STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-90-14
MARCH 10, 2014

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 policies sold through the Connecticut Health Insurance Exchange, doing business as Access Health CT (AHCT), as well as to filings for policies sold outside of the exchange. The requirements are for plan years beginning January 1, 2015.

Essential Health Benefit Plans

The State has selected the benchmark plan to set the essential health benefits for 2014 and 2015. The listing of benefits is provided as an appendix to this bulletin. 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. A copy of the selected benchmark plan can be found on the Department website.

Form Filings

CID is requiring 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.

To ensure forms are approved prior to being filed with AHCT, CID requests that filings of policies, certificates, amendments or schedules of benefits for plans offered by carriers participating in AHCT be made no later than April 30 in any calendar year. 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. These plans are not required to be actively marketed, but must be made available if requested.

Submissions of policies, certificates, amendments or schedules of benefits to be offered by carriers that do not participate in AHCT may be filed at a later date allowing no less than 3 months prior to the date marketing of the plan will begin. 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 the required deadlines, filings will otherwise be reviewed in the order received.

All form filings including 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. 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.

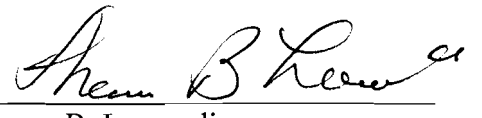
Rate Filings

Rate filings should be made in accordance with Bulletin HC-81-14 and HC-88 if applicable. For carriers that are participating in AHCT, the rate filings should be submitted no later than April 30 of each calendar year. 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 will no longer be permitted 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.

Questions

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



Thomas B. Leonardi
Insurance Commissioner

2014-2015 Essential Health Benefits in Connecticut

OUTPATIENT SERVICES	**LIMIT**
PCP Office Visits (non-preventive)	
Specialist Office Visits	
Outpatient Surgery Physician/Surgical Services	
Outpatient Facility Fee (e.g. ambulatory surgery center)	
Home Health Care Services	100 visits/year
EMERGENCY SERVICES	**LIMIT**
Emergency Room	
Emergency Transportation/Ambulance	per state mandate*
Walk-in/Urgent Care Centers	
HOSPITALIZATION	**LIMIT**
Inpatient Hospital (facility & provider services)	
Skilled Nursing/Rehabilitation Facility	90 days/year
Hospice	Life expectancy of 6 months or less
Residential Treatment Facilities	
MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES	**LIMIT**
Mental/Nervous & Substance Abuse services	Same as any other illness
REHABILITATIVE/HABILITATIVE SERVICES & DEVICES	**LIMIT**
Outpatient Rehabilitation Services (PT/OT/ST)	40 visits (combined)/year
Cardiac Rehabilitation	
Chiropractic Visits	20 visits/year
Durable Medical Equipment	
Prosthetics	
Ostomy Appliances and Supplies	per state mandate*
Diabetic Equipment and Supplies	
Wound care supplies	per state mandate*
Disposable Medical Supplies	
Hearing Aids	For children under 12: 1/every 24 months
Surgically Implanted Hearing Devices	
Wigs	per state mandate*
Birth to Three	per state mandate*
Prescription Drugs	
LABORATORY AND IMAGING SERVICES	**LIMIT**
Laboratory Services	
Non-advanced radiology	
Advanced imaging (includes MRI, PET, CAT, nuclear cardiology)	
PREVENTIVE & WELLNESS SERVICES & CHRONIC DISEASES	**LIMIT**
Adult Physical Exam	Ages 22-49 every 1-3 years, age 50 1/year as recommended by physician
Preventive Services	Based USPSTF A and B Recommendations
Prenatal and Postnatal Care	
Infant/Pediatric Physical Exam	In accordance with national guidelines
Routine Immunizations	In accordance with national guidelines
Routine Gynecological Exam	1/year
Screening for gestational diabetes	In pregnant women between 24 & 28 weeks of gestation and at first prenatal visit for high risk of diabetes
Human Papillomavirus Testing	Women aged 30+; 1/every 3 years
Counseling for Sexually Transmitted Infections	For women 1/year

