

NAIC Form Review White Paper

As Adopted by the Exchanges (B) Plan Management Form Review Team

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Introduction

Under the Affordable Care Act (ACA), an American Health Benefit Exchange will be established in each state, either by the state or the federal government, in time to operate beginning January 1, 2014.¹ Some states where there is a Federally Facilitated Exchange (FFE) may opt to handle plan management functions for the Exchange, including certification of Qualified Health Plans (QHPs), by entering into a State Partnership agreement. Regardless of the type of Exchange operating in a state, state regulators should be aware of important changes that impact the requirements of form review, whether coverage is offered inside or outside an Exchange. This paper discusses those requirements, while focusing in large part on considerations for state Departments of Insurance (DOIs) that plan to handle or participate in QHP certification for either a state-operated Exchange or an FFE.

Plans offered in the Exchanges must be QHPs that meet certain federal requirements laid out in the ACA and subsequent regulations,² as well as any additional QHP certification requirements that might be imposed by the state. Additionally, QHP form documents must meet the applicable requirements that a state might adopt on insurance forms. Since review of a QHP for certification is akin to the form review process already performed by the various state Departments of Insurance (DOIs)³ the DOIs may also determine, as part of, or concurrently to form review, if plans may be certified as QHPs, and are thereby eligible to be sold in the Exchanges.

The form review process for QHPs will be the same for individual coverage and small employer coverage offered in a state Exchange, though there may be some differences in applicable requirements. For example, all non-grandfathered plans in the individual and small group markets (inside and outside of an Exchange) will be required to be guaranteed issue.⁴ They will also be required to include the Essential Health Benefits (EHBs) and will be required to comply with the actuarial value and cost sharing standards in the ACA.⁵

¹ ACA §1304(b)(1)

² ACA §1301 and 45 CFR §156.200-295

³ Some state insurance regulators may go by different names, or responsibility may be divided among more than one entity. The term 'DOI' in this paper is used to refer to all of these arrangements.

⁴ PHS §2702

⁵ ACA §1302(a)

State DOIs responsible for, or assisting with, QHP certification will also need to verify that each issuer selling on the Exchange is offering at least one gold QHP and one silver QHP.⁶ The issuer must also offer a child-only plan at the same level of coverage as any QHP.⁷ Due to the fact that only non-grandfathered plans may be sold in the Exchanges, grandfathered plans will not be reviewed for certification requirements.

Provisions Unique to QHPs

The Exchange regulations promulgated by HHS apply some special provisions to QHPs sold in the Exchanges. These provisions include, but are not limited to, requirements for the following: offering plans to deliver federally financed cost-sharing reductions for low-income individuals⁸, enrollment periods⁹, termination of enrollment¹⁰, grace periods¹¹, minimum offering of gold, silver and child-only plans¹², network adequacy¹³, service areas¹⁴, quality accreditation of plans¹⁵, and the segregation of funds for coverage of elective abortion services¹⁶. State insurance regulators' review of QHP policy documents will need to account for these special requirements which may differ from existing state standards. States may wish to consider applying many of the QHP specific standards in federal law (such as open enrollment periods and minimum offering standards) to issuers both inside and outside the Exchange market, as a means of making market rules consistent and minimizing the risk of adverse selection.

Multi-State Plans

The ACA required the U.S. Office of Personnel Management (OPM) to enter into an agreement with at least two issuers to offer multi-state plans on the Exchanges of every state in the individual and small group markets.¹⁷ Though multi-state plans are deemed to be QHPs and the Exchanges must allow them to be offered, nothing in the law preempts state insurance regulators from ensuring that these plans, which may only be sold by licensed issuers, meet all applicable state laws. The form review process for multi-state plans will therefore not be appreciably different from the form review process for any other plan sold in the individual or small group market, except that communication with OPM will be necessary. Additional information regarding the requirements for multi-state plans will be available when OPM releases regulations for this program.

⁶ ACA 1301(a)(1)(C)(ii)

⁷ PHSA 2707(c)

⁸ ACA §1402

⁹ 45 CFR §156.265

¹⁰ 45 CFR §156.280

¹¹ 45 CFR §156.270(g)

¹² 45 CFR §156.200

¹³ 45 CFR §156.235

¹⁴ 45 CFR §155.1055

¹⁵ 45 CFR §156.275

¹⁶ 45 CFR §156.280

¹⁷ ACA §1334

CO-OPs

The ACA creates a program to help create new, private non-profit health issuers, called Consumer-Oriented and Operated Plans, or “CO-OPs.”¹⁸ CO-OPs will be able to offer health plans through the Exchanges. An Exchange must recognize a health plan offered by a CO-OP if the plan is deemed certified by CMS or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP QHPs as set forth in the ACA and except for an exception, all state specific standards established by an Exchange for QHPs operating in that Exchange.¹⁹ The form review process will not differ from the form review process for any other QHP. It should be noted that CO-OPs must be licensed as issuers in each state in which they operate and are subject to state laws and regulations that apply to all similarly situated issuers.

Dental Coverage

In addition to QHPs, the ACA permits stand-alone dental plans to be sold on Exchanges.²⁰ While dental-only coverage is considered an excepted benefit under HIPAA, and is not subject to most of the insurance reforms in the ACA, federal Exchange regulations do apply cost-sharing limits and prohibitions on annual and lifetime limits to pediatric dental coverage offered through the Exchanges and apply the same certification standards to QDPs as apply to QHPs, except for those that cannot be met because QDPs offer pediatric dental benefits.²¹ Due to the fact that QHPs may omit coverage for pediatric dental benefits if dental-only coverage is available in the Exchanges, Qualified Dental Plans²² (QDPs) will likely provide a portion of the EHBs, so states may want to consider which provisions, beyond the federal requirements, should be applied to them, as a matter of state law. In the absence of federal guidance on what federal requirements would apply, some provisions that states may want to consider will include guaranteed issue, guaranteed renewability, rating rules, and rescissions, among others. Other provisions may be difficult to apply to QDPs. There is considerable uncertainty about how the presence of QDPs in Exchanges will affect the calculation of AV for QHPs that do not offer pediatric dental benefits, and about how AV requirements will apply to QDPs. According to representatives of dental plans, metal tiers could be difficult to apply because a silver plan, with a 70% actuarial value, would include cost-sharing well in excess of what is commonly sold on the market today and would not be desirable to consumers. However, dental plans will have to change in many cases to adjust to new requirements, in particular because those offering pediatric dental coverage must ensure they do not have annual or lifetime limits on the dollar value of such coverage, which is an EHB. Additionally, while the pediatric dental portion of the EHB may be provided through a QDP, the ACA and related regulations indicate that actuarial value may

