STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN NO. HC-90-24
April 22, 2024

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 PATIENT PROTECTION AND AFFORDABLE CARE ACT

These requirements pertain to filings for non-grandfathered policies sold by carriers in the individual and small group markets subject to the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder ("PPACA"). This includes carriers that are participating in the Connecticut Health Insurance Exchange, doing business as Access Health CT ("AHCT" or the "exchange"), as well as to carriers that are not participating in AHCT. The requirements are for plan years beginning January 1, 2025.

Essential Health Benefit Plans

All plans in the individual and small employer group markets both on and off the exchange are required to provide coverage for the essential health benefits. Connecticut's current essential health benefits benchmark plan can be found at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#Connecticut.

Form Filings

The Connecticut Insurance Department ("CID") requires that complete contracts be filed for the initial filing of all fully PPACA 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 shall be part of the filing submission. The filing shall be accompanied by a cover letter that clearly indicates the types of changes being made.

All form filing submissions for plans offered in the individual and small group markets whether on or off the exchange must be submitted no later than June 1, 2024. 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 in which they were received.

All form filings may be filed with variable language for plans offered both on and off 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. Because 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 shall, however, contain a cross reference to the Health Insurance Oversight System ("HIOS") identifier included in the URRT so the form filing can be matched up to the rate filings.

The cover letter shall clearly indicate which plans will be offered on the exchange. 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 off the exchange with the same premium rate, benefits, network and administrative expense levels in accordance with section 2702 of the PPACA and associated regulations. These plans are not required to be actively marketed but must be made available if requested.

The schedule of benefits shall follow the CID's general format, similar to the template available on the National Association of Insurance Commissioners' System for Systems for Electronic Rates & Forms Filing ("SERFF"). For on exchange filings, the schedules must also comply with AHCT requirements. Schedules may contain variable language but carriers should limit the content to information required in the CID's general format.

The CID 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 shall be put into the preferred format and 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 shall be made in accordance with Bulletin HC 81-24[1] regarding rate filing submission requirements, Bulletin HC-106[2] regarding small group rate filings and Bulletin HC-88[3] regarding association business, each as applicable. Rate filings shall be submitted no later than June 1, 2024, for all individual or small group plans to be offered beginning January 1, 2025. This includes filings for plans offered on or off the exchange. No changes will be

[1] https://portal.ct.gov/cid/-/media/cid/1_bulletins/bulletin-hc-81-24.pdf
[2] https://portal.ct.gov/cid/-/media/cid/hc106ratefilingforsmallemployer102015pdf.pdf
[3] https://portal.ct.gov/cid/-/media/cid/bulletinhc88healthinsurancerateandformfilingsubmissionguidelinespdf.pdf

accepted after June 1, 2024, unless specifically requested by the CID. 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. Under no circumstances 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 Connecticut General Statutes §38a-567 for group rates and §38a-481 for individual rates. Connecticut has established rating areas based on the eight counties for both individual and small group markets.

Semi-Annual Filings for Small Group Rates

Refer to Insurance Department Bulletin HC-106 for details.[4]

Maximum Copayment Amounts

Maximum copayment amounts are eliminated with the exception of statutorily required maximums. Refer to Insurance Department Bulletin HC-124.[5]

Formulary and Network Adequacy Filings

In accordance with Bulletins HC-113-24 and HC-117-21, all plans that use formularies or networks are required to submit responses to the annual surveys that can be found on the CID website under the "Forms and Applications" tab.[6]

Questions

Please contact the CID's Life and Health Division at cid.lh@ ct.gov with any questions.

Andrew N. Mais
Insurance Commissioner

[4] https://portal.ct.gov/cid/-/media/cid/hc106ratefilingforsmallemployer102015pdf.pdf
[5] https://portal.ct.gov/cid/-/media/cid/bulletinhc-124-maxcopay.pdf
[6] https://portal.ct.gov/cid/insurance-industry-information/forms-and-applications?language=en_US