STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-97-14-2
JUNE 26, 2014

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE SMALL GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: REVISED STATUTORY PLANS REQUIRED BY CONN. GEN. STAT. §38a-568

Conn. Gen. Stat. §38a-568 requires health insurance carriers, including health care centers that transact small employer group health insurance business in this state, to offer plans established by the Board of the Connecticut Small Employer Health Reinsurance Pool (CSEHRP). The CSEHRP Board filed revised major medical and health care center plans that were approved by the Insurance Department on May 30, 2014. The HMO version of the statutory plan must be revised to be in compliance with Regulations of Connecticut State Agencies §38a-192 et. seq. This regulation sets a minimum $1500 deductible for health care centers. Increasing the $1000 deductible to $1500 for the HMO version of the statutory plan produces an actuarial value of 80.2%, so remains within the required range for a gold plan.

This bulletin rescinds Bulletin HC-97 that was issued on June 9, 2014. The revised approved schedules of benefits are attached as Exhibits I and II. The statutory plan for indemnity plans remains unchanged. A copy of the output from the actuarial value calculator is also attached as Exhibit III. Carriers must include the appropriate version of the revised plans as part of their small employer form and rate filings for January 1, 2015.

Questions

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

Anne Melissa Dowling
Deputy Insurance Commissioner

EXHIBIT I

CSEHRP

Indemnity Gold Plan

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $1,000 $2,000	 $3,000 $6,000
Prescription Drug Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $0 $0	 $350 $700
Out-of-Pocket Maximum *Individual* *Family*	 $3,000 $6,000	 $6,000 $12,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	30% coinsurance
Primary Care (injury or illness)	$20 copay	30% coinsurance**
Specialist	$45 copay	30% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	$75 copay	30% coinsurance**
Emergency Room	$150 copay	$150 copay
Ambulance	$0	$0
Hospital Services		
Inpatient	$500 copay per day to a maximum of $1,000 per admission*	30% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	$500 copay*	30% coinsurance**
Skilled Nursing Facility 90 day calendar year maximum	$500 copay per day to a maximum of $1,000 per admission*	30% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Care		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	$0	30% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	$0	25% coinsurance subject to a $50 deductible
Advanced Radiology (CT/PET Scan, MRI)	$75 copay per service up to a combined calendar year maximum of $375 for MRI and CT scans; $400 for PET scans	30% coinsurance**

*After in-network medical deductible is met **After out-of-network deductible is met

Indemnity Gold Plan

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	$45 copay	30% coinsurance**
Laboratory Services	$30 copay	30% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	$30 copay	30% coinsurance**
Chiropractic Care *20 visit calendar maximum*	$45 copay	30% coinsurance**
Other Services		
Durable Medical Equipment	30% coinsurance	30% coinsurance**
Prosthetics	30% coinsurance	30% coinsurance**
Diabetic Supplies & Equipment	30% coinsurance	30% coinsurance**
Prescription Drugs		
Generic Drugs	$5 copay	30% coinsurance****
Preferred Brand Drugs	$25 copay	30% coinsurance****
Non–Preferred Brand Drugs	$50 copay	30% coinsurance****
Specialty Drugs	$60 copay	30% coinsurance****

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	$0	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance**
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance**
Orthodontia Services *medically necessary only*	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam	$45 copay	30% coinsurance
Prescription Eye Glasses *one pair of frames & lenses per calendar year*	lenses: $0 collection frames: $0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

*After in-network medical deductible is met

**After out-of-network medical deductible is met

***After in-network prescription drug deductible is met

****After out-of-network prescription drug deductible is met.

EXHIBIT II

CSEHRP

HMO Gold Plan

Plan Overview	In-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $1,500 $3,000
Prescription Drug Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $0 $0
Out-of-Pocket Maximum *Individual* *Family*	 $3,000 $6,000
Physician Office Visits	
Preventive Care/Screenings/Immunizations	$0
Primary Care (injury or illness)	$20 copay
Specialist	$45 copay
Emergency/Urgent Care	
Urgent Care Center or Facility	$75 copay
Emergency Room	$150 copay
Ambulance	$0
Hospital Services	
Inpatient	$500 copay per day to a maximum of $1,000 per admission*
Outpatient (performed at hospital or ambulatory facility)	$500 copay*
Skilled Nursing Facility 90 day calendar year maximum	$500 copay per day to a maximum of $1,000 per admission*
Mental Health, Substance Abuse & Behavioral Health Care	
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness
Hospice Care	
Hospice Services	$0
Outpatient Services	
Home Health Care 100 visit calendar year maximum	$0
Advanced Radiology (CT/PET Scan, MRI)	$75 copay per service up to a combined calendar year maximum of $375 for MRI and CT scans; $400 for PET scans

*After in-network medical deductible is met

HMO Gold Plan

Plan Overview	In-Network Member Pays
Outpatient Services	
Non-Advanced Radiology (X-ray, Diagnostic)	$45 copay
Laboratory Services	$30 copay
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) *combined 40 visit calendar year maximum*	$30 copay
Chiropractic Care *20 visit calendar maximum*	$45 copay
Other Services	
Durable Medical Equipment	30% coinsurance
Prosthetics	30% coinsurance
Diabetic Supplies & Equipment	30% coinsurance
Prescription Drugs	
Generic Drugs	$5 copay
Preferred Brand Drugs	$25 copay
Non–Preferred Brand Drugs	$50 copay
Specialty Drugs	$60 copay

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care	
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	$0
Basic Restorative (Filling, Simple Extraction)	$45 copay
Major Restorative (Endodontic, Crown)	$45 copay
Orthodontia Services *medically necessary only*	$45 copay
Pediatric Vision Care	
Routine Eye Exam	$45 copay
Prescription Eye Glasses *one pair of frames & lenses per calendar year*	lenses: $0 collection frames: $0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount

*After in-network medical deductible is met

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)	$1,500.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$3,000.00		
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate
Medical	☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00
Specialist Visit	☐	☐		$45.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$58.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$30.00
X-rays and Diagnostic Imaging	☐	☐		$45.00
Skilled Nursing Facility	☑	☐		$500.00

Exhibit III

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	66%	
Outpatient Surgery Physician/Surgical Services	☑	☑	66%	
Drugs	☐ All	☐ All		
Generics	☐	☐		$5.00
Preferred Brand Drugs	☐	☐		$25.00
Non-Preferred Brand Drugs	☐	☐		$50.00
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐	
Specialty Rx Coinsurance Maximum:		
Set a Maximum Number of Days for Charging an IP Copay?	☑	
# Days (1-10):		2
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐	
# Visits (1-10):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐	
# Copays (1-10):		

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.2%
Metal Tier:	Gold