Insurance Department

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State of Utah
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BULLETIN 2014–3(a)

TO: Insurance Carriers Offering Health Benefit Plans or Stand-Alone Dental Plans

FROM: Todd E. Kiser, Utah Insurance Commissioner

DATE: April 21, 2014

SUBJECT: **Health Benefit Plan and Stand-Alone Dental Plan Filings for 2015 Plan Year**

This Bulletin is intended to provide individual and small employer health insurance carriers, and dental carriers, information regarding the filing process and requirements for non-grandfathered health benefit plans and certified stand-alone dental plans in the individual or small employer markets offered in the 2015 plan or policy year.

Utah will continue to participate in the Federally Facilitated Marketplace (FFM) for individual plans, and Utah's SHOP, Avenue H, for small employer plans. The Utah Insurance Department (Department) maintains all regulatory functions and oversight for plan management under these marketplace models.

Exchange Participation Notification

No later than April 30, 2014, a carrier interested in offering an individual or small employer health benefit plan or certified stand-alone dental plan in 2015, shall notify the Department of its intent. The notification must specify the market, individual and/or group, and whether or not products will be offered on Avenue H or the federally-facilitated marketplace. The notification must be filed with the Department as an informational filing via SERFF on company letterhead, and signed by an officer of the company.

Non-Grandfathered Pre 2014 Health Benefit Plan Guidance

The provisions of Utah Code Annotated (UCA) §§ 31A-8-402.3, 31A-22-721, 31A-30-107 and 31A-30-107.1 apply to transitioning an existing health benefit plan into compliance with the 2014 provisions of the Affordable Care Act (ACA).

Option A. A carrier may terminate a plan by giving a 90-day notice as required by Utah law. The carrier must then offer a new policy that fully complies with 2014 ACA market reforms. A notice to the policyholders, employees and dependents, shall be provided and include information as to whether replacement policies will be offered inside or outside an exchange, or both.

Option B. A carrier may amend each policy on the first renewal date occurring on or after January 1, 2014 to comply with the ACA market reforms, unless the plan is considered a transitional plan pursuant to guidance issued by the United States Department of Health and Human Services (HHS) as noted under Option D.

Option C. A carrier may exit the individual and small employer market after submitting, and receiving approval of, a Plan of Orderly Withdrawal, including any applicable withdrawal fees, pursuant to UCA § 31A-4-115.

Option D. A carrier may choose to renew an existing non-grandfathered health benefit plan on a plan's renewal date that occurs anytime in 2014 through October 1, 2016, provided the carrier complies each policy year with the relevant notices as specified in guidance issued, November 14, 2013 and March 5, 2014, by the Center for Consumer Information and Insurance Oversight (CCIIO) related to transition policies.

Regardless of the option chosen by a carrier, such option shall be applied uniformly without regard to health status or claim experience.

If a carrier has in force a health benefit plan that is not 2014 ACA compliant, the carrier must submit notification to the Department of the carrier's intention to bring such plans into compliance. Notification of the carrier's intent, and required notice to a policy or certificate holder, must be filed with the Department as an informational filing through SERFF no later than May 15, 2014.

Health Benefit Plan and Certified Stand-Alone Dental Plan (SADP) Filing Timeline

- **April 15, 2014**: Deadline to notify the Department of intent to offer a qualified health plan (QHP) or SADP on an exchange.
- **June 15, 2014:** Deadline to file all 2015 individual and small employer health benefit plan binder, rate, and form filings for consideration as a QHP on or off an exchange; or as a non-QHP plan exclusively off an exchange.
- **June 15, 2014:** Deadline to file 2015 SADP binder, rate, and form filings.
- **November 15, 2014:** Open enrollment begins.

Binder, Form, and Rate Filing Guidance

All filings are required to be made within SERFF.

- A binder and form and rate filing must be submitted simultaneously.
    - A separate binder is required for each single risk pool; individual or small employer.
    - The binder must include all products to be offered within a pool.
    - The rates and forms must be filed based on a single metal tier of the plan, and the applicable pool. A filing may not include products within multiple metal tiers.
    - For example, a carrier offering 3 bronze and 2 silver plans in both the individual and small employer markets will file:
        - an individual binder;
        - a small employer binder;

    - an individual bronze rate and form filing that includes all 3 plans (including applicable cost sharing reduction);
    - an individual silver rate and form filing that includes both plans, (including applicable cost sharing reduction);
    - a small employer bronze rate and form filing that includes all 3 plans; and
    - a small employer silver rate and form filing that includes both plans.
- The SERFF Filing Description shall contain information identifying the differences between any cost sharing and metal tier variations being submitted.
- The schedule page for each cost-sharing level within a metal plan filing shall have a unique form number. The form number may not be variable. Refer to Rule R590-227-6(1)(b) for guidance.
- The Department will utilize the standard templates and recommendations developed by CCIIO unless referenced differently.

