

STATE OF CONNECTICUT
INSURANCE DEPARTMENT

BULLETIN HC-109
FEBRUARY 5, 2016

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 COST SHARING

The purpose of this bulletin is to provide guidance as to maximum copayment (“copay”) amounts for health insurance plans. This bulletin rescinds Bulletin HC-94 Maximum Copays and Filing Issues that was issued on March 10, 2014.

Maximum Copays

In December 2015, the Insurance Department conducted a data call to determine reasonable levels of copayment amounts regarding specified categories of benefits. The maximum copays are set to not exceed 50% of the 90th percentile of claims for the category. For the home health care category, 25% was used in lieu of 50% to reflect the statutory requirement in Conn. Gen. Stat. §38a-493 and §38a-520 that coinsurance cover at least 75% of the charges. The maximum copay for routine radiology does not apply to advance radiology services (MRI, PET and CAT) that are subject to the limits set forth in Conn. Gen. Stat. §38a-511 and §38a-550.

The following chart indicates the revised maximum copays based on the Department’s analysis of data submitted. The copays will be effective for all policies issued or renewed on or after January 1, 2017.

Durable Medical Equipment	\$ 25
Home Health Care	25
Ambulance	225
Laboratory	10
Routine radiology services	40

The maximum copays for the following categories of benefits were not part of the most recent data call and will remain at the current allowable levels.

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

Maximum Coinsurance

Plans that use coinsurance may not impose an enrollee cost sharing amount that exceeds 50%. This applies both for in and out of network benefits. There is no restriction on the differential of the coinsurance level between in and out of network benefits. The level of coinsurance must be consistent for all services within a service category except for plans utilizing tiered networks.

Variable Copays Within a Service Category

The Insurance Department has not approved policy forms that set copayments within a service category to be variable based on the intensity of services provided, the medical condition of the enrollee or by provider specialty. One major exception is that office visit copays may vary between a primary care physician and a specialist. Variations by specialist or by intensity of service, however, are not permitted. The copay covers all services rendered at the point of service. Multiple copays may not be assessed for specific services received in one setting (i.e. office visit, outpatient treatment, inpatient stay, emergency room visit, etc.). Carriers must pay billed charges or include hold harmless clauses in their provider contracts to ensure enrollees are not balance billed beyond the copay.

A further exception will be allowed for all categories in cases when there is an ongoing course of treatment. Copays for such ongoing services may be set at a lower level. For example, if an office visit specialist copay is set at \$45, a policy may reduce the office visit copay for ongoing treatments such as allergy shots. Similarly, if services in an outpatient facility are set at \$500, the copay per treatment may be reduced for ongoing treatments such as chemotherapy.

Carriers must provide a demonstration of compliance with mental health parity for each plan that utilizes varying copays within a service category. The Final Rules under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (45 CFR Parts 146 and 147) provides tests for determining "substantially all" and "predominant" medical/surgical benefits for reviewing the financial requirements and quantitative treatment limitations. Carriers must include demonstrations that each plan utilizing varying copays meets the substantially all and predominant tests. Such demonstration must also include a certification of compliance with

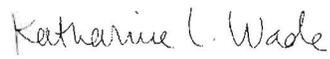
mental health parity signed by a member of the American Academy of Actuaries. After the initial approval, such demonstration and certification must be made annually.

Prescription Drug Tiers

Pursuant to 45 C.F.R. 156.122, with respect to prescription drug coverage, carriers are free to set their formularies within any requirements set by the Affordable Care Act. Under 45 C.F.R. 156.122(c), the policy or certificate must 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 may be assessed in lieu of copays, but should be one set level for any given tier up to a maximum of 50%. 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.

Questions

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


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Insurance Commissioner