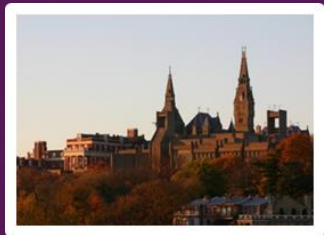


Preparing for 2015: Resources for State Regulators Policy Form and QHP Application Review Checklists & Additional Tools

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State Health Reform Assistance Network
Charting the Road to Coverage



Robert Wood Johnson Foundation

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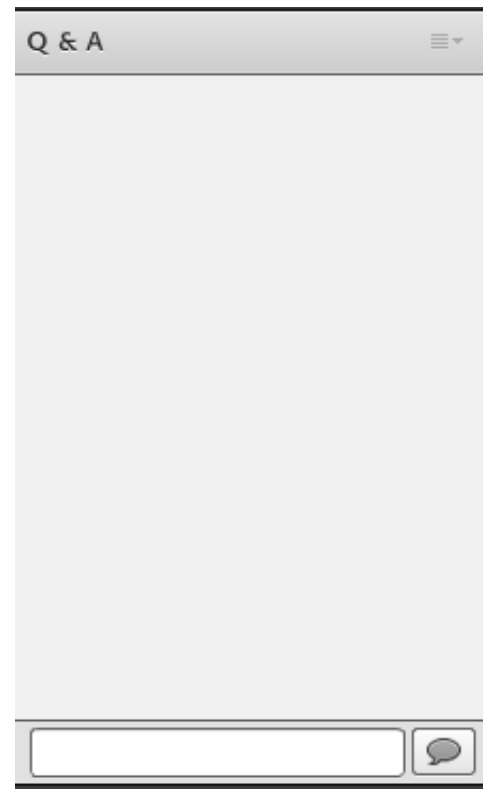
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Form and QHP Application Review Checklists & Additional Tools

All checklists and tools are available at www.statenetwork.org.

- [QHP Certification Checklist](#)
- [Form Review Checklists](#), including individual, small group, stand-alone dental, and catastrophic
- [Issuer EHB Crosswalk and Certification](#)
- [Mental Health Parity and Addiction Equity Act Issuer Checklist and Certification](#)
- [Network Adequacy Planning Tool](#)
- [Consumer Services Toolkit](#)

QHP Certification Checklist

- States may review/update as necessary to reflect state-specific processes, policies, and procedures
- Options for confirming whether a requirement is met:
 - Verify directly through evidence
 - Accept verification by company officer
 - Accept verification by company officer that company is taking steps to meet the requirement by specified date

QHP Certification Checklist Changes

- RECENT CHANGE: Cap on annual small group plan deductible eliminated
- Updated
 - Annual open enrollment information
 - Annual out-of-pocket maximum amounts for 2015 (\$6,600 Individual, \$13,200 Family)

QHP Certification Checklist Example

	Requirements	Federal Source	SERFF Supported Function*	SERFF Could be used for data function**	Notes
11.3	<input type="checkbox"/> Accepts enrollment information consistent with the privacy and security requirements established by the Exchange.	45 CFR §156.265 (c)		X	
11.4	<input type="checkbox"/> Uses the premium payment process established by the Exchange.	45 CFR §156.265 (d)		X	
11.5	<input type="checkbox"/> Provides new enrollees an enrollment information package that is compliant with accessibility and readability standards.	45 CFR §156.265 (e)		X	
11.6	<input type="checkbox"/> Reconciles enrollment files with HHS and the Exchange no less than once a month.	45 CFR §156.265 (f); 45 CFR §156.400 (d)		X	
11.7	<input type="checkbox"/> Acknowledges receipt of enrollment information transmitted from the exchange in accordance with Exchange standards.	45 CFR §156.265 (g)		X	

**SERFF collects data for analysis of the requirements in this column.*

***SERFF may be used to collect state-specific, document-based information to support review of requirements in this column.*

