State of Utah
GARY R. HERBERT
Governor
GREG BELL
Lieutenant Governor
TODD E. KISER
Insurance Commissioner

Insurance Department

Affordable Care Act Market Transition Frequently Asked Questions

v. 1.2 06/10/2013

Essential Health Benefits

1. Is the PEHP wellness program, including bio-medical testing, an EHB?

   No. However, if a carrier will be rating for smoker status, it must have a wellness program available for plans offered in the small group market.

2. Are non-preferred Rx drugs excluded from the EHB, since PEHP excluded them?

   No. You would follow the guidance from HHS that requires a plan to cover the greater of one drug in every category or class, or the same number of drugs in each category and class as the EHB benchmark plan.

3. What defines what is included in the state benchmark plan (e.g. the Certificate of Coverage or the Summary of EHB benefits, limits, and prescription drug coverage)?

   All documents should be reviewed.

4. Under federal requirements, dollar limits are not allowed for essential health benefits or benchmark plan benefits that are not specifically excepted benefits. We believe this may require removal of the $4,000 dollar amount from Utah's adoption indemnity benefit. What is the department's position on this benefit? How will carriers meet the requirement of §31A-22-610.1 while eliminating the $4,000 dollar amount?

   Utah's adoption indemnity benefit does not fall within the 10 essential health benefit categories. As such, the limitation on cost sharing does not apply.

Exchanges

1. For carriers wishing to participate in the Utah Individual Exchange, is there a requirement to file anything in HIOS in relation to the QHP application?

   Carriers must submit the URRT and actuarial memorandum in both HIOS and SERFF regardless of the exchange model in a particular state. If changes are made in SERFF to the documents, the same changes must also be manually made in HIOS.

2. We recognize that the Utah Individual Exchange is unique because it is an FFE hybrid, of sorts. Will carriers who participate in the individual exchange be able to choose whether or not they will participate in the SHOP? If not, will the department follow the <20% exemption in the federal guidelines?

There is not a Utah Individual Exchange, nor a partnership. The state has opted for the federal government to run the individual exchange.

3. As you know, issuers participating in FFEs are generally required to submit QHP applications by April 30, 2013. Due to the unique nature of the Utah Individual Exchange, has the department received approval to extend the application window to May 31?

   HHS has agreed to the Utah Insurance Department performing plan management functions. However, it is not considered a partnership. They are aware of our May 31 deadline, and anticipate carriers to be filing through SERFF, rather than HIOS. You may want to contact CCIIO regarding any unique requirements they may have for their exchange.

4. What are the commissions and exchange fees for Avenue H.

   To assure compliance with 45 CFR 156.80, Avenue H will not set or pay commissions for products sold on the exchange. Insurer commissions and Avenue H administration fees (Medical $12 PEPM; Dental $2 PEPM) are required to be built into the premiums that are submitted to the Utah Insurance Department via Binders through SERFF. The premium data submitted in the Binder will then populate the premium information on Avenue H. Avenue H will in turn collect premiums based on the data submitted and remit to the carriers such premium less the Avenue H administrative fee.

SERFF

1. Do we need to submit the SERFF binder only for exchange products, or do we also need to submit binders for non-exchange products also?

   If an insurer is participating in an exchange, the SERFF binder must include all products for the market, both in and out of the exchange. If an insurer is not participating on an exchange, a SERFF binder is not required to be filed.

2. If we do need to submit the SERFF binder, does the state require that we submit the Rate Data Template in addition to the Unified Rate Review Template?

   Yes. Non-exchange filings must include:
   - *Business rule template*
   - *Plan and benefit template*
   - *Prescription drug template*
   - *Rate data template*
   - *Any additional templates necessary to support meaningful difference*

Dental Stand Alone Policies

1. Can stand-alone dental EHB can have a separate deductible amount (dental standard example $50) that would not be subject to coordination of benefits with the medical EHB plan in order to achieve the required AV levels?

