STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN NO.HC-90-17
MARCH 2, 2017

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, 2018.

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 May 1, 2017. This date is the same deadline as for rate filing submissions for all individual and small group plans to be offered in Connecticut in 2018. 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 Bulletin HC 81-17 regarding rate filing submission requirements and Bulletin HC-88 regarding association business if applicable. Rate filings should be submitted no later than May 1, 2017 for all individual or small group plans to be offered beginning January 1, 2018. 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 potentially subjecting the carrier to continuous open enrollment in 2018. No changes will be accepted after May 15, 2017, unless specifically requested by the Insurance Department. If the carrier finds an error in the filing after the May 15 deadline, the carrier can submit a communication in SERFF filing describing the error and where it is located in the filing. A change in assumptions will not be viewed as an error. No revisions should be made to the filing except at the request of 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. Once the rate filings are approved, carriers are not allowed to add or withdraw plans or products.

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. Since tobacco use is not an allowed case characteristic under Conn. Gen. Statute §38a-567, this rating factor is not applicable in the small employer market. Premiums in the individual and small group markets 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 both the individual and small group markets.

Public Act No. 15-247 revised the definition of small employer by expanding the group size from 50 to 100 to conform to the Patient and Protection Act, P.L. 111-148, as amended ("PPACA"). The passage of the Protecting Affordable Coverage for Employees (PACE) Act repeals the change from 100 to 50 effective January 1, 2016, but provides states with the flexibility to stay at 100. Conn. Gen. Stat. §38a-564 defines small employer as up to 100, but provides the Commissioner the ability to postpone the implementation of small group to 100. This bulletin serves to notify carriers that the change to the definition of small group in CGS 38a-564 as amended by Section 17 of PA 15-247 will be postponed. In order to be consistent with federal law, the small group definition will remain 1-50 and will not go to 100 effective January 1, 2016.

"Small employer" means an employer that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year. "Small employer" does not include a sole proprietorship that employs only the sole proprietor or the spouse of such sole proprietor. The number of employees shall be determined by adding (I) the number of full-time employees for each month who work a normal work week of thirty hours or more, and (II) the number of full-time equivalent employees, calculated for each month by dividing by one hundred twenty the aggregate number of hours worked for such month by employees who work a normal work week of less than thirty hours, and averaging such total for the calendar year. If an employer was not in existence throughout the preceding calendar year, the number of employees shall be based on the average number of employees that such employer reasonably expects to employ in the current calendar year.

Semi-Annual Filings for Small Group Rates

Pursuant to federal guidance, small employer carriers are allowed to file rates no more often than quarterly. (*See* Final Rule of the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, 78 FR 65096, (Sec.156.80), Oct. 30, 2013.) This bulletin provides the criteria under which small employer carriers, as defined in C.G.S. 38a-564(16) amended by Public Act No. 15-247 §17, may file a semi-annual rate filing for the small employer market.

- An annual filing is still due in accordance with the timeframes set each year by the Commissioner.

- A semi-annual filing must be received no later than March 1.
- No changes to the filing may be made after March 1 unless requested by the Insurance Department.
- A semi-annual filing may only change rates for the third and fourth quarters of the current calendar year.
- A semi-annual filing may only reflect changes in trend or network contracting.
- New benefit designs are not permitted to be filed mid-year.
- Pricing assumptions other than trend and network changes shall be consistent with the annual filing. Revised quarterly trend or network factors shall be applied to previously approved first quarter rates in the annual filing.
- The semi-annual rate filing shall be consistent in content and format with the requirements of the annual rate filing.

Maximum Copayment Amounts

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

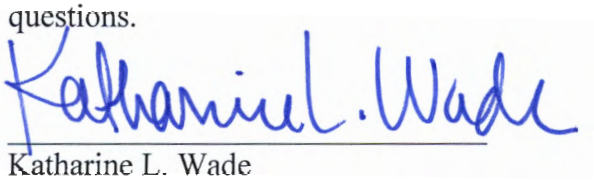
http://www.ct.gov/cid/lib/cid/HC-109-MaximumCostSharing.pdf

Formulary and Network Adequacy Filings

In accordance with Bulletins HC-113-17 and HC-117-17, 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. Such submissions should be submitted no later than May 1, 2017, but should NOT be sent via SERFF. A separate submission is required for each unique formulary or network that is offered by a carrier regardless of the market (i.e. individual, small group or large group). Networks include those for stand-alone dental or vision plans.

Questions

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



Katharine L. Wade
Insurance Commissioner