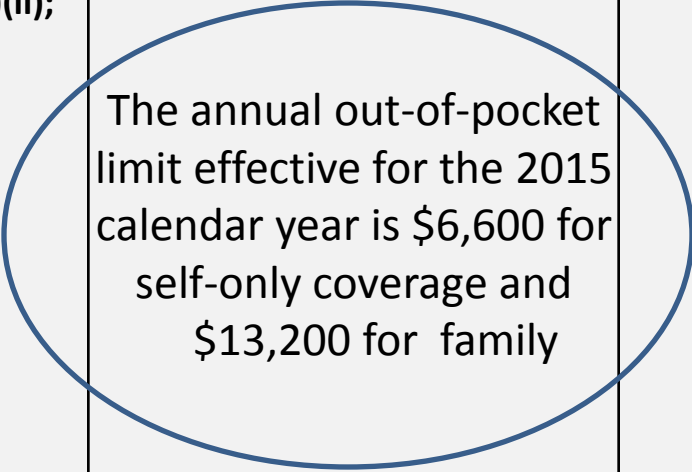
Form Review Checklists

- Four checklists for four form types:
 - Individual
 - Small Group
 - Stand-Alone Dental
 - Catastrophic
- Include ACA and implementing regulation requirements
- Include additional reform laws, e.g., Women's Health and Cancer Rights Act (WHCRA)
- Can be used as they are, or modified to include state-specific mandates

Individual Checklist 2015 Changes

- Updated
 - Annual open enrollment information
 - Effective dates of coverage
 - Annual out-of-pocket maximum amounts for 2015 (\$6,600 Individual, \$13,200 Family)
- Expanded information about
 - Special enrollment triggers and time periods
 - Effective dates of coverages
 - Effective dates of termination
 - Cost-sharing subsidies

Individual Checklist Update Example

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
<input type="checkbox"/> Cost-sharing limited to maximum out-of-pocket for high deductible health plans in 2015 (adjusted by IRS). <input type="checkbox"/> Cost-sharing includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a <u>qualified medical expense</u> for EHB covered under the plan <input type="checkbox"/> Qualified medical expense means an expense paid by the insured person for medical care for her/himself, covered spouse, and covered dependent(s) that are not compensated for by insurance or otherwise.	42 USC §18022, 26 USC §223(c)(2) (A)(ii); 45 CFR § 156.130	 <p>The annual out-of-pocket limit effective for the 2015 calendar year is \$6,600 for self-only coverage and \$13,200 for family</p>			

HHS/DOL Model Notices and Disclosures

- Notice of adverse benefit determination and appeal rights
- Internal and external review request formats and decision notices
- Notice of right to designate a primary care provider
- Notice of Rights Under the Newborns' and Mothers' Health Protection Act
- Model WHCRA enrollment and annual notices
- Examples for non-grandfathered 2015 Individual market non-exchange products form review

Small Group Checklist Changes

- RECENT CHANGE: Cap on annual deductible eliminated
- Updated
 - Annual open enrollment information
 - Effective dates of coverage
 - Annual out-of-pocket maximum amounts for 2015 (\$6,600 Individual, \$13,200 Family)
- Expanded information about
 - Special enrollment triggers and time periods

Small Group Checklist

Category Removed

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
<div></div> <div></div> <div> <input type="checkbox"/> Deductibles are limited to \$2,050 for individual and \$4,010 families for 2015. </div>	<div></div> <div></div> <div></div> <div>42 USC §18022,</div> <div>26 USC</div> <div>§223(c)(2)</div> <div>(A)(ii); 45</div> <div>§156.130(b)(2)</div>	<div></div> <div></div> <div> <p>Note: A health plan's deductible may exceed the 2015 maximum annual limitation on deductibles in instances where the plan may not reasonably reach the AV of a given level of coverage without exceeding the annual deductible limit.</p> </div>			

Catastrophic Plan Checklist Differences

- Must be an eligible individual
 - Not yet 30 years old, or
 - Have a certificate of exemption due to
 - Hardship, or
 - Lack of affordable coverage
- Family catastrophic coverage
 - All family members must be eligible

Catastrophic Plan Checklist Differences

- “Affordable Coverage” defined as:
 - Premium costs exceed 8% of household income
 - For non-employer plan - lowest cost bronze Exchange plan premium, minus subsidies
 - For employer plan - employee share of premium for employer’s least expensive plan that achieves minimum (60%) actuarial value

Catastrophic Plan Checklist Differences

- Certain services covered whether or not the deductible has been met
 - Three primary care office visits
 - Preventive services
- No actuarial value requirement
- Deductible is same as maximum-out-of-pocket for other Qualified Health Plans

