STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-94
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 GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

SUBJECT: MAXIMUM COPAYS AND FILING ISSUES

The purpose of this bulletin is to provide guidance as to maximum copay amounts and to address some recent inquiries regarding specific filing issues.

Copays

The Insurance Department ("Department") received requests from some carriers to update the maximum copays that would be approved for health insurance policies sold in Connecticut. The Department requested that the carriers submit a claims distribution showing number of claims and total dollars spent at incremental claims levels for each category of service. Data was received on a limited number of service categories and from a limited number of carriers.

The following chart indicates the revised maximum copay amounts based on the Department's analysis of data submitted.

	Revised Limit	Previous Limit
PCP Office Visit	$ 40	$ 30
Specialist Office Visit	50	45
Urgent Care	75	75
Emergency Room	200	150
Inpatient Admission	500/day up to $2000	500/day up to $2000
Outpatient Surgery/Services	500	500
Generic Drug	5	40
Brand Drug	60	40

In the future, the Insurance Department intends to send out periodic data calls to carriers offering health insurance policies in the state to review and update current copay limits.

Prescription Drug Tiers

With respect to prescription drug coverage, carriers are free to set their formularies within any requirements set by the Affordable Care Act. The policy or certificate must, however, include language to cover any FDA approved drug if medically necessary. Generic only plans are not

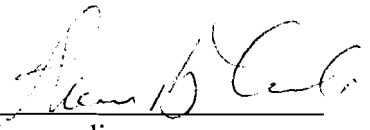
permitted. Carriers can determine the structure of any tiered cost-sharing within the confines of the copay limits above or a minimum coinsurance level of 50% coverage. If a carrier opts to offer tiers that mix generic and brand name drugs, the copay for that tier should not exceed the generic copay of $5. Coinsurance levels of 50-100% may be applied in lieu of copays, but should be one set amount for any given tier. This applies to both indemnity carriers and health care centers. Health care centers are defined as providing services as compared to indemnity carriers that reimburse for services, so have not been permitted to use coinsurance except for out of network services. Health care centers may also offer coinsurance options for goods that are provided as benefits such as drugs, eyeglasses or durable medical equipment whether in or out of network.

End-Stage Renal Disease

The Insurance Department met with dialysis vendors who were concerned that policies issued in the state did not cover services for end-stage renal disease or coordinate with Medicare. Form filings were inconsistent in addressing coverage and coordination with Medicare specifically related to end-stage renal disease. Policies should include language regarding benefit coverage and coordination with Medicare for end- stage renal disease. Language dealing with coordination of benefits should be consistent with Medicare payer rules and Regulations of State Connecticut Agencies §38a-480.

Questions

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



Thomas B. Leonardi
Insurance Commissioner