If a carrier chooses to use a previously filed form, the filing description shall include the filed form number, the SERFF tracking number under which the form was submitted, and any updates. The previously filed form shall also be attached to the Supporting Documentation tab.

Age Slope

The Market Rules and Rate Review Final Rule, 45 CFR 147.102(e), requires each state have age rating ratios of 3:1. Utah has adopted an age slope that varies from the slope proposed by CCIIO. The Utah defined age slope is the only age slope to be utilized. The uniform age slope for Utah is:

Age Band	Slope Factor	Age Band	Slope Factor	Age Band	Slope Factor
0-20	0.793	35	1.390	50	2.127
21	1.000	36	1.390	51	2.212
22	1.050	37	1.404	52	2.300
23	1.113	38	1.425	53	2.392
24	1.191	39	1.450	54	2.488
25	1.298	40	1.479	55	2.588
26	1.363	41	1.516	56	2.691
27	1.390	42	1.562	57	2.799
28	1.390	43	1.616	58	2.911
29	1.390	44	1.681	59	3.000
30	1.390	45	1.748	60	3.000
31	1.390	46	1.818	61	3.000
32	1.390	47	1.891	62	3.000
33	1.390	48	1.966	63	3.000
34	1.390	49	2.045	64	3.000

Geographic Rating Areas

The Department has adopted geographic rating areas based on counties. Counties are assigned to the following areas:

Area 1:	Cache and Rich
Area 2:	Box Elder, Morgan, and Weber
Area 3:	Davis, Salt Lake, Summit, Tooele, and Wasatch
Area 4:	Utah
Area 5:	Iron and Washington
Area 6:	Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne

QHP & SADP Certification Requirements

General Filing Requirements	
Federal Standard ACA §1311 ACA §1002 42 USC § 18021 42 USC § 18022 42 USC § 18031 45 CFR 155 & 156 CMS Guidance Rules	A carrier shall— (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in Utah; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as will later be defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agrees to charge the same premium rate for each QHP of the carrier without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the carrier or through an agent; (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in initial and annual open enrollment periods, as well as special enrollment periods; (10) Collect enrollment information, transmit such to an exchange and reconcile enrollment files with the exchange enrollment files monthly; (11) Provide and maintain notice of termination of coverage. A standard policy shall be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency shall be provided; (12) Segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception; (13) Timely notify an exchange if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice; (14) In the event that the QHP becomes decertified, terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage; and (15) Meet all readability and accessibility standards.
State Standard	The Department will utilize a certification approach to reviewing, recommending, and submitting the rate, form and binder filing for compliance with federal and state laws and regulations. Certification will be good for a period of one plan year. If a carrier wishes to continue offering a certain plan following that plan year, the carrier shall apply to have that plan recertified. Should less than two stand-alone dental plan carriers show intent to offer SADPs, all QHPs will be required to offer pediatric dental benefits.

Licensure and Solvency	
Federal Standard 45 CFR 156.200	A carrier shall be licensed and in good standing with the State.
State Standard	A carrier shall be licensed, meet state solvency requirements, have unrestricted authority to write its authorized lines of business, and have no outstanding sanctions in Utah in order to be considered "in good standing."
Network Adequacy	
Federal Standard ACA § 2702c 45 CFR 155.1050 45 CFR 156.230 45 CFR 156.235	A carrier shall ensure that the provider network of each of its plans is available to all enrollees and: (1) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area. This shall be instituted utilizing CMS established requirements for inclusion of ECPs in QHPs based on CMS's Annual Letter to Issuers. (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and (3) Makes its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.
State Standard	The Department will require an attestation and completion of the Network Adequacy Cover Page from the carrier that states it is in compliance with all network adequacy requirements in addition to one of the following: • The carrier provides evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or • The carrier provides sufficient information related to its policies and procedures to determine that the carrier's network meets the minimum federal requirements.
Accreditation	
Federal Standard 45 CFR 155.1045 45 CFR 156.275	Carriers shall maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: clinical quality measures, such as the HEDIS; patient experience ratings on a standardized CAHPS survey; consumer access; utilization management; quality assurance; provider credentialing; complaints and appeals; network adequacy and access; and patient information programs. Carriers without existing commercial or exchange health plan accreditation from a HHS-recognized accrediting entities shall schedule an accreditation review during their first year of certification and receive accreditation on the carrier's policies and procedures prior to their second year of certification. Prior to the carrier's fourth year of certification and in every subsequent year of certification, a carrier shall be accredited in accordance with 45 CFR 156.275 Carriers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to the Department.
State Standard	The Department will follow the federal requirements related to accreditation and will require the authorized release of all accreditation data. If the QHP carrier is not already accredited, an attestation that the carrier will schedule to become accredited on policies and procedures in the plan types used, and provide proof of such accreditation, on policies and procedures prior to submission of any application for recertification. The QHP carrier shall also indicate that it will receive and provide proof of receipt of full exchange accreditation prior to its third recertification application.

