



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN NO. HC-90-21
JANUARY 7, 2021

- 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: 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, 2022.

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 [Information on Essential Benefits \(EHB\) Benchmark Plans](#).

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 July 2, 2021. 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.

All form filings 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. Since the Uniform Rate Review Template (URRT) and required documentation 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.

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 on 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.

The schedule of benefits should follow the general format similar to the design available on SERFF. For on Exchange filings the schedules must also comply with AHCT requirements. Schedules may contain variable language, but are asked to limit pages to information required in the format provided by the Department. The Department has also established a preferred format for the certificate to assist in expediting the review process. The preferred format for the certificates is also available on SERFF. Any previously approved language should be put into the preferred format and then changes to any language other than formatting must be redlined. If forms are not submitted in the preferred certificate format, carriers must cross reference where each section is included in their certificate by page number.

Rate Filings

Rate filings should be made in accordance with Bulletin HC 81-21 regarding rate filing submission requirements and Bulletin HC-88 regarding association business if applicable, and Bulletin HC 106 regarding small group rate filings. Rate filings should be submitted no later than July 2, 2021 for all individual or small group plans to be offered beginning January 1, 2022. This includes filings for plans offered on or off of the exchange. No changes will be accepted after July 2, 2021, unless specifically requested by the Insurance Department. If the carrier finds an error in the filing, the carrier can submit a communication in the SERFF filing describing the error and where it is located in the filing. A change in assumptions will not be viewed as an error. 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. Once the rate filings are approved, carriers are not allowed to add or withdraw plans or products.

Rate filings must be made in accordance with all requirements of 45 CFR §147.102 regarding allowable rating factors with the exception of geographic rating areas and Conn. Gen. Statute §38a-567 for group rates and 38a-481 for individual rates. Connecticut has established 8 rating areas by county for both individual and small group markets.

Semi-Annual Filings for Small Group Rates

Refer to Insurance Department Bulletin HC-106 for details.

Maximum Copayment Amounts

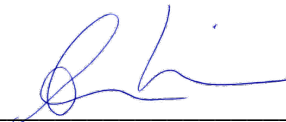
Maximum copayment amounts are eliminated with the exception of statutorily required maximums. Refer to Insurance Department Bulletin HC-124.

Formulary and Network Adequacy Filings

In accordance with Bulletins HC-113-19 and HC-117-21, all plans that utilize formularies or networks are required to submit responses to the annual surveys that can be found on the Insurance Department website under the “Forms and Applications” tab.

Questions

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



Andrew N. Mais
Insurance Commissioner