



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN NO. HC-90-26
May 6, 2026

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 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 on the Connecticut Health Insurance Exchange, doing business as Access Health CT (the “Exchange”) as well as to carriers that are not participating on AHCT. The requirements are for plan years beginning January 1, 2027.

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 benefits¹, which are included in Connecticut’s federally approved benchmark plan. Such plan information can be found at <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#Connecticut>.

Form Filings

The Connecticut Insurance Department (“Department”) requires that health carriers file with the Department complete contracts for all fully PPACA compliant individual and small group policies and certificates available both on and off the Exchange, and issued on or after January 1, 2014. 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 made.

¹ Conn. Gen. Stat. § 38a-492q (individual health insurance) and Conn. Gen. Stat. § 38a-518q (group health insurance).

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, 2026. 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 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.

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 established by the Centers for Medicare and Medicaid Services Actuarial Value Calculator (“AV Calculator”). Because of this, certification or demonstration of compliance with the various metal tiers is no longer required as a form filing component. The form filing shall, however, contain a cross reference to the Health Insurance Oversight System identifier included in the URRT to allow for the matching of the form filing to the rate filings.

The cover letter shall clearly indicate which plans will be offered on the 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. Active marketing of these plans is not required but they must be made available if requested. Carriers are no longer required to make a separate filing for any plan offered both on and off the Exchange.

The filed schedule of benefits shall comply with the Department’s preferred format. The Schedule of Benefit template available on the National Association of Insurance Commissioners’ System for Electronic Rates & Forms Filing (“SERFF”) is consistent with the Department’s preferred requirements. For on Exchange filings, the schedules must also comply with the Exchange requirements. Schedules may contain variable language, but carriers shall limit the content to information required in the Department’s preferred format.

Use of the Department’s preferred format will expedite the review process. Any previously approved language shall be included in the preferred format and changes to any language other than formatting must be redlined. If forms are not submitted in the preferred format, carriers must cross reference where each section is included in their policy or certificate by page number.

Rate Filings

Rate filings shall be made in accordance with (i) Bulletin HC 81-26² regarding rate filing submission requirements, (ii) Bulletin HC-106³ regarding small group rate filings, and (iii) Bulletin HC-88⁴ regarding association business, each as applicable. Rate filings shall be submitted no later than June 1, 2026, for all individual or small group plans to be issued beginning January 1, 2027. This includes filings for plans offered on or off of the Exchange. No changes will be accepted after June 1, 2026, unless specifically requested by the 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 may not add or withdraw plans or products.

Rate filings must be made in accordance with (i) 45 CFR §147.102 regarding allowable rating factors with the exception of geographic rating areas, and (ii) 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.⁵

Maximum Copayment Amounts

As communicated in Insurance Department Bulletin HC-124⁶, maximum copayment amounts were eliminated due to the implementation of the AV Calculator, with the exception of statutorily required maximums.

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 Department's website under the "Forms and Applications" tab.⁷

² https://portal.ct.gov/cid/-/media/cid/1_bulletins/bulletin-hc-81-26.pdf?rev=0e87139b2f404aa5980f5d06d239d8c7&hash=F392415115B5D860AE0B860D6398F70C

³ <https://portal.ct.gov/cid/-/media/cid/hc106ratefilingforsmallemployer102015pdf.pdf>

⁴ <https://portal.ct.gov/cid/-/media/cid/bulletinhc88healthinsurancerateandformfilingsubmissionguidelinespdf.pdf>

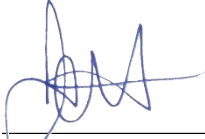
⁵ <https://portal.ct.gov/cid/-/media/cid/hc106ratefilingforsmallemployer102015pdf.pdf>

⁶ <https://portal.ct.gov/cid/-/media/cid/bulletinhc-124-maxcopay.pdf>

⁷ https://portal.ct.gov/cid/insurance-industry-information/forms-and-applications?language=en_US

Questions

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



Josh Hershman
Insurance Commissioner