Service Area	
Federal Standard 45 CFR 155.1055	Service area is the geographic area in which an individual shall reside or be employed in order to enroll in a plan. A carrier shall specify what service areas it will be utilizing. The service area shall be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.
State Standard	The carrier may choose their service area(s) as long as the service area is not smaller than a county.
Rating Area	
Federal Standard 45 CFR 156.255	The ACA defines a "rating area" as a geographic area established by a state that provides boundaries by which carriers can adjust premiums.
State Standard	The Department has adopted a configuration of six rating areas to be utilized in Utah.
Quality Improvement	
Federal Standard ACA §1311 ACA §2717 45 CFR 156.200	A carrier shall implement and report on a quality improvement strategy or strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of: • A payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; • Activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient□centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
State Standard	The Department will require an attestation of compliance with quality improvement standards and regulatory requirements outlined in CMS's Annual Letter to Issuers.
General Offering Requirements	
Federal Standard 42 USC § 18022 45 CFR 147.126 45 CFR 147.120 45 CFR 147.138 45 CFR 155 & 156 CMS Guidance Rules	A carrier shall offer at least one QHP in the silver coverage level, at least one QHP in the gold coverage level, and a child-only plan at the same level of coverage as any QHP offered through either the individual exchange or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. Additionally, a catastrophic plan may be filed to be sold on the exchange in addition to the tiered metal levels. All QHP offerings by a carrier, excluding a stand-alone dental carrier, on a single metal tier shall show a meaningful difference between the plans and comply with standards in the best interest of the consumer. Pediatric dental and vision benefits are required to cover dependents to age 19. Emergency services shall be covered with no prior authorization, no limitation to participating or in-network providers. Emergency services shall be covered at in-network cost-sharing level. Carriers will be required to meet all annual limitation and cost sharing requirements without affecting the actuarial value of the plans within each of the tiers. The carrier shall demonstrate in an exhibit filed with the plan that annual out of pocket cost sharing under the plan does not exceed the limits established by federal regulations.

	The QHP shall contain no lifetime limits on the dollar value of any Essential Health Benefits (EHB), including the specific benefits and services covered under the EHB-Benchmark Plan. Catastrophic plans can be sold to Individuals that have not attained the age of 30 before the beginning of the plan year; or an individual who has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. If offered, Catastrophic Plans are offered only in the individual exchange and not in the SHOP. A QHP carrier shall comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates shall be based upon the analysis of the plan rating assumptions and rate increase justifications.
State Standard	Specific rate and form filing requirements are found in SERFF and outlined in this bulletin.
Essential Health Benefits	
Federal Standard 42 USC. § 18022 45 CFR 147.130 45 CFR 148.170 45 CFR 155.170 45 CFR 156.110 45 CFR 156.115 45 CFR 156.125 45 CFR 156.280	The QHP carrier shall offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. This may be done by substituting benefits only if the QHP carrier demonstrates actuarial value of the substituted benefits. A QHP carrier is not required to offer abortion coverage within their benefit plans. The QHP carrier will determine whether the benefits offered include abortion. If the QHP carrier chooses to offer abortion benefits, public funds may not be used to pay for these services unless the services are covered as part of the Hyde Amendment exceptions. The QHP carrier shall provide notice through its summary of benefits if such benefit is being made available. The QHP shall cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention). Additionally, coverage for the medical treatment of mental illness and substance use disorder shall be provided under the same terms and conditions as that coverage provided for other illnesses and diseases.
State Standard	The Department has adopted PEHP's Basic Plus Plan as the benchmark plan to set the essential health benefits for Utah. Additionally, UCA § 31A-22-726, prohibits offering coverage of elective abortions. The Department will require an attestation from the carrier that attests to compliance with all EHB standards.
Essential Health Benefit Formulary Review	
Federal Standard 45 CFR 156.122 45 CFR 156.295	The QHP shall cover at least the greater of one drug in every U.S. Pharmacopeia Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan. Carriers shall report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or carrier): Percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; Aggregate amount and type of rebates, discounts or price concessions that the carrier or its contracted PBM negotiates that are attributable to patient utilization and passed through to the carrier; Total number of prescriptions that were dispensed; Aggregate amount of the difference between the amount the carrier pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
State Standard	The Department will require an attestation of compliance with EHB formulary standards.

Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 42 USC § 300gg-3 45 CFR 148.180 45 CFR 155.1045 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225	A QHP carrier shall: • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: o Adjusting premiums based on genetic information; o Discriminating with respect to its QHP on the basis of race, color, national origin, disability, age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; o Utilizing any preexisting condition exclusions; o Requesting/requiring genetic testing; or o Collecting genetic information from an individual prior to, or in connection with enrollment in a plan or at any time for underwriting purposes. A QHP carrier may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.
State Standard	The carrier shall comply with all applicable laws and rules regarding marketing by a health insurance.
Actuarial Value	
Federal Standard 45 CFR 156.135 45 CFR 156.140 45 CFR 156.150	Plans being offered at the various metal tiers within the Exchange shall meet the specified levels of actuarial value (or fall within the allowable variation): Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%) Stand-alone dental plans shall offer plans at the actuarial value level determined in 2015 Notice of Benefits and Payment Parameters, and Actuarial Value Calculator Final Rule.
State Standard	The Department will require an attestation of compliance with actuarial value standards.
Quality Rating Standards	
Federal Standard ACA 2794 45 CFR 156.200 45 CFR 156.1105	HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges with reporting requirements related to all QHP carriers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP carriers in all Exchanges. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements. QHP carriers shall also provide plain language information/data on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights shall be submitted to the exchange, HHS, and the state insurance commissioner.
State Standard	The Department will adopt the Quality Rating Standards as provided in federal guidance.

Rate Filing	
Federal Standard 45 CFR 147.102 45 CFR 154.215 45 CFR 155.1020 45 CFR 156.210 45 CFR 156.255 45 CFR 156.80	Premiums may vary by geographic rating area, but premium rates shall be the same inside and outside the exchange. • Rating will be allowed on a per member basis. • Premium rates may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) All rates filed for individual QHPs will be set for an entire benefit/plan year.
State Standard	The Department will continue to effectuate its rate review program and will review all rate filings and rate increases for prior approval. Rate filing information shall be submitted with any rate increase justification prior to the implementation of an increase. A URRT is not applicable to SADP.

Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR 155.1030 45 CFR 156.420	The QHP carrier shall offer three silver plan variations for each silver QHP, one zero cost sharing plan variation, and one limited cost sharing plan variation for each metal level QHP. Silver plan variations shall have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minims range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing shall be eliminated for the zero cost sharing plan variation. Cost sharing for certain services shall be eliminated for the limited cost sharing plan variation.
State Standard	The Department will require an attestation of compliance with plan variation standards. Not applicable to SADP
Stand Alone Dental Plans (SADP)	
Federal Standard ACA 2791 45 CFR 155 & 156 45 CFR 155.1065 45 CFR 156.150 45 CFR 156.440	SADPs must meet the same QHP certification standards as medical plans unless noted in the above sections. Additionally, SADP are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. SADPs shall offer plans at the actuarial value level and reasonable annual limitation on cost sharing as determined in 2015 Notice of Benefits and Payment Parameters, and Actuarial Value Calculator Final Rule. SADP intended to be utilized outside the Marketplace only for use to supplement medical plans such that the medical plans will comply with federal requirement of offering all 10 EHBs outside the Marketplace as required under the Public Health Services Act must follow the Marketplace certification filing process as described within this Bulletin.
State Standard	SADPs must comply with the Utah EHB benchmark plan that has the following as pediatric dental EHB services: oral examinations, cleanings, fluoride, sealants and x-rays. If less than three carriers offer a SADP on an exchange, the Department will not consider any carrier for a SADP to be offered exclusively off-exchange.

If you have any questions or comments, please call the Health and Life Division at 801-538-3066 or email us at health.uid@utah.gov.

DATED this 21st day of April 2014.

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