State Health Reform Assistance Network
Charting the Road to Coverage

TOOLKIT
August 2012

ACA Implementation Toolkit for Departments of Insurance

Prepared by: ***Mila Kofman****, Research Professor,* ***Katie Dunton****, Assistant Research Professor and* ***Sally McCarty****, Senior Faculty, Georgetown University Health Policy Institute*

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ABOUT THE PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

The Health Policy Institute is a multi-disciplinary group of faculty and staff dedicated to conducting research on key issues in health policy and health services research. A team of research professors at the institute (supported by the RWJF *State Network*) are working with states, providing technical assistance focused on implementation of the private market reforms and exchanges under the Affordable Care Act. For more information on the Health Policy Institute, visit *http://ihcrp.georgetown.edu/.*

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter *www.rwjf.org/twitter* or Facebook *www.rwjf.org/facebook*.

For more information, please contact Katie Dunton at ktd23@georgetown.edu or (202) 744-5173.

Robert Wood Johnson Foundation

Overview

States have significant and important responsibilities in implementing many of the provisions outlined in the Patient Protection and Affordable Care Act (ACA). While this reliance on state implementation comes with flexibility, it does not diminish the level of effort and urgency required. States must accomplish a substantial number of tasks under short timelines. Furthermore, state implementation will require not only changes in state statutes and regulations, but also in resource use. This will require significant planning.

In order to assist states in accomplishing the tasks related to insurance market reforms and exchanges, the Georgetown University Health Policy Institute has developed a toolkit for the State Health Reform Assistance Network (*State Network*) initiative.

This toolkit includes several self-audits, templates, and checklists to help departments of insurance to implement health insurance market reforms and to work in concert with other state agencies in ascertaining the locus of exchange related functions and operationalizing those responsibilities. The toolkit is a living document that will be updated periodically with additional resources as they are developed and in response to any future federal guidance.

TOOLKIT SECTIONS

Form Review Checklist, Model Notices and Examples

The form review checklist is a document that insurance regulators can use or modify for use in reviewing forms associated with products (insurance contracts, policies, certificates of coverage, etc.) filed by issuers for approval prior to offering the products to consumers. A form review is one way insurance regulators ensure compliance with state law. Generally, regulators also make form review checklists available to issuers to help the regulated community develop products consistent with state law requirements.

When complete, the toolkit will include five form review checklists to assist state insurance regulators:

- non-grandfathered 2014 compliant products for individual market outside the exchange;
- non-grandfathered 2014 compliant products for individual market inside and outside the exchange;
- non-grandfathered 2014 compliant products for small group market outside the SHOP exchange;
- non-grandfathered 2014 compliant products for small group market inside and outside the SHOP exchange; and
- essential health benefits package required for 2014 individual and small group market products.

The first of the five checklists, included in this initial version of the toolkit, includes specific standards, consumer protections, and disclosures required in insurance contracts filed by health insurance issuers for use in the individual market outside the exchange. The checklist includes tips such as problematic contract language and examples to assist regulators in analyzing insurance contracts for compliance with minimum standards under the ACA. The minimum standards are from the ACA statute and federal implementation guidance (e.g., regulations, technical bulletins, etc.). Examples of problematic contract language (for 2010 standards) are from actual insurance policies currently sold.

In addition to minimum standards in the form review checklist, the toolkit includes two other documents to use with the checklist: model notice language and examples illustrating how the legal standards work. Model language and examples are from federal guidance. Model notices include: adverse benefit determination; final internal adverse benefit determination; final external review decision; right to designate a primary care provider; rights under the Newborns' and Mothers' Health Protection Act; and Women's Health and Cancer Rights Act (WHCRA) notices. Notices applicable to group coverage were only included when individual models were not available and when HHS clarified that group coverage model notices could be used for individual market coverage, where available.

ACA Insurance Self-audit

The self-audit is a chronological, step-by-step checklist that gives states a guide as they analyze their insurance laws, rules and regulations, etc. for compliance with ACA. This exercise is an important first step for states to determine what changes are required and what they will do to make those changes (e.g., legislative packages, regulatory changes, bulletins, etc.).

Exchange Functions Checklist
For a state to be certified by the Department of Health and Human Services (HHS) as having a state-based exchange, all functions must be directly performed by an exchange or the exchange must enter into agreements with other entities to perform selected Exchange duties and responsibilities. The *Exchange Functions Checklist* is a tool to help departments of insurance work with their exchanges to identify and document functions they may currently perform and to determine which entities should perform these functions going forward. This tool can also be used to help determine where there is overlap among agencies and to ensure that none of the essential functions that an exchange must perform falls through the cracks. Once completed, the *Exchange Functions Checklist* can be used as a basis for agreements/Memoranda of Understanding as required by the federal government in the Exchange Establishment rules and the Exchange Blueprint for HHS approval of state-based or partnership exchanges.

Workplan Template
The workplan template is a matrix designed to ensure that "nothing falls through the cracks," including certain plan management functions. By walking through the document, state officials will be able to identify tasks that have been completed, what is on-going, and what needs to begin. States can use the columns provided to color-code priorities, assign start and end dates, identify lead personnel, and define deliverables. This tool is organized by activity (keep in mind, activity number does not represent priority).

Qualified Health Plan (QHP) Certification 'Cheat Sheet'
A summary of QHP provisions from federal guidance is designed as a quick reference for states providing a high level outline of requirements including certification of and minimum standards for QHPs.

