System rate tables shall be filed in a portable document format. Insurers shall also provide a summary of benefits for each plan design along with the federal Department of Health and Human Services' Actuarial Value Calculator output that confirms compliance with the corresponding metal tier set forth in the PPACA. The Health Insurance Oversight System plan ID and the corresponding plan name on the summary of benefits for each plan shall be indicated.

(b) Every rate filing submission for individual health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) that includes an increase to previously approved rates shall include a summary of the rate increases requested and shall be clearly marked as Appendix A. The appendix shall include, but not be limited to, the following:

(1) The requested rate increase for each product contained within the rate filing and the effective date of each proposed rate increase. The requested increase for each product shall 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.

(2) 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.

(3) Each component of the rate increase including trend, experience adjustments and

any other factors that are a component of the requested rate increase. These may be identified as a specific percent or, if appropriate, a percent range.

(4) 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, geographic area, and smoking.

(Effective August 2, 2016; Amended December 3, 2018)

Sec. 38a-481-10. Formulary annual filing requirements

Insurers that deliver, issue for delivery, renew, amend or continue any individual health insurance policy that includes prescription drug coverage and utilizes a formulary shall submit an annual report to the Commissioner regarding the development and use of formularies and P&T committees. Such report shall be in a form prescribed by the commissioner and shall be submitted with the annual form filing.

(Effective December 3, 2018)

Sec. 38a-481-11. Minimum standards for formularies

No individual health insurance policy that offers prescription drug coverage that is subject to a formulary shall be delivered or issued for delivery in this state if the formulary does not meet the following required minimum standards:

(1) The formulary shall be easily searchable and posted online, accessible to members and non-members.

(2) The medications within the formulary shall be grouped in alphabetical order by therapeutic class.

(3) Definitions or explanations, or both, of each prescription drug tier, including specialty drug tiers, shall be clearly stated.

(4) Definitions for utilization controls, including, but not limited to, quantity or dosage controls, prior authorization, and step therapy shall be clearly stated.

(5) Tier coverage and utilization controls for each medication (by dosage, if applicable) shall be clearly stated.

(6) The formulary shall include information on how to obtain drugs that are off formulary.

(7) The formulary shall specify if and how drugs may be obtained through mail order pharmacy.

(8) The formulary shall clearly state when it was created, when it was last updated, and when the next anticipated update will be.

(9) The formulary shall provide customer service contact information.

(10) The formulary shall meet all additional requirements as set by the Commissioner.

(Effective December 3, 2018)

Sec. 38a-481-12. Minimum standards for pharmaceutical and therapeutics committees

(a) (1) No insurer shall utilize a P&T committee that does not have appropriate membership.

(A) A majority of P&T committee members shall be practicing physicians, pharmacists, and other professionals who are licensed to prescribe drugs.

(B) P&T committee members shall represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.

(2) Insurers shall put in place a process to ensure that there is no conflict of interest among members of the P&T committee with respect to the issuer or any pharmaceutical manufacturer. The process shall include an explanation of how conflicts of interest are dealt with if they arise.

(3) Insurers shall put in place a process to ensure that P&T committee members abstain from voting if there is a conflict of interest.

(b) The P&T committee shall meet regularly.

(1) Insurers shall put in place a process, including timeframes, to ensure that the P&T committee meets and makes decisions on new FDA-approved drugs within a reasonable time frame after the drug is released into the market.

(2) The P&T committee shall meet at least quarterly and maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary.

(3) The P&T committee shall evaluate and analyze treatment protocols and procedures related to the plans' formulary at least annually.

(c) Insurers shall develop and document procedures to ensure appropriate formulary drug review and inclusion.

(1) Insurers shall provide a copy of the policies and procedures in place to ensure that the P&T committee:

(A) Bases clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.

(B) Considers the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(C) Reviews new FDA-approved drugs and new FDA-approved uses for existing drugs.

(D) Reviews policies that guide exceptions and other utilization management processes, including, but not limited to, drug utilization review, quantity limits, prior authorizations, step therapies, generic substitutions, and therapeutic interchange.

(2) Insurers shall provide information on how often the formulary is updated on the company website and whether timeframes vary depending on whether the changes are advantageous to the enrollee.

(3) Insurers shall develop a process to ensure the formulary recommended by the P&T

committee:

(A) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommends drug treatment regimens that treat all disease states.

(B) Does not discourage enrollment of any group of enrollees through discriminatory tiering and utilization management processes.

(C) Includes multiple drugs, strengths and dosage forms for each therapeutic class and, if multiple drugs are available to treat a disease, they are not all placed in the highest cost share tier.

(D) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time and based on use of a tool set forth by the Commissioner.

(Effective December 3, 2018)

Sec. 38a-481-13. Notice to insureds regarding formulary changes

Insurers that deliver, issue for delivery, renew, amend or continue any individual health insurance policy that includes prescription drug coverage and utilizes a formulary shall provide at least sixty (60) days' advance notice to each insured and to each participating provider under the policy utilizing a prescription drug within the formulary before the insurer may remove such prescription drug from the formulary or make any change to the structure of prescription drug benefits under such policy.

(Effective December 3, 2018)