Stand-alone Dental Checklist Differences

- No lifetime or annual limits on dollar value of pediatric dental EHBs
- Minimum actuarial value
 - Low coverage level, 70 percent
 - High coverage level, 85 percent
 - de minimis allowable variation, + or (-) 2 percent
- Annual cost-sharing limits must be “reasonable”
 - Example: FFE cost sharing is \$700 for one child, \$1400 for two or more

Issuer EHB Crosswalk and Certification

- Allows form reviewers to quickly find and verify that EHB requirements are met.
- Issuers complete Crosswalk and Certification by:
 - Identifying required benefit with corresponding benefit in the product filing, including page number
- Issuers certify:
 - Information on Crosswalk is accurate and complete
 - Filing meets EHB requirements per state's benchmark plan

Issuer EHB Crosswalk and Certification

Benefit	Description and Location of Benefit in Issuer's Policy	Description and Location of Corresponding Benefit in [INSERT STATE]'s Benchmark Plan (BP)
<p>The benefits included in [INSERT STATE]'s benchmark plan are “essential health benefits” (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 C.F.R. §§147.150 & 156.100 et. seq.</p> <p>The issuer must complete and submit this Crosswalk and Certification for each policy filed for review.</p>		
[INSERT BENEFIT]	See page __ of _____.	See page __ of BP.

I, on behalf of [INSERT ISSUER], hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in [INSERT STATE]'s benchmark plan are included in the policy or policies filed by [INSERT ISSUER] for review and approval.

Name:

Title:

Mental Health Parity and Addiction Equity Act Issuer Checklist and Certification

- Used to review products for MHPAEA compliance
- Issuers must:
 - Indicate compliance with the following requirements:
 - Parity in aggregate lifetime and annual dollar limits
 - Parity in financial, quantitative and non-quantitative treatment limitations
 - Availability of medical necessity criteria upon request
 - Provide an explanation for any requirement not met
 - Certify to the accuracy and completeness of the information provided and its general compliance with MHPAEA

MHPAEA Checklist and Certification

Company Name:	
Product Name:	
Plan:	
<input type="checkbox"/>	Individual
<input type="checkbox"/>	Small Group
<input type="checkbox"/>	Large Group

YES: The plan should check this box if it meets the requirements.

NO: The plan should check this box if it does not meet requirements. The plan should provide detailed explanations for any “No” boxes that are checked.

Requirement	Federal Law	Yes	No
Aggregate lifetime and annual dollar limit requirements for mental health and substance use disorder benefits <input type="checkbox"/> The plan complies with the aggregate lifetime and annual dollar limit requirements set forth in 45 CFR §146.136(b).		<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanation (if necessary):</i>			

MHPAEA Checklist and Certification

General Certification Language:

I, on behalf of [INSERT ISSUER] (“Company”), hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) Company complies with, and will continue to comply with, the Mental Health Parity and Addiction Equity Act and 45 C.F.R. § 146.136 et. seq.

Name:

Title:

Network Adequacy Planning Tool

- States can use to guide Network Adequacy program planning.
- Ten categories of considerations with regulatory options:

- Reasonable access
- Choice
- Availability
- Continuity of care
- Essential Community Providers

- Multi-Tiered Plans
- Narrow Network Plans
- Nondiscrimination
- Transparency
- Filing Requirements

- An 11th section to add formulae, e.g., Medicare Advantage formula

- Selected options can convert to:
 - Network adequacy form review checklist
 - Framework for regulation/legislation

Example: Reasonable Access

	CONSIDERATIONS	REGULATORY OPTIONS	SELECTIONS
Reasonable Access	<ul style="list-style-type: none"> Standard for assuring that the following are available within Issuer's service area: <ul style="list-style-type: none"> Sufficient in total numbers of practitioners and facilities Sufficient in types of practitioners and facilities 	<ol style="list-style-type: none"> Minimum # of providers <ol style="list-style-type: none"> Based on population density Based on a formula (See "Formula") Maximum mileage standard for each provider type <ol style="list-style-type: none"> ___% of network must meet standard Entire network must meet standard or rural and urban standards Required minimum number or percentage of hospitals Define and require inclusion of Centers of Excellence for certain conditions (e.g., transplants) Define and require inclusion of certain specialty facilities (e.g., advanced trauma units). Explore regulation of insurer formularies to assure patient access to certain pharmaceuticals. Require issuers to demonstrate that all network providers are actively accepting new patients at the time of open enrollment. <ol style="list-style-type: none"> Require issuers to include a provision in provider contracts requiring providers to give issuer ___ weeks' notice before discontinuing accepting new patients. 	<ol style="list-style-type: none"> 30 Miles PCP 60 Miles SCP a) 90% Children's Hospitals a) 4 weeks notice
	MONITORING OPTIONS: Self report, Geoaccess or alternative software, test formula		

