STATE OF CONNECTICUT

INSURANCE DEPARTMENT

MARCH 7, 2016

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND SMALL EMPLOYER GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: FILING REQUIREMENTS FOR INDIVIDUAL AND SMALL EMPLOYER GROUP HEALTH INSURANCE POLICIES SUBJECT TO THE AFFORDABLE CARE ACT (ACA)

These requirements pertain to filings for non-grandfathered policies sold by carriers in the individual and small group markets. This includes carriers that are participating in the Connecticut Health Insurance Exchange, doing business as Access Health CT (AHCT), as well as to carriers that are not participating in AHCT. The requirements are for plan years beginning January 1, 2017.

Essential Health Benefit Plans

All plans in the individual and small employer group markets both inside and outside of the exchange are required to provide coverage for the essential health benefits. Information regarding the selected benchmark plan can be found at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#Connecticut.

Form Filings

CID requires that complete contracts be filed for the initial filing of all fully ACA compliant individual and small group policies or certificates issued on or after January 1, 2014 both in and out of AHCT. Subsequent changes to approved policies or certificates may be filed as endorsements or amendatory riders. Where appropriate, a red-lined version should be part of the filing submission. The cover letter should clearly indicate the types of changes being made.

All form filing submissions for plans offered in the individual and small group markets whether on or off of the exchange must be submitted no later than June 1, 2016. This date is the same deadline as for rate filing submissions for all individual and small group plans to be offered in Connecticut in 2017. Late filing submissions cannot be guaranteed to be reviewed prior to open enrollment. Any plans that are not approved prior to open enrollment are subject to a continual

open enrollment period. Although priority may be provided for exchange filings to meet any required federal deadlines, filings will otherwise be reviewed in the order received.

The cover letter should clearly indicate which plans are to be offered on the exchange. Such carriers are no longer required to make a separate filing for the plans offered off exchange. Carriers that participate in the exchange must make all exchange plans available outside of the exchange at the same premium rate, benefits, network and administrative expense levels in accordance with section 2702 of the ACA and associated regulations. These plans are not required to be actively marketed, but must be made available if requested.

All form filings except schedules of benefits may be filed with variable language for plans offered both inside and outside of the exchange. A detailed explanation of variability must be included as part of the filing submission. Such explanation of variability shall include the full range of options a carrier plans to offer including any variations in contract language that may apply. A schedule of benefits must be filed for each plan option to be offered. Variable language will be allowed only for references to coverage for American Indians and for options to include or exclude abortion coverage. Carriers participating on the exchange may be required by AHCT to use a standardized schedule to obtain certification as a QHP. Since the Uniform Rate Review Template (URRT) included with the rate filing must detail specific plan options and provide the demonstration of adherence to the appropriate actuarial values, the form filing no longer needs to provide any certification or demonstration of compliance with the various metal tiers. The form filing should, however, contain a cross reference to the HIOS identifier included in the URRT, so the form filing can be matched up to the rate filings.

Rate Filings

Rate filings should be made in accordance with the 2016 rate filing guidelines published in a notice released on March 4, 2016 and HC-88 if applicable. Rate filings should be submitted no later than June 1, 2016 for all individual or small group plans to be offered beginning January 1, 2017. This includes filings for plans offered on or off of the exchange. Late filing submissions cannot be guaranteed to be reviewed prior to open enrollment thereby subjecting the carrier to continuous open enrollment in 2017. No changes will be accepted after June 15, 2016, unless specifically requested by the Insurance Department. Generally, policy form and rate filings are not approved until the review of both submissions is complete. Conditional approval may be provided for one, subject to the approval of both submissions. In no circumstance can an unapproved rate or plan be offered during an open enrollment period.

Connecticut has reported to the Centers for Medicare and Medicaid Services that the state will conform to all requirements of 45 CFR §147.102 regarding allowable rating factors with the exception of geographic rating areas. Connecticut requested and was approved to establish 8 rating areas by county for both the individual and small group markets. Age factors should be in accordance with the uniform age rating curve established by HHS. Gender rating will no longer be permitted. Rating for family must be in conformance with the final rule cited above. The family rate is the sum of the rates for policyholder/employee, spouse, children aged 21 or older, and the rates for the three oldest children under age 21. In addition, for small employer rating,

industry and group size are no longer permitted to be case characteristics. Tobacco use is permissible in the individual market and may be applied at a plan level. Premiums in the individual market may reflect differentials in network costs if a carrier offers plans with different networks. Similarly, differentials in administrative costs other than exchange user fees may be reflected at a plan level in the individual market. Since tobacco use, administrative expense differentials and network cost differentials are not allowed case characteristics under Conn. Gen. Statute §38a-567, these rating factors are not applicable in the small employer market.

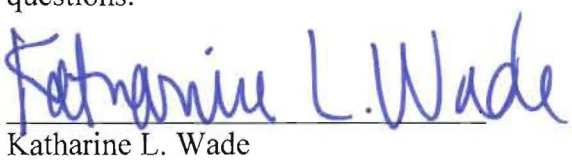
Maximum Copayment Amounts

Maximum copayment amounts can be found in Bulletin HC-109 on the Department's website at the following link.

http://www.ct.gov/cid/lib/cid/HC-109-MaximumCostSharing.pdf

Questions

Please contact the Insurance Department Life and Health Division at cid.lh@ ct.gov with any questions.



Katharine L. Wade
Insurance Commissioner