¹⁸ ACA §1322

¹⁹ 45 CFR §156.520(e) of the HHS final rule on CO-OPs says health plans offered by a loan recipient may be deemed certified as a CO-OP qualified health plan to participate in the Exchanges for two years and may be recertified every two years for up to ten years following the life of any loan awarded to the loan recipient if it meets all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those State-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO-OP. *(Change Recommended by BCBSA)*

²⁰ ACA §1311(d)(2)(b)

²¹ 45 CFR §155.1065

²² While the term “Qualified Dental Plan” does not appear in the ACA, the NAIC’s American Health Benefit Exchanges Model Act uses this term to refer to stand-alone dental products sold on Exchanges.

be calculated not for individual dental plans but based on EHB coverage as a whole. The summary of benefits and coverage (SBC) was not developed with dental plans in mind and may not be appropriate for QDPs. HHS has not to date proposed an alternative SBC document for QDPs.

Grandfathered Plans

Plans in effect on the date of enactment of the ACA (March 23, 2010) may be considered grandfathered plans, and are therefore exempt from most of the law's requirements, if significant changes have not been made to them.²³ The major provisions of the ACA that apply to the form review of all grandfathered health plans include the elimination of lifetime dollar limits on EHBs, the prohibition of rescissions except in the case of fraud or intentional misrepresentation of material fact, and the extension of dependent coverage for children until age 26.²⁴ Grandfathered health plans in the small and large group markets must also comply with limitations on annual dollar limits on EHBs and, as of January 1, 2014, the prohibition on preexisting condition exclusions (the prohibition on such exclusions for children under age 19 went into effect on September 23, 2010).²⁵

Changes to the Form Review Process

While the ACA makes sweeping changes to the substantive requirements that the form review process is designed to verify compliance with, the process itself will remain the same in many respects. For most provisions of the ACA, form reviewers will be verifying that the policy documents either contain required elements, such as extended dependent coverage for adult children up to age 26²⁶, or do not contain provisions that violate prohibitions or restrictions in the law, such as prohibitions on preexisting condition exclusions²⁷ and limitations on cost-sharing²⁸. State regulators are already very familiar with this type of review, even if the substantive requirements will be new. The Appendix at the end of this paper contains summaries of some of the major new requirements, prohibitions, and restrictions that form reviewers may be looking for in policy documents.

Other reforms in the ACA, however, will require important changes to the way that issuers file policy forms and states review them. Most significantly, while forms are currently filed and evaluated at the product level, several provisions of the ACA will require analysis at the plan level.

A *product* is a package of benefits that an issuer offers that is reported to State regulators in an insurance filing²⁹. A single product filing may include many different plans, each of which is a discrete pairing of a

²³ Conditions under which a plan will lose its grandfathered status are specified in federal regulations, at 45 CFR 147.140.

²⁴ 45 CFR 147.140(d)

²⁵ 45 CFR §147.140(e)

²⁶ PHSA §2714

²⁷ PHSA §2704

²⁸ ACA §1302(c)

²⁹ 45 CFR 159.110

package of benefits and a particular cost sharing option (not including premium rates or premium quotes).³⁰ It should be noted that a product, as defined in the federal EHB guidance, does not include a cost-sharing structure.

Product filings typically include:

- Contracts (also referred to as evidence of coverage or policies)
- Certificates (also referred to as member handbooks)
- Summary of Benefits (also referred to as explanation of benefits, schedule of benefits)
- Riders or endorsements that alter the provisions of the contract

In addition to the use of riders or endorsements to alter provisions of the contract, the language of one or more product filings may include bracketed material where individual plans differ from one another. Such filings are often accompanied by statements of variability presenting form reviewers with more information about these differences. For most provisions of the ACA, this approach will continue to work well, allowing regulators to review common policy provisions in an efficient manner. Other provisions, particularly those dealing with the cost-sharing³¹ and actuarial value of plans³², must be reviewed on a plan-by-plan basis. For this reason, issuers will most likely need to submit the necessary information for review of these provisions on a plan-by-plan basis, indicating which product filings these plans are based upon. States should evaluate if and how their form and related rate review processes should be amended to accommodate a plan level review in addition to a form, product, or market level review.

For those plans that are intended as QHPs, some additional requirements will apply, mainly related to procedures for enrollment and disenrollment through the Exchange, though states may also impose their own QHP certification requirements. DOIs may need to coordinate the form review process for compliance with these requirements with the Exchange, which is addressed in more detail in the “Interactions with Exchanges and other Entities” section of this paper. Also, states with use and file dispositions may need to consider how to adjust that process to address QHP certification, since someone in the state must review each plan to ensure it meets all state and federal requirements before it can be sold as a QHP on the Exchange.

Because of the changes that will be occurring in the form filing and review processes and because of the increased volume of filings leading up to 2014, states may want to consider issuing bulletins and guidance on changes to the form filing and review process in order to ensure that issuers are aware of what the new requirements are and to assure a timely and uniform review process. Some states require form filings to be accompanied by rate filings. For purposes of ACA-related form review, states may consider decoupling form review from rate review to allow form review to proceed with the related rates filed subsequently. This could assist with workflow while also ensuring that rates accurately reflect the product design in the approved forms.