Example: Narrow Networks

- Standard for identifying and regulating narrow networks

- 1) Determine a definition for “Narrow networks”
- 2) For networks that meet definition:
 - a) Require full disclosure of all criteria used to select network providers.
 - b) Require full disclosure of selection process.
- 3) Require issuer to establish and disclose an appeals procedure for providers who were not selected for the network.
- 4) Require issuers offering Narrow networks to offer alternative plans:
 - a) Offer a broad network program at each metal level.
 - b) Offer a plan with less out-of-network cost sharing at each metal level.
- 5) Require the issuer to disclose whether the narrow network is tied to quality improvement and care management; and to submit an annual certification that the two types of activities were completed.

- 1) _____
- 2) a)
- 3) Appeals procedure to be filed for review and approval.
- 4) b) Offer a plan that requires less out-of-network sharing.

MONITORING OPTIONS: Require the filing and review of disclosures in #2 and #5 with forms for review. As part of form review, comparison of criteria with provider network, consumer complaints

Consumer Services Toolkit

- Manual
 - User-friendly format with easy-to-locate entries, grouped by function, e.g.,
 - Enrollment and Eligibility
 - Policy Coverage Requirements
 - Discrimination
- Just enough, but not too much, information or easy review and access

Consumer Services Toolkit

- Glossary
 - Acronym page
 - Approximately 190 terms
- Reference table that walks ACA requirements and state mandates to provisions in the state benchmark plan
- Table that sets forth applicability of specific ACA requirements to grandfathered and transitional plans
- Toolkit components can be adapted to any state

Example of Crosswalk Entry

EHB/ State Mandate	State and Federal Mandate Citation and Description (if applicable)	EHB Description in Benchmark	Summary of Requirements
Contraception	<p>Rhode Island General Law §27-20-43</p> <ul style="list-style-type: none"> Covers FDA approved contraceptive drugs and devices requiring a prescription. Coverage of RU 486 not required <p>PHSA 2713</p> <ul style="list-style-type: none"> All FDA approved contraceptive methods, sterilization procedures, and patient education/counseling for all women with reproductive capacity. No cost sharing permitted. 	<ul style="list-style-type: none"> Provides coverage for FDA approved contraceptive drugs requiring a prescription and devices requiring a prescription. 	<ul style="list-style-type: none"> Applies to all individual and group market health insurance. Does not apply to GF self-funded plans. If covered then no annual or lifetime dollar limits permitted except that GF self-funded plans may impose \$2M for plan years beginning prior to Jan 1, 2014. Covers all FDA approved contraceptive methods, sterilization procedures, and patient education/counseling for all women with reproductive capacity. For all non-GF, contraceptive coverage must be first dollar coverage (no cost sharing permitted).

Example from Grandfathered and Transitional Plan Applicability Table

Requirement	Applicability to Grandfathered Plans	Applicability to Self-Funded Plans	[Applicability to Transitional Plans]
Guaranteed Issue	<p>Applies to grandfathered small employer group plans under HIPAA.</p> <p>Does not apply to grandfathered large employer group plans or grandfathered individual policies.</p>	Does not apply to self-funded employer group plans.	[This column can be added for those states that have allowed transitional plans to continue for some period between 2014 through 2016]
Premium Rating Restrictions	Does not apply to grandfathered plans.	Does not apply to self-funded employer group plans.	