Essential Health Benefits (EHB) Planning Template
This template provides the key decisions and considerations states need to address in choosing an EHB benchmark plan and the related work to operationalize that decision once it is made.

Form Review Checklist – Individual Health Insurance (Non-grandfathered – 2014)*

Updated: July 6, 2012

**The following document serves as an example of the Form Review Checklist. To fill out the form, download the editable file here.*

Company Name:	
Product Name:	
Plan:	
☐	60% AV (Bronze)
☐	70% AV (Silver)
☐	80% (Gold)
☐	90% (Platinum)
☐	Child-only
☐	Catastrophic Plan (no minimum AV requirement, only available to individuals under age 30 or those with hardship/affordability exemption)

YES: Check this box if all contract provisions in the section meet minimum requirements.

NO: Check this box if any of the contract provisions do not meet minimum requirements, restrict coverage in a way not allowed by law, or for any other reason are inconsistent with the law.

N/A: Check this box if a contract does not have to meet this requirement (e.g., does not use Primary Care Physicians and therefore does not have to include designation of PCP option).

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ **No pre-existing condition exclusions for child under age 19** ☐ **No pre-existing condition exclusions** ☐ "Pre-existing condition exclusion" means a limitation or exclusion on benefits based on the fact that the condition was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was received before that day. ☐ A pre-existing condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's	PHSA §2704 PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108)	Attachment: Examples from federal regulations	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
health status before the individual's effective date of coverage (or date of denial).					
Explanation:					
☐ **No lifetime limits on the dollar value of Essential Health Benefits (EHB):** ☐ Ambulatory patient services ☐ Emergency services ☐ Hospitalization ☐ Maternity and newborn care ☐ Mental health and substance use disorder services, including behavioral health treatment ☐ Prescription drugs ☐ Rehabilitative and habilitative services and devices ☐ Laboratory services ☐ Preventive and wellness services and chronic disease management ☐ Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply. Tip: Check benefit maximums and service limitations to ensure no dollar limits for EHBs. Problematic contract language/example: EHB-eligible hospital services limited to $100,000. This violates the prohibition on lifetime limits on EHB.	☐	☐	☐
Explanation:					
☐ **No annual limits on the dollar value of EHB:** ☐ Ambulatory patient services ☐ Emergency services ☐ Hospitalization ☐ Maternity and newborn care ☐ Mental health and substance use disorder services, including behavioral health treatment ☐ Prescription drugs ☐ Rehabilitative and habilitative services and devices ☐ Laboratory services ☐ Preventive and wellness services and chronic disease management ☐ Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Tip: If there are maximum dollar limits, check to ensure that these are not for benefits within one of the EHB categories. Problematic contract language/example: EHB-eligible hospital services limited to $100,000 annually. This violates prohibition on annual dollar limits on EHB.	☐	☐	☐
Explanation:					
☐ **No rescissions except in cases of fraud or intentional misrepresentation of material fact**	PHSA§2712 (75 Fed Reg 37188,	Tip: Look for insurer's right to cancel to ensure that in a case of retroactive cancellation, the only conditions listed in the contract are fraud or intentional misrepresentation of	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid . ☐ Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.	45 CFR §147.128)	material fact. Attachment: Examples from federal regulations			
Explanation:					
☐ **Covers 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 USPSTF; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); • Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and • Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (do not include recommendations issued in or around Nov. 2009). ☐ Coverage without cost-sharing (deductibles, co-payments, co-insurance)	PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130)	Note: Issuers must make changes to coverage and cost-sharing based on new recommendations/guidelines for the first policy year beginning on or after the date that is one year after the new recommendation/guideline went into effect. Note: Network plans may have cost-sharing for preventive benefits when out-of network providers are used. An issuer does not have to cover items/services if removed from guidelines. Issuers may use reasonable medical management techniques to determine frequency, method, treatment, or setting for USPSTF recommendations if not specified by the USPSTF. Tip: If a policy has co-pays, co-insurance, deductibles or other cost-sharing, look for language that exempts preventive benefits from those cost-sharing provisions. Look for exclusionary language for any of the preventive benefits. Issuers may have cost-sharing for office visits. Examples of allowed and not allowed cost sharing: • preventive service is billed separately from an office visit – cost-sharing ok for the office visit; • preventive service is the primary purpose of the office visit and is not billed separately from the office visit – cost-sharing may not be imposed; • preventive service is provided but is not the primary purpose of the office visit and is not billed separately	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
		– cost-sharing ok for the office visit. Issuers must provide 60 days advance notice, generally, to enrollees before the effective date of any material modification and this includes changes in preventive benefits. An issuer may provide or deny coverage for items and services in addition to the defined preventive services. An issuer may impose cost-sharing requirements for a treatment not included in the defined preventive services, even if the treatment results from an item or service described as a preventive service. Attachment: Examples from federal regulations			
Explanation:					
☐ **Provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits.**	PHSA 2715 (75 Fed Reg 41760)		☐	☐	☐
Explanation:					
☐ **Coverage for dependents must be available up to age 26 if policy offers dependent coverage.** ☐ Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: • financial dependency on primary subscriber; • residency; • student status; • employment; • eligibility for other coverage; and • marital status. ☐ Terms of the policy for dependent coverage cannot vary based on the age of a child.	PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)	Impermissible restriction example: Adult child can stay on parent's coverage only if child spends at least 6 months in the state. Issuers are not required to cover the child of a child dependent. Attachment: Examples from federal regulations	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
Explanation:					
☐ **Provides Essential Health Benefits –** ☐ **Form reviewer: complete EHB form review**	PHSA §2707		☐	☐	☐
☐ **Coverage for emergency services required (See EHB above) and:** ☐ Cannot require prior authorization; ☐ Cannot be limited to only services and care at participating providers; ☐ Must be covered at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider); and ☐ Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate. ☐ "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity that a person would reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn child. ☐ "Emergency medical services" means a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate the condition; and within the capabilities of the staff/facilities available at the hospital, examination/ treatment required to stabilize the patient. ☐ "Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138) SSA §1395dd	Note: for pre-2014 non-grandfathered policies, this requirement only applies if policy covers emergency services. Cost-sharing requirements that apply generally to out-of-network benefits may be imposed on out-of-network emergency services. Attachment: Examples from federal regulations	☐	☐	☐
Explanation:					

