Sec. 38a-474-2. Rate submission requirements

(a) Each insurer shall submit the rates on every Medicare supplement policy form for initial approval by the Commissioner and annually thereafter.

(b) An insurer seeking to change rates on a Medicare supplement policy form shall submit the revised rates to the insurance department at least sixty days prior to the proposed effective date of the change. The department shall review the revised rates and, with respect to any request for an increase in rates, shall hold a public hearing on such request in accordance with the department's rules of practice. The commissioner shall approve or deny any request for a change in rates on a Medicare supplement policy form within forty-five days of its receipt.

(c) Where an insurer does not seek to change rates for a policy form, the insurer shall submit the previously approved rates at least forty-five days before the expiration of twelve months from the effective date of those rates. The commissioner shall either approve the continued use of such rates or notify the insurer that premium adjustments are necessary to achieve the appropriate loss ratio. If the insurer fails to make premium adjustments acceptable to the commissioner, the commissioner shall order premium adjustments, refunds or premium credits necessary to achieve the appropriate loss ratio.

(d) All submission of rates for Medicare supplement policy forms shall be made in duplicate, accompanied by a postage paid return envelope of sufficient size to accommodate the filing. An Actuarial Memorandum describing the basis on which rates were determined shall accompany the submission and shall include the following items:

(1) The policy form number for which rates are being submitted.

(2) A cover letter that includes a description of the form in sufficient detail to accurately illustrate its benefits and terms.

(3) The method of marketing used. A statement that the policy form is actively offered for sale. If a policy has been discontinued, the date when sales ceased shall be stated.

(4) The rates appropriate for the state, including all modal factors. The assumed period for which the rates are to be effective should be stated.

(5) The explicit assumptions and factors used in calculating the community rate. These shall include, but are not limited to, any loads for the guaranteed issue requirement, the required offering to the disabled or the automatic crossover system (piggybacking). Experience rating by case is not allowed for group policies.

(6) A statement of the anticipated loss ratio over the total lifetime of the policy. A demonstration that the minimum loss ratio requirements of 65% for individual policies and 75% for group policies will be met. Such demonstration shall exclude active life reserves.

(7) The expected future loss ratio projected through the period for which the rates will be effective. An expected third-year loss ratio which is greater than or equal to the applicable loss ratio standard shall be demonstrated for policies or certificates in force less than three years.

(8) A statement signed by a member of the American Academy of Actuaries or another individual acceptable to the commissioner, certifying that: the loss ratios are in compliance with section 38a-495 (b) or section 38a-522 (b) of the general statutes, or section 38a-495a-10 of the regulations of state agencies, as appropriate; the calculations were made in accordance with actuarial standards of practice; the premiums are neither excessive nor

inadequate; and the premiums are reasonable in relation to benefits. The address and phone number of the actuary should be stated on the certification.

(9) A demonstration that the rates do not incorporate factors for expenses which exceed one hundred fifty per cent of the average expense ratio for the entire written premium for all of the insurer's lines of health insurance for the previous calendar year in accordance with section 38a-473 of the general statutes. The average expense factor shall be calculated from Schedule H (Accident and Health Exhibit) of the prior year's annual financial statement, as the ratio of A to B where:

A is equal to the Total General Insurance Expenses (excluding taxes, licenses and fees), and

B is equal to the Total Premiums Written.

(10) If the insurer currently sells Medicare supplement policies in this state, a demonstration that the insurer makes at least standardized Plan A available to persons eligible for Medicare by reason of disability. For group filings, a description of the eligibility requirements of the group that includes at a minimum identification of the policyholder, requirements for membership and the purpose of the group.

(11) For forms where underwriting is permitted, a general statement of underwriting limitations.

(12) A table showing amounts proposed to be charged to consumers if the rates are approved as submitted.

(13) Such additional information as the commissioner may deem necessary for an adequate review of the proposed rates.

(e) The Actuarial Memorandum accompanying a submission of revised rates shall include in addition to the information required under subsection (c) the following items:

(1) The policy inforce count and the age/sex distribution both statewide and nationwide for the policy form.

(2) For each policy form, for each calendar year since inception, both statewide and nationwide: incurred claims; earned premium including modal loadings and policy fees; and resulting loss ratios. All claim and premium figures shall reflect actual experience to date.

(3) A history of rate changes for the policy form in Connecticut, including the effective date and magnitude of each previous rate change.

(4) Such additional information as the commissioner may deem necessary for an adequate review of the proposed revised rates.

(Adopted effective November 28, 1995)