³⁰ *Ibid.*

³¹ ACA §1302(c)

³² ACA §1302(d)

A number of ACA provisions will require review procedures that are well outside of those currently employed by state regulators in the form review process which merit a separate discussion:

Essential Health Benefits (EHBs)

Plan compliance with EHB requirements will most likely be determined in much the same way that states currently enforce mandated benefit laws. For QHP products to be offered on the Exchange, states initially may want to consider streamlined workflow processes, as suggested elsewhere in this paper, to ensure appropriate review but also timely approval for initial Exchange offerings.

The major difference will be that issuers will, unless a state prohibits it, be allowed to make actuarially equivalent substitutions of benefits within each of the ten required service categories.³³ From the preliminary information currently available, it is likely that products offering benefits that vary from a state's benchmark package will need to be accompanied by a demonstration of equivalent value in each category using actuarial methodology following accepted standards of practice. This demonstration may include a description of the methodology used by the issuer to make the equivalence determination, as well as data used to support the determination. Evaluation of these filings will likely require substantial actuarial resources, depending upon how complex and subjective the process is. It should be noted that nothing in the statute or the guidance would appear to prevent a state from limiting or prohibiting these substitutions. States with limited resources in form and actuarial review may wish to consider how such limits or prohibitions may facilitate the state's review of insurance forms and plans for use after 2014.

NOTE: Additional guidance from HHS will be needed regarding whether states can limit or prohibit benefit substitutions and how to evaluate benefit substitutions, as the current guidance is both incomplete and preliminary in nature.

Actuarial Value and Cost-Sharing Reductions

While additional guidance and a completed AV calculator³⁴ will be needed before specific regulatory processes can be developed, states will likely require form filings for each plan to include a disclosure of how benefits were defined and entered into the AV calculator. Additionally, although information issued by HHS indicates that states will verify AV using the calculator for each plan inside and outside the Exchange, states may wish to consider requiring filings to include a printout of the inputs and results from the AV calculator (if the calculator allows this functionality) in order to facilitate the submission and review/approval process, provided future federal guidance permits such. This will allow states to use the calculator to verify the plan's AV or to review the submitted results, and may dispense with the need for actuarial staff to review AV calculations for plans without features, such as tiered provider networks with expected utilization spread across tiers and some value-based insurance designs, that cannot be easily captured in a calculator. In these cases, issuers may also need to provide their methodology for augmenting the results of the AV calculator. Evaluation of this

³³ Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Frequently Asked Questions on Essential Health Benefits Bulletin," February 17, 2012, p. 3.

³⁴ --, "Actuarial Value and Cost-Sharing Reductions Bulletin," February 24, 2012, p. 6.

supplemental information will require additional actuarial resources that are not today used in the form review process. To the extent that the calculator can be designed with an API or other interface that allows programmatic access to the calculator by the System for Electronic Rate and Form Filing (SERFF), the state regulatory workflow could be streamlined by automating this verification process. Additionally, states may wish to consider the use of issuer attestations and certifications in certain instances in order to reduce the volume of plans whose AV must be independently confirmed by the state.

NOTE: Additional federal guidance and a completed AV calculator are needed before specific regulatory processes can be developed.

Discriminatory Benefit Design

The ACA prohibits discriminatory benefit designs that would discourage enrollment by individuals with significant health care needs.³⁵ The bulletin issued by HHS in December 2011 indicates that this prohibition will also be incorporated into EHB regulations to satisfy the requirement that EHBs not discriminate against individuals because of their age, disability, or expected length of life.³⁶

NOTE: HHS has indicated that it is in the process of developing an electronic tool that it will use in a federally facilitated Exchange to determine QHP compliance. It is unclear yet whether a state in a partnership Exchange must use the federal tool or whether it may use its own procedures.

This tool may be made available for use by State-Based Exchanges (SBEs), though states wishing to use their own procedures and tools for enforcing these prohibitions would be free to do so.

Meaningful Difference

HHS has indicated that as part of QHP certification process related to “being in the best interest of the public,” that “meaningful difference” between QHPs on the FFE will be performed in order to assure that QHPs within a single metal level and issuer have some meaningful difference in benefit design. States with SBEs may wish to perform a similar analysis in order to help address risk avoidance through benefit design.

“Consumer Best Interest”

The ACA provides that in addition to other certification requirements, an Exchange must determine if a QHP is in the “best interest” of qualified individuals and qualified employers.³⁷ States have significant discretion in determining what criteria will be considered in making this determination. State insurance regulators performing QHP certification may wish to

³⁵ ACA §1311(c)(1)(A)

³⁶ ACA §1302(b)(4)(B)

³⁷ ACA §1311(e)(1)(B)

coordinate with their Exchange which entity should perform this part of the QHP certification process. Issues of state insurance regulator authority and possible conflicts of interest may hinder state insurance regulators ability to perform this part of certification.

Resource Considerations

Implementation of the ACA in 2014 is likely to require that additional resources in the DOI be devoted to the form review process for QHPs in the Exchange and for health plans outside the Exchange. The state may require additional actuarial resources, such as actuaries, actuarial students, or administrative staffing, in order to accommodate the review of new and revised plan designs, the accuracy of actuarially equivalent substitutions of EHBs, the assessment of the actuarial value, the implications and effects of cost-sharing reductions, and discriminatory benefit design analysis.

In addition to new actuarial resources, the DOI and other state agencies will need adequate professional and administrative staffing to review new and revised forms, as well as to ensure compliance with new and existing state and federal laws. In particular, the period leading up to the October 2013 initial open enrollment period will likely be quite busy as issuers prepare QHP filings to be sold on the Exchange. In addition to the increased number of filings, the ACA's new requirements may cause some confusion, extending the amount of time needed for review. As filers and reviewers become accustomed to the new requirements over time, the process will likely become more efficient. In the interim, states may want to implement tools to streamline the process by updating their current product review standards through statutory or regulatory amendments, on-line state specific standardized checklists, or other on-line filer tools to assist the health care industry in submission of plans to states for review. Additional training for industry filers and state form review and actuarial staff will be paramount in order to ensure a good knowledge base for the most efficient and consistent review of products and plans.