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ **For network plans requiring a primary care provider to be designated and requiring referrals:** ☐ allow each enrollee to designate any participating primary care provider who is available to accept such individual; ☐ a physician specializing in pediatrics may be designated as PCP; and ☐ no referral required for services from in-network OB/GYNs. ☐ Notice of these is required when issuer provides primary subscriber with a policy, certificate, or contract of health insurance.	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)	Attachments: • Model Notice of Right to Designate a Primary Care Provider • Model Notice of Right to Designate a Primary Care Provider (addition for pediatrician) • Model Notice of Right to Receive Services from an OB/GYN without a referral	☐	☐	☐
Explanation:					
☐ **Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth:** ☐ Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ☐ EXCEPTION: this does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. ☐ No prior authorization required for 48/96 hour hospital stay. ☐ Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. The issuer is not allowed to: ☐ Deny the mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements; ☐ Provide monetary payments/rebates to encourage mothers to accept less than the minimum requirements; ☐ Penalize an attending provider who provides services in accordance with these requirements; ☐ Provide incentives to an attending provider to induce the provider to provide care inconsistent with these requirements; ☐ Restrict benefits for any portion of a period within the 48/96-hour stay in a manner less favorable than the benefits provided for any	PHSA §2725 (45 CFR §148.170)	Note: for non-grandfathered policies pre-2014, this applies only if maternity is a covered benefit. In 2014, maternity must be covered as one of the Essential Health Benefits. Note: in the case of multiple births, hospital length of stay begins at the time of the last delivery. Attachments: • Model Newborns' Act Disclosure	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
preceding portion of such stay; ☐ Require the mother to give birth in a hospital; and ☐ Require the mother to stay in the hospital for a fixed period of time following the birth of her child. ☐ *An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother.*					
Explanation:					
☐ **Parity in Mental Health and Substance Use Disorder Benefits**	PHSA §2726	PLACEHOLDER	☐	☐	☐
☐ **Coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act)** ☐ If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include: ☐ Reconstruction of the breast on which the mastectomy was performed (all stages); ☐ Surgery and reconstruction of the other breast to produce symmetrical appearance; ☐ Prostheses; and ☐ Treatment of physical complications at all stages of mastectomy. ☐ This benefit can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the coverage. ☐ The issuer is prohibited from denying a patient eligibility to enroll or renew coverage solely to avoid these requirements; penalizing or offering incentives to an attending provider to induce the provider to furnish care inconsistent with these requirements.	PHSA §2727	Tip: Look for exclusions for cosmetic surgery and make sure it is clear that reconstructive surgery for mastectomy is NOT considered cosmetic and therefore excluded. Tip: Look for limitations for only cancer patient/diagnosis of cancer before benefit kicks in (statute does not limit mastectomy to cancer diagnosis). Attachment: • Model WHCRA Enrollment Notice • Model WHCRA Annual Notice	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ Notice about the availability of mastectomy-related benefits must be given at issue and annually.					
Explanation:					
☐ **Coverage for dependent student on <u>medically necessary leave of absence</u> ("Michelle's Law")** ☐ Issuer cannot terminate coverage due to a medically necessary leave of absence before: • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. ☐ Change in benefits prohibited – child on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a medically necessary leave of absence; however, if there is a change in the manner in which the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence. ☐ Eligibility for protections: a dependent child under the terms of the coverage of the beneficiary, enrolled in the coverage on the basis of being a student immediately before the first day of the medically necessary leave of absence involved. ☐ "Medically necessary leave of absence" means: a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that: 1. commences while the child is suffering from a serious illness or injury; 2. is medically necessary; and 3. causes the child to lose student status for purposes of coverage under the terms of coverage. ☐ Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the	PHSA §2728 (45 CFR §147.145)	Note: ACA requires issuers to provide dependent coverage to age 26 regardless of student status. Under some circumstances, an issuer may provide dependent coverage beyond age 26, in which case these provisions would apply. The issuer can require receipt of written certification by a treating physician of the dependent child that states that the dependent is suffering from a serious illness or injury and that the leave of absence is medically necessary.	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
terms for continued coverage during medically necessary leaves of absence.					
Explanation:					
☐ **Coverage is guaranteed renewable** ☐ May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 (45 CFR §148.122)	Tip: Renewability statements that include other reasons for not renewing are not permissible.	☐	☐	☐
Explanation:					
☐ **Coverage is not based on <u>genetic information (GINA)</u>** An issuer is not allowed to: ☐ Adjust premiums based on genetic information; ☐ Request /require <u>genetic testing</u>; or ☐ Collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for <u>underwriting purposes</u>. EXCEPTION FOR MEDICAL APPROPRIATENESS (only if the individual seeks a benefit under the plan): ☐ If an individual seeks a benefit under a plan, the issuer may limit or exclude the benefit based on whether the benefit is medically appropriate and the determination of whether the benefit is medically appropriate is not for underwriting purposes. ☐ If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information (the issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness). ☐ The incidental collection of genetic information is permitted, as long as it is not used for underwriting purposes.	PHSA §2753 (74 Fed Reg 51664, 45 CFR §148.180)	Tip: A test to determine whether an individual has a BRCA1 or BRCA2, genetic variants associated with a significantly increased risk for breast cancer, is a genetic test. An HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. Attachment: Examples from federal regulations	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
EXCEPTIONS: ☐ A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. ☐ An issuer can obtain and use results of a genetic test for making a determination regarding payment (minimum amount of information necessary to make the determination). ☐ An issuer may request but not require that a beneficiary undergo a genetic test if the request is pursuant to research and the following conditions are met: ☐ Research must be in accordance with Federal regulations and applicable state/local law or regulations; ☐ The issuer makes a written request, and the request clearly indicates that compliance is voluntary, and noncompliance will have no effect on eligibility for benefits; ☐ No information collected can be used for underwriting purposes; and ☐ The issuer completes a copy of the "Notice of Research Exception under the Genetic Information Nondiscrimination Act." ☐ "Genetic information" is information about an individual's/family members' genetic tests, the manifestation of a disease or disorder in family members of the individual, or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual/family member. • With respect to a pregnant woman, genetic information includes information about the fetus. • With respect to an individual using assisted reproductive technology, genetic information includes information about the embryo. • Genetic information does NOT include information about the sex or age of any individual. ☐ "Manifestation" means that an individual has been or could reasonably be diagnosed with a disease, disorder, or pathological condition; not manifested if the diagnosis is based principally on genetic information.					