   A stand-alone dental plan may have a separate deductible amount and will not need to coordinate with the medical plan. Because AV levels are different for stand-alone dental plans, high of 85% and low of 70%, as established in 45 CFR 156.150, CCIIO does not currently expect that stand-alone dental plans will exceed allowable deductible amounts in the small group market in order to reach AV targets.

   Utah is aware of the issues with the low EHB benefit for dental and requested a waiver for the AV requirements for stand-alone dental pediatric plans. HHS has denied the waiver and indicated the plans must comply with the AV levels required by their rule.

Participation Requirements

1. Does the new rule on 90 day waiting periods start upon the group's renewal date or into effect on January 1, 2014?

   January 1, 2014

2. Does coverage have to begin before the 90 days or can it begin the first of the month after 90 days? For example, if a new employee joins a company on January 12, 2014, do we need to make their effective date April 12 or May 1?

   The 90-day waiting period rule applies to all grandfathered and non-grandfathered health plans. As long as an employee is able to elect coverage that becomes effective on or before the 91st day after the start of the waiting period, the requirement is satisfied with respect to an employee who chooses to begin coverage beyond the end of the 90-day waiting period. All calendar days are counted, including weekends and holidays. If the 91st day is a weekend or holiday, the plan or insurance issuer may choose to permit coverage to be effective earlier than the 91st day for administrative convenience; however, a plan or insurance issuer may not make the effective date of coverage later than the 91st day. The proposed regulations clarify that it is not permissible under the 90-day rule to delay coverage until the first day of the month following completion of a 90-day waiting period. Employers that wish to use a first day of the month or first day of the payroll period as their enrollment date would need to apply a shorter waiting period to ensure that coverage would become effective on or before the 91st day. Also, the proposed regulations clarifies that if an employee or dependent enrolls as a late enrollee or a HIPAA special enrollee, any period before such late or special enrollment is not a waiting period.

   HHS noted that plans and insurance issuers may not use "three months" as a substitute for 90 days. If an individual is already in a waiting period for coverage before the first day of the plan year starting on or after January 1, 2014, the waiting period applicable to the individual as of the 2014 plan year cannot exceed 90 days.

General

1. The bulletin notes the differences between state and federal definitions for a small employer. Please confirm that Utah will continue to define small employer based on 50 rather than 100 employees.

   Based on Bulletin 2011-7, the definition for a small employer remains at 50 eligible employees for all purposes other than the MLR calculation. For compliance with the ACA the Utah definition for "small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

   (a) employed an average of at least one employee but not more than 50 eligible employees on each business day during the preceding calendar year; and

   (b) employs at least one employee on the first day of the plan year.

2. Is it the department's opinion that a carrier can terminate a non-grandfathered plan by providing a 90 day notice, even if that provision is not included in the individual policy?

   If the carrier did not include a provision allowing for termination based on the provisions of 31A-30-107.1, the contract cannot be terminated.

3. The bulletin contains a filing checklist. How will the checklist be used? Will carriers be required to submit the checklist with the QHP application?

The list is for informational purposes only. It is not necessary to include it with the filings.

4. Are carriers required to comply only with the State Standard with respect to Form and Rate Filing Requirements, or must both the State and Federal standards be met?

   Generally both.

5. What is the department's form and rate filing timeline for off-exchange individual and small group plans to be offered in 2014?

   If a carrier is offering plans on an exchange, the filing for both in and out of the market must be filed at the same time. However if a carrier is not offering coverage in an exchange, the process remains as filed and use.

6. Can premium rates be billed separately for different levels of dependent coverage (e.g. EO, EC, ES, EF) or must they be billed for employee only coverage versus employee plus family coverage (e.g. 2-tier rating)?

   Yes. Per-member rating or a method that employs average enrollee amounts within a group can be used as long as the total premium charge to a group equals the amount that would be derived from per member rating.