Interactions with Exchanges and other Entities

Once the form review process at the DOI has been completed, it is important to consider how the Department will interact with the Exchange in order for an issuer to have plans available for purchase. These interactions should be carefully designed, keeping in mind the amount of time involved for a DOI to complete its policy form and rate reviews, followed by a review to determine if a plan should be certified as a QHP. Bypassing any redundant work flows will be necessary to assure the accuracy of plan information displayed on an Exchange. Electronic processes for communication between DOIs and an Exchange will also be imperative to ensure timely and accurate QHP approval processes.

In all Exchange options as described below, a state retains its regulatory authority for plan review for compliance with all state laws. An entity that performs both plan form review and QHP certification will most likely be able to significantly reduce the timeline and resources necessary for a QHP to be offered on an Exchange. When an entity other than a DOI performs QHP certification, the DOI will still review the plan for compliance with all state and federal insurance laws. Another entity, the federal government or the Exchange (whether state-operated or a federal-state partnership), will also have to review the plan for compliance with QHP certification requirements. Issues to be resolved and decisions made will then need to be communicated and reconciled among all entities. Communication between the DOI and Exchanges may be facilitated through SERFF in order to leverage existing technology that is already in

use today. HHS has made a commitment to working with the NAIC so that SERFF can be leveraged by SBE and partnership states to perform certain plan management functions, including QHP certification, benefit and rate data collection and reporting associated with QHP submissions. HHS has also committed to working with the NAIC to ensure that in the FFE, issuers will not be overly burdened by duplicative data entry and states may continue to utilize existing technology to perform regulatory review of forms and rates to confirm that benefit and rate information intended for display within the FFE is consistent with that which was approved by the state.

State-Based Exchange

A SBE will offer the greatest amount of flexibility for states and will need to determine which entity will certify a plan as a QHP. The DOI is familiar with similar processes and is best suited for an effective and efficient review for QHP certification; however, a state may alternatively vest QHP certification responsibilities with the Exchange or some other entity, particularly if it pursues a selective contracting Exchange model. If some or all of the QHP certification is to be undertaken by the Exchange or another entity, insurance departments may consider recommending their proven, effective and efficient processes as guidance to assist with timely approval of QHPs to be offered on the Exchange. Processes for loading QHPs onto an Exchange once they have been properly filed, reviewed, and approved by a DOI and have received QHP certifications should be streamlined. Again, incorporating SERFF into the Exchange's plan management infrastructure will help facilitate this process.

Partnership Exchange

A state that enters into a Partnership Exchange will have the option to retain plan management responsibility, which includes QHP certification, or to delegate plan management in its entirety to the federal government. In a Partnership Exchange where the state maintains plan management, the interaction between the state and a FFE will be similar to the interaction with a SBE. Once the certification process is complete, the state would need to communicate that fact to HHS via SERFF or some other method.

Federally Facilitated Exchange

The federal plan management process is not yet fully defined. In a FFE a state will retain existing form and rate review responsibilities for compliance with state laws, though plans intended for sale on the Exchange will likely undergo an additional, subsequent round of review by HHS for QHP certification purposes.

Multi-State Plans and OPM

States will review plans for compliance with all state laws, while OPM will likely review them for compliance with the terms of its contractual requirements with multi-state plans.

NOTE: How interactions such as communication and reconciliation between a state and OPM will be accomplished is unknown until when OPM releases regulations governing multi-state plans.

Use of SERFF

Over the past ten years states have worked to improve the process for issuers to submit their rate and form filings to DOIs. The NAIC has assisted in this process through Speed to Market initiatives and the submission of electronic rate and form filings via SERFF. SERFF can play a role in Exchange administration for regulators who need to implement new requirements, husband resources and integrate regulation inside and outside of Exchanges.

States can continue to use SERFF for form review as they establish their ACA-related requirements for health insurance forms. SERFF can be an avenue for each state to configure and publish its new substantive and procedural requirements. For example, with regard to benefit design, when a state has decided on its EHBs, the state can maintain a list of its EHBs in SERFF to function as a compliance checklist for issuers and regulators. As an example with regard to consumer protection and transparency, SERFF is one of the places where a state can inform issuers how that state will treat the federally required SBC: as a form subject to review, as supporting documentation, or as an informational item. A state can also use SERFF to instruct issuers whether forms must be redlined to show ACA-related changes from previously approved versions, whether supplemental benefits or non-discrimination provisions should be flagged for state reviewers, and how other ACA requirements apply in that state. States using SERFF will need to review federal ACA requirements and related final rules in relation to their state requirements, update those respective standards accordingly, and re-post within SERFF.

While not yet available, enhancements to SERFF that are currently underway will enable states to use SERFF not only for form and rate review but to review QHP applications, certify QHPs to participate in Exchanges, and carry out related oversight functions, such as renewing, monitoring, recertifying, and decertifying QHPs. It is envisioned that an issuer that wants to base a QHP on an insurance product it already offers in a state will have the ability to “build” a QHP in SERFF using forms and rates that the state has already accepted, depending on the state’s existing requirements.

This QHP-building capability is one way to bridge the gap between products and plans. This capability also will minimize the duplication of submission efforts for issuers, as well as the duplication of form review and enforcement efforts for regulators. However, issuers and regulators should expect that the initial rounds of QHP applications may require new and revised forms and rates, with efficiency increasing as the number of QHPs increases. Finally, if QHP forms and related information reside in SERFF along with non-QHP forms and information, regulators will have consistent, simultaneous access to health insurance products on and off the exchange. This will facilitate any parallel and cross-walked reviews required by ACA.