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ "Genetic services" means a genetic test, genetic counseling or genetic education. ☐ "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. A genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. ☐ "Underwriting purposes" means: • Rules for determination of eligibility for benefits under the coverage; • The computation of premium or contribution amounts under the coverage; • The application of any pre-existing condition exclusion under the coverage (until 2014); and • Other activities related to the creation, renewal, or replacement of a contract of health insurance.					
Explanation:					
☐ **Providers operating within their scope of practice cannot be discriminated against** ☐ Issuers may not discriminate against any provider operating within their scope of practice.	PHSA§2706	Tip: Check to ensure that if a service /treatment is covered that there are no limitations on licensed providers who can provide that service.	☐	☐	☐
Explanation:					
☐ **Coverage for individuals participating in approved clinical trials:** ☐ Issuer must cover "routine patient costs" – items and services consistent with benefits for typically covered services. ☐ If an in-network provider is participating in a clinical trial, the issuer may require participation in the trial through the participating provider if the provider will accept the individual as a participant. ☐ An individual may participate in an approved clinical trial conducted outside the state in which the individual resides.	PHSA §2709		☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ "Qualified individual" – eligible to participate according to trial protocol and referring health care professional/ medical information establishing appropriateness. ☐"Approved clinical trial" – phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.					
Explanation:					
Special enrollment period	*further guidance needed*		☐	☐	☐
Open enrollment period(s) required [If no state standard, issuers may determine the number and length of open enrollment periods].	*further guidance needed*		☐	☐	☐
☐ **Minimum 60% actuarial value is required for individual coverage.** ☐ Individual policies must meet the AVs in the metal tiers. ☐ *Reviewer check*: included printout of AV calculator and methodology. ☐ *Reviewer check*: included disclosure of how benefits were defined and entered into AV calculator.	ACA §1302	AV is measured as a percentage of expected health care costs a health plan will cover; calculated based on the cost-sharing provisions for a set of benefits.	☐	☐	☐
Explanation:					
☐ **Claims procedures, including applicable time frames** ☐ **General requirements:** ☐ required to include a description of: ○ claims procedures; ○ procedures for obtaining prior approval; ○ preauthorization procedures; ○ utilization review procedures; and ○ applicable time frames. ☐ The claims procedure cannot unduly inhibit the initiation or	45 CFR §147.136, 29 CFR §2560.503-1	Tip: If the issuer requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination, it is considered to unduly inhibit the initiation and processing of claims. Tip: Check for any additional criteria in the contract that a patient must meet before being allowed to submit claims and for asking for review of claims to ensure that the procedure does not unduly inhibit initiation or processing of claims.			