Counseling and Screening for HIV	For women 1/year
Contraceptive Methods and Counseling	For women
Breastfeeding Support, Supplies and Counseling	For women
Screening/Counseling for interpersonal & domestic violence	For women 1/year
Preventive Lab Services	Complete blood count & urinalysis 1/year
Baseline Routine Mammography	1 between ages 35-39, 1/year age 40+
Adult Routine Vision Exam	1/year
Routine Cancer Screenings	In accordance with national guidelines
Blood lead screening & risk assessment	per state mandate*
Bone density	1/every 23 months
Pediatric Hearing Screening	Under age 19 as part of physical
OTHER SERVICES	**LIMIT**
Craniofacial Disorders	per state mandate*
Oral Surgery for Treatment of Tumors, Cysts, Injuries, Treatments of Fractures Including TMJ & TMD	TMJ for demonstrable joint disease only
Dental Anesthesia	per state mandate*
Reconstructive Surgery	To correct serious disfigurement or deformity resulting from illness or injury, surgical removal of tumor, or treatment of leukemia; For correction of congenital anomaly restoring physical or mechanical function
Maternity	
Mastectomy	per state mandate*
Breast reconstructive surgery after mastectomy including on non-diseased breast to produce a symmetrical appearance	per state mandate*
Breast prosthetics	per state mandate*
Breast implant removal	per state mandate*
Autism Coverage	per state mandate*
Clinical Trials	per state mandate*
Solid organ and bone marrow transplants	
Medically necessary donor expenses and tests	
Transportation, lodging and meal expenses for transplants	Up to $10,000 per episode (initial evaluation until sooner of discharge or cleared to return home)
Lyme Disease Treatment	per state mandate*
Allergy testing	Up to $315 every 2 years
Diabetes education	per state mandate*
Sterilization	
Casts and dressings	
Renal dialysis	
Sleep studies	1 complete study/lifetime
Pain management	per state mandate*
Neuropsychological testing	per state mandate*
Accidental ingestion of a controlled drug	per state mandate*
Diseases and abnormalities of the eye	Annual retina exams for members with glaucoma or diabetic retinopathy
Corneal pachymetry	1 complete test/lifetime
Infertility	per state mandate*
Genetic testing	For members who have or are suspected of having a clinical genetic disorder
Specialized formula	per state mandate*
Nutritional counseling	2 visits/year
Enteral or intravenous nutritional therapy	
Modified food products for inherited metabolic disease	per state mandate*

PEDIATRIC VISION CARE	LIMIT
Routine eye exam	1 exam/year
Lenses	1 pair/year
Frames	1 frame/year
Contact lenses	1 fitting and set of lenses/year
PEDIATRIC ORAL CARE	**LIMIT**
Exams	1 every 6 months
Bitewings	1 time/year
Other X-rays	
Sealants	On premolar and molar teeth
Fluoride treatments including topical therapeutic fluoride varnish application	For clients with moderate to high risk of dental decay
Access for baby care early dental examination and fluoride varnish where an oral health screen, oral health education and fluoride varnish are applied to children's teeth during well child exams	Up to 4 years of age
Dental orthodontia (under age of 19)	
Replacement retainer	Limited to one time per lifetime
Amalgam and composite restorations (fillings)	
Fixed prosthodontics: Crowns, inlays and onlays	
Recement bridges, Crowns, inlays and space maintainers	
Removable prosthodontics: Full or partial dentures	
Repair, relining and rebasing dentures	
Intermediate endodontic services	
Major endodontic services: Root canal treatment, retreatment of root canal therapy, apicoectomy, apexification	
Oral surgery; Surgical Extraction, including impacted teeth	
Non-surgical extraction	
Periodontal surgery and services	
Space maintainers	
General anesthesia and sedation	
Miscellaneous adjunctive procedures	

(* Any dollar limits in state mandates no longer apply because PPACA prohibits annual dollar limits)