APPENDIX: 2014 ACA Rules and Regulations that will Impact Form Filings

The following summarizes federal law and regulations relating to market reforms found in the ACA that are effective on January 1, 2014. As noted, some market reforms are specific requirements related to QHPs only. States may wish to analyze existing state protections against the federal standards in light of the preemption provisions of the ACA.

Benefit Design Requirements

Essential Health Benefits (EHB)

The ACA requires that all non-grandfathered individual and small group plans, inside and outside the Exchange, provide coverage for the EHBs outlined in §1302(b) of the Act. This section provides that the EHBs include items and services within the following 10 benefit categories:

1. ambulatory patient services
2. emergency services
3. hospitalization
4. maternity and newborn care
5. mental health and substance use disorder services including behavioral health treatment
6. prescription drugs
7. rehabilitative and habilitative services and devices
8. laboratory services
9. preventive and wellness services and chronic disease management, and
10. pediatric services, including oral and vision care

HHS issued a bulletin in December 2011 that outlined a process for states to select a benchmark plan from the following list whose benefits will constitute the EHBs for the individual and small group markets for the State for calendar years 2014 and 2015:

- the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- any of the largest three state employee health benefit plans by enrollment;
- any of the largest three national FEHBP plan options by enrollment; or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

HHS has also advised that a state may select only one of the benchmark options as the applicable EHB benchmark plan across its individual and small group markets, both inside and outside of the Exchange. If

the selected benchmark package does not include services from any one of the required categories, the state must supplement the package as outlined in the bulletin issued December 16, 2011 or as may be outlined in future guidance or rules with the benefits in that category from another one of the benchmark plans or from another source. HHS also defined the largest plan by enrollment in the largest small group product as the default benchmark should a state not make an election.³⁸

HHS guidance has indicated that plans will be permitted to make actuarially equivalent substitutions within each of the 10 categories specified. At this point, whether a state can limit or prohibit such substitutions is not clear. Nonetheless, companies requesting actuarially equivalent substitutions will be expected to provide supporting documentation and detailed demonstrations that the form meets all required EHB categories; and include additional demonstrations if actuarially equivalent substitutions are made within any of the categories.

States may accept a certification of compliance from issuers requesting actuarially equivalent substitutions and/or request review by an actuary. Where applicable, states may require statements of variability and/or copies of previously approved forms with “tracked” changes.

Dental Plan Benefits

A plan may not be excluded from the Exchange for failure to provide pediatric dental benefits if a stand-alone dental plan (QDP) is available on the Exchange

Benefit limits

Currently, annual limits on the dollar value of EHBs are restricted and lifetime limits on the dollar value of EHBs are prohibited. In 2014, issuers will additionally be prohibited from imposing annual limits on the dollar value of EHBs. This limitation does not apply to any individual or group plan for specific covered benefits that are not EHBs to the extent that such limits are otherwise permitted under applicable federal or state law.

Mental Health Parity (MHPAEA)

Section 1311(j) of ACA states “Section 2726 of the Public Health Service Act (PHSA) shall apply to QHPs in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.” In turn, Section 2726 of the PHSA applies to a “group health plan or a health insurance issuer offering group or individual health insurance coverage³⁹.” Therefore, the requirements of the MHPAEA must be applied to all plans of health insurance coverage whether issued inside and outside of the Exchange, to an individual or through an employer group.

The MHPAEA requires plans that cover mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations upon mental health and substance abuse treatment services that are more restrictive than the predominant

³⁸ For full details on HHS’ specification of the default EHB benchmark plan, please see:

Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, “Essential Health Benefits Bulletin,” December 16, 2011, p. 11

Additional details are expected in forthcoming EHB regulations.

³⁹ PHSA §2726

requirements and limitations that apply to substantially all medical and surgical services. Financial requirements includes deductibles, copayments, coinsurance, and out of pocket maximums. Although the MHPAEA regulation excludes aggregate lifetime and annual dollar limits from the meaning of financial requirements, the ACA requirements for annual and lifetime dollar limits includes mental health and substance abuse disorders as part of the EHBs.

Additionally, mental health and substance abuse services may not be subject to separate cost-sharing requirements, and if a plan provides for out of network coverage of medical and surgical services, it must also provide out-of- network coverage for mental health and substance abuse treatment.

Cost-Sharing Limitations

Subsection 1302(c) of the ACA and section 2707 of the PHS, as added by the ACA, address the restrictions on cost-sharing that may be applied to non-grandfathered health plans. The law limits cost-sharing under a health plan to the maximum cost-sharing allowed for high-deductible health plans in 2014 (currently \$5,950 for individual/ \$11,900 family). In subsequent years, the limitation on cost-sharing is indexed to the rate or average premium growth. Additionally, deductibles for plans in the small group market are limited to \$2,000 individual / \$4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.

NOTE: Additional information regarding cost sharing limitations should be provided as further guidance is released.

Prohibition on Discriminatory Benefit Design

HIPAA protections already in effect for the small employer market include these same health status-related factors with the exception of “any other health status-related factor deemed appropriate by the Secretary.” In addition, the benchmark plan that will be in place in 2014 will be reviewed and approved by HHS; therefore, the benchmark plan will include eligibility provisions that comply with this requirement. When issuers make substitutions in the benchmark, states will need to conduct an in-depth form review to ensure that benefit design substitutions are not discriminatory. In the absence of HHS-established guidelines governing benefit design prohibitions that have the effect of discouraging the enrollment of individuals with significant health needs in a particular plan, some states may choose to require company certification of compliance in this area. A related provision prohibits the use of health status-related factors by issuers. For more information on that provision, see XXXXXXXX

NOTE: States will look to HHS for additional guidance or rules regarding the prohibition of plans that employ discriminatory plan design.

Prohibition on Preexisting Condition Exclusions

Since September 23, 2010, issuers have been prohibited from excluding coverage for preexisting conditions for children under age 19. This prohibition applies to all health benefit plans and health insurance policies except for grandfathered individual market policies.