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
processing of claims. ☐ A "claim for benefits" is a request for benefits made by a claimant in accordance with an issuer's reasonable procedure for filing benefit claims, including pre-service and post-service claims. ☐ **Time and process for urgent care (pre-service, post-service):** ☐ Determination for urgent care made within 72 hours. ☐ Notice of the determination within 72 hours of receipt of the claim. ☐ Notice of urgent care decisions include a description of the expedited review process applicable to such claim. ☐ No extension of the determination time-frame is permitted. ☐ If the claimant fails to provide sufficient information, issuer must notify the claimant within 24 hours and must include specific information necessary to complete the claim. ☐ The claimant must have at least 48 hours to provide the specified information. ☐ A determination must be made within 48 hours of receiving specified information or expiration of time afforded to the claimant to provide the specified information (whichever is earlier). ☐ **Time and process for concurrent urgent care (at the request of the claimant):** ☐ Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. ☐ Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. ☐ Determination must be made within 24 hours. ☐ Notification is required within 24 hours of the claim's request ☐ **Time and process for pre-service claim:** ☐ Determination for a pre-service claim must be made within 15 days of the request of the claim.		An authorized representative of the claimant may act on behalf of the claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Attachment: • Model Notice of Adverse Benefit Determination			

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ Notice of the determination within 15 days of the claim. ☐ Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. ☐ Notice required of the extension prior to the expiration of the initial 15-day period, ☐ The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision. ☐ If the claimant fails to provide sufficient information, the issuer must notify the claimant and specifically describe the required information needed to render a decision. ☐ Claimant has 45 days from receipt of notice of insufficient information to provide specified information. ☐ **Time and process for on-going services/treatment (concurrent care decisions):** ☐ Reduction/termination of benefits of ongoing courses of treatment (concurrent care) before the end of the time/treatments is considered an adverse benefit determination. ☐ Determination for concurrent care must be made sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. ☐ Notice of the determination sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. ☐ **Time and process for post-service claim:** ☐ Determination for post-service claim must be made within 30 days of receipt of claim. ☐ Notice of the determination within 30 days of receipt of the claim. ☐ Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer:					

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ Notice of the extension must be provided to the claimant prior to expiration of the initial 30-day period. ☐ The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. ☐ If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information necessary to render a decision. ☐ The claimant has at least 45 days from the receipt of notice to provide the specified information. ☐ **Standards for all required notices:** ☐ Issuer must provide the claimant with written or electronic notification of any adverse benefit determination for pre-service, post-service, and concurrent treatment claims. ☐ All notices of adverse benefit determination (including final internal adverse benefit determinations) must be provided in a culturally and linguistically appropriate manner and must include: ☐ Information sufficient to identify the claim involved including date of service, health care provider, and, upon request, diagnosis/treatment codes and their meanings; ☐ Specific reason for the adverse determination, including the denial code and its corresponding meaning and a description of the issuer's standard that was used in denying the claim. ☐ A final internal adverse benefit decision must include: ☐ a discussion of the decision; ☐ a description of available internal appeals and external review processes; and ☐ a description of how to initiate an appeal. ☐ An adverse benefit determination must describe: ☐ applicable expedited review process; and ☐ availability of and contact information for health insurance consumer assistance or ombudsman.					

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
Explanation:					
☐ **Internal appeals of adverse benefit determinations - processes, rights and required notices:** ☐ Enrollees have a right to appeal an adverse benefit determination. ☐ Enrollees may review the claim file and present evidence and testimony as part of the internal appeals process. ☐ Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. ☐ Enrollees must have access to an expedited review process. ☐ Requests for expedited review must be allowed to be submitted orally or in writing. ☐ <u>Pre-service claim</u>: ☐ Determination must be made within 30 days after receipt of the claimant's request. ☐ Notice of the determination within 30 days after receipt of the claimant's request. ☐ <u>Post-service claim</u>: ☐ Determination must be made within 60 days after receipt of the claimant's request. ☐ Notice of the determination within 60 days after receipt of the claimant's request. ☐ <u>Urgent claim</u>: ☐ Determination must be made within 72 hours after receipt of the claimant's request. ☐ Notice of the determination within 72 hours after receipt of the claimant's request. ☐ If claimant fails to provide sufficient information to determine covered/payable benefits for an urgent claim, the issuer must: ☐ Notify the claimant within 24 hours of the information necessary to complete the claim. ☐ Give the claimant at least 48 hours to provide the	PHSA §2719 (75 Fed Reg 43330, 76 Fed Reg 37208, 45 CFR §147.136)	Attachment: • Model Notice of Final Internal Adverse Benefit Determination			

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
specified information. ☐ Provide notice of the determination within 48 hours of the earlier of receiving the specified information and the end of the time period provided to return the specified information. ☐ The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner. ☐ In the case of an adverse benefit determination, the notification shall include: ☐ Information sufficient to identify the claim involved (including date of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); ☐ Diagnosis/treatment codes and meanings must be provided as soon as practicable. Requests for this information cannot be considered a request for an internal appeal or external review; ☐ Specific reason(s) for the determination, including the denial code and corresponding meaning, as well as a description of issuer's standard that was used in denying the claim (including a discussion of the decision in final internal adverse benefit determination); ☐ Description of available internal appeals and external review processes. ☐ Information on how to initiate an appeal; ☐ Information about the availability of, and contact information for, office of health insurance consumer assistance or ombudsman; and ☐ A statement that the claimant is entitled to receive reasonable access to/copies of all documents, records, and other information relevant to the claim. ☐ An *adverse benefit determination* means a denial, reductions, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide					

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. ☐ A rescission of coverage must be treated as an adverse benefit determination. ☐ If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an external review or any remedies available under state law. ☐ The internal claims and appeals process will not be deemed exhausted if the violation did not cause harm to the claimant so long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer, and ☐ That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant. ☐ <u>Ongoing (concurrent care) decisions</u>: ☐ Issuer is required to provide continued coverage pending the outcome of an appeal; ☐ must provide benefits for an ongoing course of treatment; and ☐ cannot reduce or terminate benefits. ☐ Provide advance notice and an opportunity for a review in advance of reducing or terminating benefits.					
Explanation:					
☐ **External review processes rights and required notices:** ☐ External review of an adverse benefit determination for: ☐ medical necessity; ☐ appropriateness; ☐ health care setting; ☐ level of care;	PHSA §2719 (75 Fed Reg 43330, 76 Fed Reg 37208, 45 CFR §147.136)	Tip: If there is a filing fee, it cannot be more than $25. Attachment: • Model Notice of Final External Review Decision			

