OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

Issue Brief

Connecticut's Health Insurance Rate Review Process

Rate Review Requirements

State law requires health carriers (e.g., insurers and HMOs) to file rates for certain fully insured commercial health insurance products offered in Connecticut with the Connecticut Insurance Department (CID) for review and approval. CID reviews health insurance rate filings for (1) individual plans, (2) small employer plans, and (3) HMO plans offered to large employers. (However, CID does not have authority to review rates for, or otherwise regulate, employer groups that self-fund their health plans.) By law, no rate subject to review is effective until the commissioner has approved it.

Individual Health Plans

Health carriers must file rates with the insurance commissioner for health insurance plans offered to individuals (CGS §§ 38a-183 & 38a-481). Rates may vary based on age, geographic area, and tobacco use, as well as by actuarially justified differences in plan design, provider network, and administrative expenses.

Small Employer Health Plans

Health carriers must file rates with the insurance commissioner for health insurance plans offered to small employers (i.e., those with up to 50 employees) (CGS §§ 38a-183, 38a-513 & 38a-567). In practice, rates may vary based on age and geographic area, as well as by actuarially justified differences in plan design, provider network, and administrative expenses. (Grandfathered plans in existence before March 23, 2010, may also vary rates on other factors (e.g., gender, industry, family size).)

Large Employer HMO Plans

HMOs must file rates with the insurance commissioner for health insurance plans offered to large employer groups (i.e., those covering more than 50 employees) (CGS § 38a-183).

The Annual Filing, Review, and Rate Setting Process

The timeline for the annual health insurance rate filings and review is determined in part by the federal Centers for Medicare & Medicaid Services (CMS) and the Center for Consumer Information and Insurance Oversight, part of the Department of Health & Human Services. According to CID, the rate review generally follows the timeline shown below.

January – CID publishes a bulletin in January of each year with instructions for carriers to file rates effective for the following calendar year (e.g., Bulletin HC-81-22, Health Insurance Rate Filing Submission Guidelines).

July – At the beginning of July, the carriers submit their health rate filings for the next year, based on the prior years' data, with CID. CID's Life & Health Unit and actuaries review the filings and correspond with the carriers on any questions. The filings and correspondence are publicly available and posted on the CID website.

August – CID usually hosts a public informational meeting with the carriers concerning the filings. The public is invited to participate and submit comments. Following the public meeting, CID continues its actuarial review of the filings.

September – The insurance commissioner makes a final decision on the rate filings, either approving, modifying, or denying the rate requests. Rates must be submitted to CMS and Access Health CT by mid-September. CMS and Access Health CT post the rates by November 1.

November – Open enrollment begins November 1.

December – Consumers decide on and enroll in health care plans by December 15 for a January 1 effective date.

January – New plans go into effect for the calendar year on January 1.

Rate Review Factors

CID's authority to review health insurance rates is limited to three factors: whether the rates are excessive, inadequate, or unfairly discriminatory (CGS §§ 38a-481 & 38a-513 and related regulations). There is no statutory authority for CID to consider other factors, including affordability or executive compensation.

Excessive rate – A rate that is unreasonably high in relation to the benefits provided and underlying risks.
Inadequate rate – A rate that is unreasonably low in relation to the benefits provided and underlying risks, and continued use of it would endanger the carrier's solvency.
Unfairly discriminatory rate – A rate that is not actuarially sound and is not applied in a consistent manner so that the resulting rate is not reasonable in relation to the benefits and underlying risk.

Actuarial Analysis

Upon receipt of a carrier's rate filing, CID performs an actuarial analysis to determine if a requested rate is warranted. Among other things, CID actuaries review (1) the carrier's historical claim experience, (2) "claim lag triangles" to analyze incurred claims versus paid claims, (3) loss ratios (i.e., the ratio of earned premium to incurred claims), and (4) the carrier's expenses using their most recent financial statement. CID tests the validity of the carrier's assumptions in the filing and reviews other pricing adjustments proposed to determine if the rate requested meets the above rate review factors.

Learn More

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CID Health Insurance Rates for 2023

CID Frequently Asked Questions

CID 2023 Rate Filing Fact Sheet

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