For plan years beginning January 1, 2014, the prohibition on preexisting condition exclusions will extend to people of any age, but will still not apply to grandfathered individual market policies. This prohibition

will apply to all other health benefit plans and health insurance policies sold inside and outside the Exchange and will also apply to Qualified Dental Plans.⁴⁰

It is not expected that issuers will need to submit any additional supplemental information. However, the regulating state will need to perform an appropriate review of the forms to ensure the presence of required provisions and the absence of prohibited language.

Network Adequacy/Service Areas

Section 156.230 of the final Exchange regulations require that a QHP include within its provider network a sufficient number of *essential community providers*, where available, that serve predominantly low-income, medically underserved individuals. This section defines *essential community providers* as those health care providers defined in section 340B(a)(4) of the Public Health Service Act.

At a minimum, QHP plans should ensure a sufficient choice of providers in a manner consistent with applicable network standards of section 2702 (c) of the Public Health Service Act, provide information to enrollees and prospective in-net-work and out-of-network providers, and include those defined *essential community providers* as referenced previously. Furthermore, states with tribal organizations may wish to explore designating Indian Health Service providers as essential community providers.

NOTE: Additional federal guidance may be forthcoming relating to adequacy of essential community providers.

Considerations include the need to address how QHPs respond to areas with recognized shortages of health providers (especially rural and remote areas); provider participation; reimbursement levels; requirements for health issuers and participating providers; filing requirements and state administration; network and provider disclosure to insured and enforcement.

Reviewers of QHP-related forms that include in and out-of network provisions should be mindful of descriptions of service areas, and consult current statutes governing managed health care arrangements along with the ACA directives.

A separate White Paper deals with network adequacy issues in greater depth. For more information, please see that paper.

Abortion Services and Separation of Funds

The ACA requires QHPs to segregate funds in a separate allocation account to pay for coverage of certain elective abortion services that cannot be paid for with federal funds. A QHP issuer satisfies this requirement if it issues an itemized bill that separates the costs of abortion coverage from the costs of all other coverage, collects the required separate payments through a single transfer of funds in response to the itemized bill, and maintains “allocation accounts” in line with current industry practice. A QHP issuer must collect separate payments *only* from individuals receiving premium assistance credit; therefore, the segregation requirements apply only to these individuals. QHPs must also submit a plan to the state Insurance Commissioner that details its process and methodology for complying with these requirements.

⁴⁰ 45 CFR 155.1065

Reviewers of forms with the provision for abortion coverage should be mindful of such statutory and regulatory requirements and any relevant state laws.

Individuals in Clinical Trials

Effective January 1, 2014, the ACA requires that if a “qualified individual” is in an “approved clinical trials,” the plan cannot deny coverage for related services. Plans are not required to cover treatments that fall outside the designated class of approved clinical trials, and plans may not deny coverage because a member is participating in an approved clinical trial conducted outside of the state in which the member lives.

A “qualified individual” is someone who is eligible to participate in an “approved clinical trial” and either the individual’s doctor has concluded that participation is appropriate or the individual provides medical and scientific information establishing that their participation is appropriate.

An “approved clinical trial” is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

In connection with expenses, “routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan’s network area unless out-of-network benefits are otherwise provided under the plan.

If a participating provider is participating in an approved clinical trial, the plan may require the individual to participate in the trial through that participating provider if the provider will accept the individual as a participant in the trial.

Many states may already mandate coverage for clinical trials relating to cancer and other diseases or conditions. The ACA provision extends to life-threatening conditions. State coverage mandates should be examined to ensure that they are consistent with these federal requirements.

Consumer Protection and Transparency Requirements

Guaranteed Availability

Effective 2014, Section 2702 of the PHSA requires each QHP issuer to accept every qualifying employer and individual that applies for coverage and who works or resides in its state. However, issuers may restrict enrollment to open and special enrollment periods and enrollment periods for qualifying events.

Currently effective for plan years starting 6 months after enactment, plans must already comply with the requirement providing coverage to enrollees up to age 19.

Regulators should review QHP forms to assure that prohibited provisions are not included.

Guaranteed Renewability

Section 2703 of the PHSA, as amended by the ACA guarantees the renewability of insurance coverage. An issuer that offers health insurance coverage in the individual or group market must renew or continue in force coverage at the option of the plan sponsor or individual. An issuer may only non-renew or cancel coverage in the event of nonpayment of premiums, fraud, violation of participation or contribution rates, market exit, movement outside the service area, or cessation of association membership.

Forms will be reviewed to ensure continued compliance.

Enrollment

QHPs within the Exchange must provide an initial open enrollment period, an annual open enrollment period and a special enrollment period for triggering events. Such dates must be clearly defined. Enrollments as a result of birth, adoption, or placement for adoption must be effective on the date of birth, adoption or placement for adoption. Additionally beginning in 2014, issuers in the exchange must provide a written notification of annual open enrollment to each enrollee.

Forms will need to be revised, or an endorsement/amendment form(s) will need to be attached to current forms. Regulators will need to review such forms for compliance with these required provisions and notification(s). Additionally, application/enrollment forms and possibly marketing materials may also require review to determine compliance with the updated enrollment requirements.

NOTE: States will need to consider additional, anticipated federal guidance on open enrollment periods outside an Exchange.

Termination of Coverage

Section § 155.430 of the final Exchange regulations sets rules establishing when individual's coverage in a QHP may be terminated, when an enrollee may terminate his or her coverage, the appropriate effective date of termination and proper notification of termination requirements.

Regulators will need to review QHP-related forms and any endorsements or amendments for compliance with these provisions.

Grace Periods

Section §156.270 of the final Exchange regulations requires a provision within the termination coverage section that directs QHP issuers to provide notice to all enrollees who are delinquent on premium payments. Individuals receiving an advanced premium tax credit, who lose coverage due to non-payment of premium must be provided a three-month grace period. The QHP must cover all allowable claims for the first month of the three-month grace period and may pend subsequent claims in the second and third months of the grace period. During the grace period a QHP issuer will continue to collect subsidy payments on the delinquent enrollee's behalf and return such payments of the premium tax credit for the second and third months of the grace period if the enrollee exhausts the grace period.