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ effectiveness of a covered benefit; and ☐ rescission. ☐ External review of adverse benefit determinations for experimental or investigational treatments or services. ☐ Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. ☐ Issuers must provide effective written notice to claimants of external review rights in plan materials, and in each notice of adverse benefit determination. ☐ If exhaustion of internal appeals is required prior to external review, requirement to exhaust does not apply if: ☐ issuer did not meet internal appeal process timelines (with limited exceptions); or ☐ in cases of urgent care. ☐ Cost of an external review must be borne by the issuer. ☐ Claimant cannot be charted a filing fee greater than $25. ☐ Restriction on the minimum dollar amount of a claim is not allowed. ☐ Claimant must have at least 60 days to file for external review after the receipt of the notice of adverse benefit determination (including final internal adverse benefit determination). ☐ IRO decision is binding on the issuer. ☐ For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 60 days from receipt of the request for review. ☐ **Urgent care:** ☐ The process must provide for expedited external review of urgent care claims. ☐ The IRO must inform the issuer and the claimant of an urgent care decision within 4 business days from receipt of the request for review. ☐ If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral					

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
notification.					
Explanation:					

Model Notice Language for Individual Form Review Checklist

Technical Release 2011-02 - APPENDIX, Department of Health and Human Services

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records. This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Patient Name:	**ID Number:**
Address: (street, county, state, zip)	
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Description of service:	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below].

Explanation of Basis for Determination:

If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

[Insert language assistance disclosure here, if applicable].

SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].

CHINESE (中文): 如果需要中文的帮助, **请拨打这个号码** [insert telephone number].

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? [Complete the bottom of this page, make a copy, and send this document to {insert address}]. [or] [insert alternative instructions]. See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also [insert instructions for filing request for simultaneous external review].

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. [Insert information on how to designate an authorized representative].

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information].

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at [insert contact information].

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information].

Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____

Circle one: □Covered person □ Patient □ Authorized Representative

Contact information of person filing appeal (if different from patient)

Address: _____Daytime phone: _____Email:_____

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Are you requesting an urgent appeal? □Yes □ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

_____

_____

Model Notice of Final Internal Adverse Benefit Determination – Revised as of June 22, 2011
Technical Release 2011-02 - APPENDIX, Department of Health and Human Services

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records. This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Internal Appeal Case Details:

Patient Name:			**ID Number:**				
Address: (street, county, state, zip)							
Claim #:			**Date of Service:**				
Provider:							
Reason for Upholding Denial (in whole or in part):							
Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**
YTD Credit toward Deductible:			**YTD Credit toward Out-of-Pocket Maximum:**				
Description of Service:			**Denial Codes:**				

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below].

Background Information: *Describe facts of the case including type of appeal and date appeal filed.*

Final Internal Adverse Benefit Determination: *State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination.*

Findings: *Discuss the reason or reasons for the final internal adverse benefit determination.*

[Insert language assistance disclosure here, if applicable].
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].

CHINESE (中文): 如果需要中文的帮助, **请拨打这个号码** [insert telephone number].

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].

Model Notice of Final Internal Adverse Benefit Determination – Revised as of June 22, 2011

Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? For certain types of claims, you are entitled to request an independent, external review of our decision. Contact [insert external review contact information] with any questions on your rights to external review. [For insured coverage, insert: If your claim is not eligible for independent external review but you still disagree with the denial, your state insurance regulator may be able to help to resolve the dispute]. See the "Other resources section" of this form for help filing a request for external review.

How do I file a request for external review? Complete the bottom of this page, make a copy, and send this document to {insert address}]. [or] [insert alternative instructions]. See also the "Other resources to help you" section of this form for assistance filing a request for external review.

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. [Insert information on how to designate an authorized representative].

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at [insert contact information].

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [If coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact: [insert contact information]].

NAME OF PERSON FILING REQUEST FOR EXTERNAL REVIEW: _____

Circle one: Covered person Patient Authorized Representative

Contact information of person filing request for external review (if different from patient)

Address: _____ **Daytime phone:** _____ **Email:** _____

If person filing request for external review is other than patient, patient must indicate authorization by signing here: _____

Are you requesting an urgent review? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

_____

_____

Technical Release 2011-02 - APPENDIX, Department of Health and Human Services

Model Notice of Final External Review Decision – Revised June 22, 2011

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records. This document serves as notice of a final external review decision. We have **[upheld/overturned/modified]** the denial of your request for the provision of, or payment for, a health care service or course of treatment.

Historical Case Details:

Patient Name:			**ID Number:**				
Address: (street, county, state, zip)							
Claim #:			**Date of Service:**				
Provider:							
Reason for Denial (in whole or in part):							
Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**
YTD Credit toward Deductible:			**YTD Credit toward Out-of-Pocket Maximum:**				
Description of Service:			**Denial Codes:**				

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below].