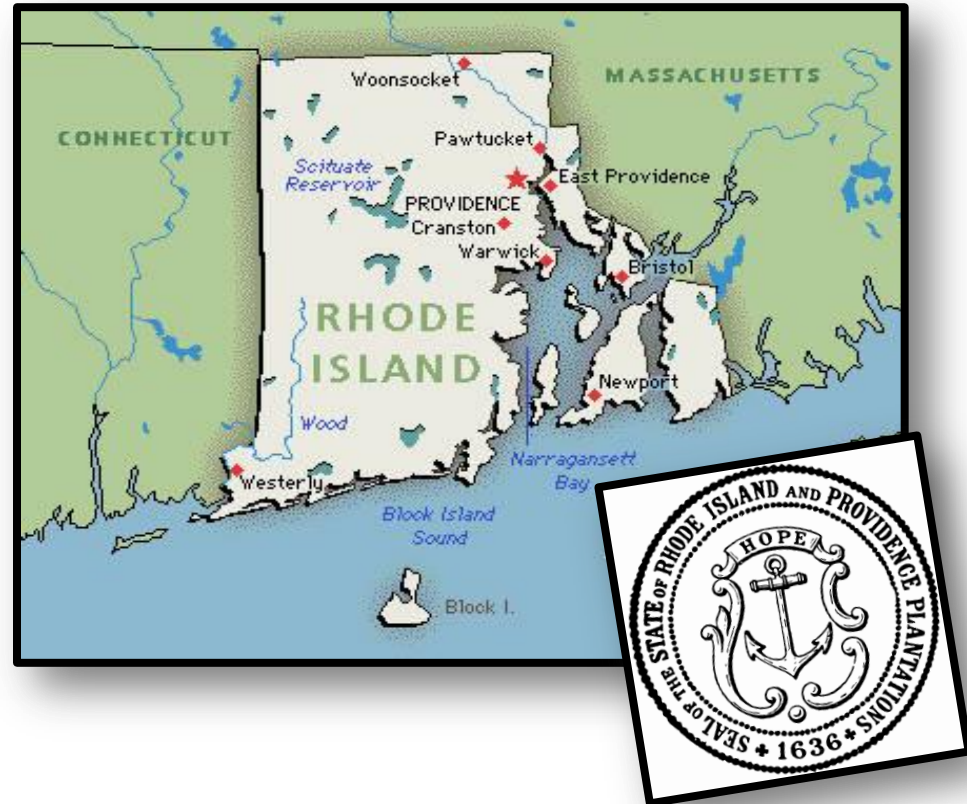
Rhode Island's Experience

Herb Olson

Legal Counsel

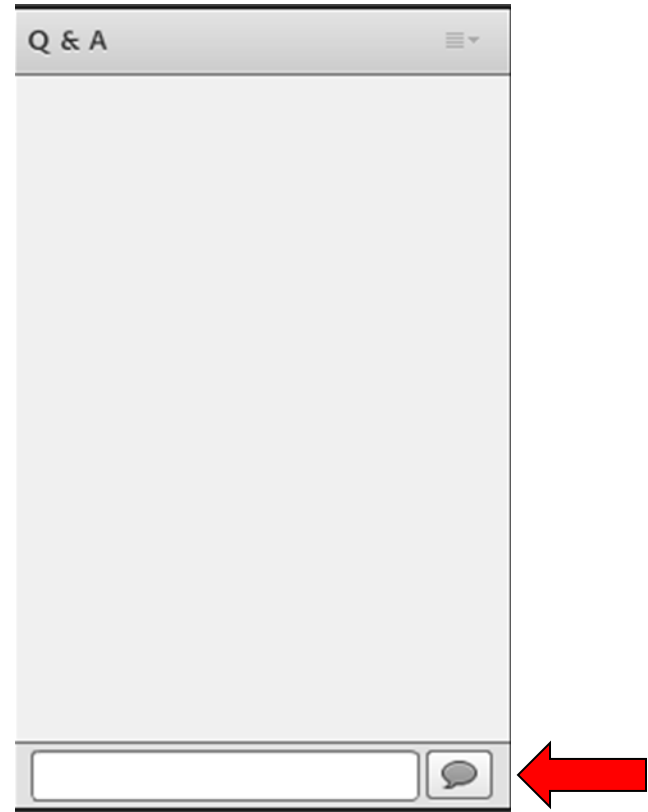
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- Upcoming webinar:
 - [Rate Development, Filing and Review - A Compilation of Guidance and Expectations for 2015 Rates](#), May 6 at 1pm ET



Thank You!

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