Regulators will need to review QHP-related forms and any endorsements or amendments to assure compliance with QHP grace period and proper notification requirements, and necessary disclosure regarding retention of premium tax credits.

Regulators also must assure that the grace period is applied uniformly to all QHP enrollees in similar circumstances and that the QHP maintains proper records of the termination of coverage.

Waiting Periods

PHS Act section 2708 sets rules prohibiting group health plans and coverage from imposing excessive waiting periods. A waiting period begins on the date the employee becomes a qualifying employee and must not exceed 90 days.

QHP forms must be revised to include an updated definition of a waiting period pursuant to section 2704(b)(4) to state: the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. NOTE this definition does not distinguish between Full-Time and Part Time employees.

Regulators must review forms for prohibited excessive waiting period provisions (also known as probationary periods) which may appear within application or enrollment forms.

Regulators must review forms, including application/enrollment forms, for prohibited excessive waiting period provisions (also known as probationary periods).

Prohibition on Utilization of Health-status Related Factors

The ACA requires that for plan years beginning January 1, 2014, non-grandfathered plans may not include in eligibility provisions or continued eligibility provisions, rules for eligibility based on any “health status-related factor.” A “health status-related factor” means any of the following: health status, medical condition (physical or mental), claims experience, receipt of health care, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability, or any other health status-related factor deemed appropriate by the Secretary.

Non-Discrimination against Participants and their Beneficiaries Based on Race, Ethnicity, Nationality, Gender, Age, Disability, Sexual Orientation, Genetic Information and Religion

Under §1557 of the ACA and existing civil rights laws, no enrollee shall, on the basis of race, color, national origin, sex, age or disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, under any health program or activity, any part of which is receiving Federal financing assistance, including credits, subsidies, or contracts of insurance.

Some states may require a review of forms to assure prohibited provisions are not present. Some states may only require the issuer to submit written certification providing acknowledgement and assurance that the issuer does not discriminate based on Race, Ethnicity, Language, Nationality, Gender, Age, Disability, Sexual Orientation or Domestic Violence.

In any case, since §1557 of the ACA and existing civil rights laws apply broadly, Regulators must review application and enrollment forms for questions that may include any prohibited elements and the potential underwriting or eligibility determinations based on such responses. Issuers of QHPs are covered under §1557 and other federal civil rights laws because they will receive insurance premium payments through

federal premium credits, a form of federal financial assistance. In addition, Exchanges must also comply with §1557's ban on discrimination as entities established under Title I of the ACA. Exchanges are, therefore, barred from allowing insurance companies that discriminate to participate in Exchanges because to do so would be to provide assistance to discriminatory policies themselves in violation of §1557 and other federal civil rights laws. Additional requirements in the ACA require that regulators be assured that SBC documents are provided in linguistically correct language. Additionally, actuarial memorandums and rate manuals may need to be analyzed for such non-discrimination underwriting practices.

Prohibition on Discrimination against Providers Acting within Scope of own Licensure or Certification

Plans may not discriminate against any provider acting within his scope of practice. However, this law does not require that a plan contract with any willing provider and does not prohibit tiered networks. QHPs must ensure a sufficient choice of providers in a manner consistent with network adequacy provisions.

This is an insurance plan/provider contract issue and it is not clear where this provision would be applicable within a QHP insurance coverage plan other than assuring that medical staff and facilities are sufficient enough for compliance with the provisions of preventive health benefits as it applies to Woman's health services and screenings for infants, children and adolescents.

Additional guidance from HHS is needed.

Prohibition on Discrimination against Individuals Receiving Subsidies and Cooperating with Investigations

This section also prohibits issuer and health benefit plan discrimination against individuals because the employee receives a credit or subsidy, or because they provide information to investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act, or objected to any activity the employee believed to be in violation of the Act.

Summary of Benefits and Coverage

A group or individual plan must provide without charge, a written uniform Summary of Benefits and Coverage (SBC) document for each benefit package, to individuals and beneficiaries, or plan sponsors upon receipt of an application, if there is a change in the SBC, or within 7 days upon request. Additional time period scenarios are also specifically defined.

An SBC is to be provided to participants and beneficiaries who enroll or re-enroll in group health coverage beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. In the individual market, these requirements are applicable to health insurance issuers beginning on September 23, 2012.

There are 12 content elements required to be within the SBC, including uniform standard definitions of medical and health coverage terms, a description of the coverage including the cost-sharing requirements such as deductibles, coinsurance, and copayments; and information regarding any exceptions, reductions, or limitations under the coverage, illustrative coverage examples, network provider information, contact information, and a clear disclosure that the SBC is only a summary.

Specific rules also regard the manner in which the SBC is to be provided, the appearance and format of the SBC and that it is to be delivered in a culturally and linguistically appropriate manner.

Some states have determined that the SBC is a form of advertising, outline of coverage, or marketing material and is therefore required to be submitted to the DOI for review and approval. Other states have determined that the SBC is not a part of the contract, and as such, there is no regulatory authority for review. States also may request the SBC to be submitted (perhaps as a variable template) for informational purposes thereby not taking review and approval action.

Any States that review of the SBC document may wish to confirm the benefits of the SBC reflect the covered EHBs, cost-sharing and AV (metal level) that the final approved rates and forms permit. The SBC can only be completed once the rate and form filings have been finally approved.

The SBC document may need to be modified for Qualified Dental Plans, though HHS has not yet provided such a document.

Actuarial Requirements

A number of ACA provisions will likely require states to devote actuarial resources to determine whether health insurance plans are in compliance with the law. Actuarially equivalent substitutions of EHBs, compliance with actuarial value requirements, and the provision of reduced cost-sharing to individuals with household incomes below 250% of the Federal Poverty Level (FPL) are all likely to require some level of actuarial analysis in the form review process.

