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2015 Plan Year Frequently Asked Questions

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Essential Health Benefits (EHB) and Qualified Health Plans

1. Are non-preferred Rx drugs excluded from the EHB, since the state benchmark plan (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.

2. 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.

3. 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.

4. Should coverage for prosthetic devices be considered an EHB since they are mandated per statute §31A-22-638?

   No, prosthetic devices are not considered an EHB as they are not listed in the state benchmark plan nor a required benefit on all plans. Per statute, §31A-22-638, prosthetic coverage shall be offered on at least one plan in each market and may limit coverage. The plan may be off-exchange only.

5. Can embedded pediatric vision and/or dental services be considered preventative services and subject to the no cost-sharing provision as outlined in 45 CFR 147.130?

   That would be at the carrier's discretion on all plans except for High Deductible Health Plans (HDHP) and the individual catastrophic plans. These plans have specific IRS guidelines that require the deductible to be satisfied before benefits can be considered.

Exchanges/Marketplaces

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?

No, however regardless of marketplace participation, all carriers must submit the URRT and actuarial memorandum in both HIOS and SERFF. If changes are made in SERFF to the documents, the same changes must also be 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. Therefore, this provision is not applicable. A carrier may participate in either or both markets.

3. 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 need to submit binders for non-exchange products also?

   For plan year 2015, all issuers offering ACA compliant plans must complete a binder in SERFF. The binder must include all products for the market, both in and out of the exchange. If an insurer is not participating on an exchange, they do not need to complete the Administrative and Essential Community Provider Templates or the Compliance Plan and Organizational Chart and Program Attestations in supporting documentation of the SERFF binder. Conditional supporting documents maybe required.

2. What documentation is to uploaded and supplied under Associated Schedule Items in the binder?

   The policy, certificate or outline-of-coverage and variable material that goes along with the form.

3. Since the Department is requiring forms to be filed at the metal level is the Department accepting rate and forms together or can a carrier submit just the forms and a separate rate filing?

   There should be only one rate filing (URRT and actuarial memorandum) per single risk pool that includes all plans, it would be appropriate to submit just forms at each metal level and a separate filing for just the rates.

Dental Stand Alone Policies

1. Can stand-alone dental EHB 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.

2. Must stand-alone dental issuers file plans with both the high and low Actuarial Values, or can issuers file plans that meet just one of the two stand-alone dental Actuarial Values?

   Issuers of stand-alone dental plans (SADP) are not required to offer plans at both the high and low actuarial values. SADP carriers can offer one or the other, or both the high and the low designs.

Participation Requirements

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

   For policies effective on or after January 1, 2014, insurers may not impose a waiting period greater than 90 days for a newly eligible employee. For policies issued prior to January 1, 2014, an insurer must allow an eligible employee to enroll at renewal if the otherwise eligible employee has completed 90 days of a waiting period, regardless of the length of waiting period in effect prior to 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. 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.

2. Has the state established an approved and/or different tiered- composite premium standard for off-exchange small employer?

   Guidance will be forthcoming

3. The ACA requires that Summary of Benefits and Coverage (SBC) be provided. Please advise if the SBC is sufficient and appropriate in the replacement of the outline of coverage.

   Per Bulletin 2012-5, an SBC does not need to be submitted to the Department for review but shall provide a unique form number and revision dates. The issuer shall maintain a complete SBC and be subject to regular review and inspection. An outline of coverage is still required to be submitted per §R590-233-8.

4. Per Bulletin 2014-2, quarterly rating is allowed for small groups. What is required to update rates and/or add new plans?

If only updating the rates; the carrier needs to send an inquiry to the Department for opening of the corresponding binder, submit a rate filing with all appropriate documentation and send an update to HIOS with the URRT and Actuarial Memorandum.

If adding a new plan; the carrier needs to complete a new binder, submit all templates and supporting documentation for all plans in risk pool, submit a form and rate filing and send HIOS the new URRT and Actuarial Memorandum.