Background Information: *Describe facts of the case including type of appeal, date appeal filed, date appeal was received by IRO and date IRO decision was made.*

Final External Review Decision: *State decision. List all documents and statements that were reviewed to make this final external review decision.*

Findings: *Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.*

OMB Control Number 0938-1099 (expires 04/30/2014)

Model Notice of Final External Review Decision – Revised June 22, 2011

Important Information about Your Appeal Rights

What if I need help understanding this decision?
Contact us [insert IRO contact information] if you need assistance understanding this notice.

What happens now? If we have overturned the denial, your plan or health insurance issuer will now provide service or payment.

If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, you can contact your consumer assistance program at [insert contact information]].

Model Language – Notice of Right to Designate a Primary Care Provider (45 CFR 147.138(a)(4))

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider.

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you]. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [issuer] at [insert contact information].

Statement of Rights Under the Newborns' and Mothers' Health Protection Act
(45 CFR §148.170(d)(2))

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Model WHCRA Enrollment Notice
Compliance Assistance Guide, US DOL, EBSA (Oct. 2010)

The following is language that group health plans may use as a guide when crafting the WHCRA enrollment notice:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

ModelWHCRA Annual Notice
Compliance Assistance Guide, US DOL, EBSA (Oct. 2010)

The following is language that group health plans may use as a guide when crafting the WHCRA annual notice:

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at [insert phone number] for more information.

Examples for Non-Grandfathered 2014 Individual Market Non-Exchange Products Form Review:

No Pre-Existing Condition Exclusions for Enrollees Under Age 19 (*45 CFR §147.108)*
Example. (i) Facts. Individual G applies for a policy of family coverage in the individual market for G, G's spouse, and G's 13-year-old child. The issuer denies the application for coverage on March 1, 2011 because G's 13-year-old child has autism.

(ii) *Conclusion.* In this *Example,* the issuer's denial of *G's* application for a policy of family coverage in the individual market is a pre-existing condition exclusion because the denial was based on the child's autism, which was present before the date of denial of coverage. Because the child is under 19 years of age and the March 1, 2011, denial of coverage is after the applicability date of this section, the issuer is prohibited from imposing a pre-existing condition exclusion with respect to *G's* 13-year-old child.

Prohibits Rescissions Once the Enrollee is Covered (45 CFR §147.128)
Example 1.(i) *Facts.* Individual *A* seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires *A* to complete a questionnaire regarding *A's* prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: "Is there anything else relevant to your health that we should know?" *A* inadvertently fails to list that *A* visited a psychologist on two occasions, six years previously. *A* is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about *A's* visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1,* the plan cannot rescind *A's* coverage because *A's* failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2.(i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual *B* has coverage under the plan as a full-time employee. The employer reassigns *B* to a part-time position. Under the terms of the plan, *B* is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from *B* and paying claims submitted by *B.* After a routine audit, the plan discovers that *B* no longer works at least 30 hours per week. The plan rescinds *B's* coverage effective as of the date that *B* changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2,* the plan cannot rescind *B*'s coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for *B* prospectively, subject to other applicable Federal and state laws.

Coverage of Preventive Services Without Cost-Sharing Requirements Including Deductibles, Co-Payments, and Co-Insurance (45 CFR §147.130)
Example 1. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1,* the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2.(i) *Facts.* Same facts as *Example 1.* As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2,* because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.
Example 3.(i) *Facts.* An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 3,* the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) *Facts.* A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 4,* the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

Preventive care – Health Savings Accounts – Additional Qs & As (Internal Revenue Bulletin: 2004-33)
Q-26. Does a preventive care service or screening that also includes the treatment of a related condition during that procedure come within the safe harbor for preventive care in Notice 2004-23?

A-26. Yes. Although Notice 2004-23 states that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition, in situations where it would be unreasonable or impracticable to perform another procedure to treat the condition, any treatment that is incidental or ancillary to a preventive care service or screening as described in Notice 2004-23 also falls within the safe-harbor for preventive care. For example, removal of polyps during a diagnostic colonoscopy is preventive care that can be provided before the deductible in an HDHP has been satisfied.

Coverage for dependents must be available up to age 26 if policy offers dependent coverage – Uniformity based on age (45 CFR §147.120)

Example 1. (i) *Facts.* A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

(ii) *Conclusion.* In this *Example 1,* the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2.(i) *Facts.* A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

(ii) *Conclusion.* In this *Example 2,* the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example 3 (i) *Facts.* A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(iii) *Conclusion.* In this *Example 3,* the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

Coverage for Emergency Services – Cost-Sharing Requirements (45 CFR §147.138)
Example 1. (i) *Facts.* A group health plan imposes a 25 percent coinsurance responsibility on individuals who are furnished emergency services, whether provided in network or out of network. If a covered individual notifies the plan within two business days after the day an individual receives treatment in an emergency department, the plan reduces the coinsurance rate to 15 percent.

(ii) *Conclusion.* In this *Example 1,* the requirement to notify the plan in order to receive a reduction in the coinsurance rate does not violate the requirement that the plan cover emergency services without the need for any prior authorization determination. This is the result even if the plan required that it be notified before or at the time of receiving services at the emergency department in order to receive a reduction in the coinsurance rate.

Example 2. (i) *Facts.* A group health plan imposes a $60 copayment on emergency services without preauthorization, whether provided in network or out of network. If emergency services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition.

(ii) *Conclusion.* In this *Example 2,* by requiring an individual to pay more for emergency services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover emergency services without the need for any prior authorization determination. (By contrast, if, to have the copayment waived, the plan merely required that it be notified rather than a prior authorization, then the plan would not violate the requirement that the plan cover emergency services without the need for any prior authorization determination.)