Actuarially Equivalent Substitutions of EHBs

Of these three provisions, the most intensive actuarial work will most likely come from actuarially equivalent substitutions of EHBs. Subsection 1302(b) of the ACA requires all health insurance plans sold through Exchanges to include EHBs, including benefits in each of 10 categories of services, as defined by the Secretary. Subsection 2707(a) of the Public Health Service Act, as added by section 1201 of the ACA extends this requirement to all plans in the individual and small group markets. In a bulletin issued on December 16, 2011, HHS signaled that it was considering permitting issuers with “some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories.” The bulletin suggested that these substitutions could potentially occur both within and across the 10 categories, though a subsequent FAQ document seems to limit them to those within a category. All substitutions must be actuarially equivalent; using the same measures defined in CHIP,⁴¹ and must also comply with prohibitions on discriminatory benefit designs. Since the benefits of the EHB Benchmark as adopted by a state and approved by the Secretary, if required, should be non-discriminatory, states may wish to focus limited actuarial resources for discriminatory benefit design analysis upon plans that have utilized actuarial substitutions.

⁴¹ 42 CFR § 457.431

Actuarial Value

Subsection 1302(d) of the ACA requires non-grandfathered individual and small group health insurance plans, except for catastrophic plans, to fall within one of four “metal tiers” defined by the actuarial value⁴² (AV) of the benefits offered by the plan relative to the full cost of the EHBs:

- Platinum: 90% AV
- Gold: 80% AV
- Silver: 70% AV
- Bronze: 60% AV

Subsection 2707(a) of the Public Health Service Act, as added by section 1201 of the ACA extends this requirement to all plans in the individual and small group markets. Plans would be allowed a margin of +/- 2% of the required actuarial value for each metal tier. At a minimum, all issuers selling coverage through the Exchange must make available at least one plan in the silver level and one plan in the gold level.

Subsection 1302(e) defines a catastrophic plan which is a permissible benefit design offered to certain qualified individuals that does not meet a specific AV but must comply with the maximum out-of-pocket limits.

On February 24, 2012, HHS issued a bulletin describing their intent to develop an actuarial value calculator that will be publicly available and based upon a single set of nationwide data reflecting the price of care and utilization patterns of non-elderly individuals in the individual and small group health insurance markets. States would be divided into three tiers, reflecting geographic variations in the cost and use of health care services, in order to more accurately calculate the AV of a plan sold in a specific market. Alternatively, states would be allowed to substitute their own data sets in order to gain further accuracy. Issuers would enter major cost-sharing features of each health insurance plan to be sold in the calculator, which would return the expected actuarial value of the plan.

Some state DOIs have considered using standard benefit designs on the Exchange, but the federal law does not require it and the majority of states will not standardize them. Each state DOIs will have the option to either develop specific benefit design for each of the metal plans that include the EHBs and cost-sharing or allow issuers to design the plan as long as it meets the required actuarial value. State DOIs will develop EHBs, but those do not reflect cost-sharing or metal tiers. Some state DOIs will require base metal plans offered inside the Exchange to be offered outside of the Exchange.

Some states have considered using standard benefit designs on the Exchange, but the federal law does not require it. Each state will have the option to develop specific benefit designs or benefit design parameters for each of the metal coverage levels, which could greatly increase consumers’ ability to understand their coverage options and compare plans on the basis of price and quality. Alternatively, states could allow issuers broad leeway to design their products as long as they meet all applicable federal and state standards. EHB benchmark plans will not reflect cost-sharing or metal tiers. Some states DOIs will require plans offered inside the Exchange to be offered outside of the Exchange.

⁴² “Actuarial Value” is a measure of the percentage of expected health care costs a health plan will cover and can be considered a general summary measure of health plan generosity.

Consumer representatives have urged regulators to consider the potentially discriminatory effects of complex and unusual cost-sharing interactions. Representatives of health issuers, however, caution that overly broad caution could limit health plan innovation or the use of quality-driven networks and tiers. Consumer representatives also suggested that portions of the form filing demonstrating actuarial value be subject to independent actuarial review and available to the public. Issuer representatives disagreed, citing a need to maintain the confidentiality of proprietary information and trade secrets.

Cost-sharing Reductions for Individuals below 250% of Federal Poverty Level (FPL)

Section 1402 of the ACA outlines requirements for QHPs to provide reduced cost-sharing for individuals with household incomes below 250% of FPL purchasing coverage through the Exchange. The actuarial value bulletin published by HHS in February 2012 also provides guidance for the provision of reduced cost-sharing. Each silver-level plan submitted to the Exchange must be accompanied by three variants providing AVs of 73%, 87% and 94%. These AVs would be verified in the same way as AVs for the metal tiers are verified. In addition, it must be verified that the reduced cost-sharing was achieved in accordance with federal requirements. According to the bulletin, cost-sharing must first be reduced by reducing the out-of-pocket limit to levels specified in annual guidance that will be provided by HHS, and then by applying adjustments to other cost-sharing factors. Nothing in the law or federal regulations would prevent a state from being more specific, about how issuers offering silver plan variants must reach the higher AVs associated with the cost-sharing reductions. (Such state specifications would have to be consistent with the federal standards described above.) Some states may wish to consider such specifications, for example, as a way to ensure low-income people can access plans with up-front cost-sharing charges that are as low as possible, ease comparability of different coverage options for consumers, and simplify regulators' work in ensuring plans provide the required actuarial values. Like AVs for metal tier levels, states will also need to ensure that the design of reduced cost-sharing variants does not violate prohibitions on discriminatory benefit design.

Additionally Section 1402 provides that QHPs covering an American Indian/Alaskan Native whose family income is under 300% of the FPL shall not be subject to any cost-sharing under the plan. This provision is not specifically addressed in the AV bulletin, so additional guidance from HHS would be expected to address how the plans should be structured to comply with AV requirements.