Example 3. (i) *Facts.* A group health plan covers individuals who receive emergency services with respect to an emergency medical condition from an out-of-network provider. The plan has agreements with in-network providers with respect to a certain emergency service. Each provider has agreed to provide the service for a certain amount. Among all the providers for the service: one has agreed to accept $85, two have agreed to accept $100, two have agreed to accept $110, three have agreed to accept $120, and one has agreed to accept $150. Under the agreement, the plan agrees to pay the providers 80 percent of the agreed amount, with the individual receiving the service responsible for the remaining 20 percent.

(ii) *Conclusion.* In this *Example 3,* the values taken into account in determining the median are $85, $100, $100, $110, $110, $120, $120, $120, and $150. Therefore, the median amount among those agreed to for the emergency service is $110, and the amount under paragraph (b)(3)(i)(A) of this section is 80 percent of $110 ($88).

Example 4. (i) *Facts.* Same facts as *Example 3.* Subsequently, the plan adds another provider to its network, who has agreed to accept $150 for the emergency service.

(ii) *Conclusion.* In this *Example 4,* the median amount among those agreed to for the emergency service is $115. (Because there is no one middle amount, the median is the average of the two middle amounts, $110 and $120.) Accordingly, the amount under paragraph (b)(3)(i)(A) of this section is 80 percent of $115 ($92).

Example 5. (i) *Facts.* Same facts as *Example 4.* An individual covered by the plan receives the emergency service from an out-of-network provider, who charges $125 for the service. With respect to services provided by out-of-network providers generally, the plan reimburses covered individuals 50 percent of the reasonable amount charged by the provider for medical services. For this purpose, the reasonable amount for any service is based on information on charges by all providers collected by a third party, on a zip code by zip code basis, with the plan treating charges at a specified percentile as reasonable. For the emergency service received by the individual, the reasonable amount calculated using this method is $116. The amount that would be paid under Medicare for the emergency service, excluding any co-payment or co-insurance for the service, is $80.

(ii) *Conclusion.* In this *Example 5,* the plan is responsible for paying $92.80, 80 percent of $116. The median amount among those agreed to for the emergency service is $115 and the amount the plan would pay is $92 (80 percent of $115); the amount calculated using the same method the plan uses to determine payments for out-of-network services—$116—excluding the in-network 20 percent co-insurance, is $92.80; and the Medicare payment is $80. Thus, the greatest amount is $92.80. The individual is responsible for the remaining $32.20 charged by the out-of-network provider.

Example 6. (i) *Facts.* Same facts as *Example 5.* The group health plan generally imposes a $250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a $500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted $260 of covered claims prior to receiving the emergency service out of network.

(ii) *Conclusion.* In this *Example 6,* the plan is not responsible for paying anything with respect to the emergency service furnished by the out-of-network provider because the covered individual has not satisfied the higher deductible that applies generally to all health care provided out of network. However, the amount the individual is required to pay is credited against the deductible.

Genetic Information (45 CFR §146.122)
GENETIC TEST Example 1. (i) *Facts.* Individual *A* is a newborn covered under a group health plan. *A* undergoes a phenylketonuria (PKU) screening, which measures the concentration of a metabolite, phenylalanine, in *A's* blood. In PKU, a mutation occurs in the phenylalanine hydroxylase (PAH) gene which contains instructions for making the enzyme needed to break down the amino acid phenylalanine. Individuals with the mutation, who have a deficiency in the enzyme to break down phenylalanine, have high concentrations of phenylalanine.

(ii) *Conclusion.* In this *Example 1,* the PKU screening is a genetic test with respect to *A* because the screening is an analysis of metabolites that detects a genetic mutation.

MANIFEST Example 2. (i) *Facts.* Individual *A* has a family medical history of diabetes. *A* begins to experience excessive sweating, thirst, and fatigue. *A's* physician examines *A* and orders blood glucose testing (which is not a genetic test). Based on the physician's examination, *A's* symptoms, and test results that show elevated levels of blood glucose, *A's* physician diagnoses *A* as having adult onset diabetes mellitus (Type 2 diabetes).

(ii) *Conclusion.* In this *Example 1, A* has been diagnosed by a health care professional with appropriate training and expertise in the field of medicine involved. The diagnosis is not based principally on genetic information. Thus, Type 2 diabetes is manifested with respect to *A.*

MANIFEST Example 3. (i) *Facts.* Individual *B* has several family members with colon cancer. One of them underwent genetic testing which detected a mutation in the MSH2 gene associated with hereditary nonpolyposis colorectal cancer (HNPCC). *B's* physician, a health care professional with appropriate training and expertise in the field of medicine involved, recommends that *B* undergo a targeted genetic test to look for the specific mutation found in *B's* relative to determine if *B* has an elevated risk for cancer. The genetic test with respect to *B* showed that *B* also carries the mutation and is at increased risk to develop colorectal and other cancers associated with HNPCC. *B* has a colonoscopy which indicates no signs of disease, and *B* has no symptoms.

(ii) *Conclusion.* In this *Example 3,* because *B* has no signs or symptoms of colorectal cancer, *B* has not been and could not reasonably be diagnosed with HNPCC. Thus, HNPCC is not manifested with respect to *B.*

MANIFEST Example 4. (i) *Facts.* Same facts as *Example 3,* except that *B's* colonoscopy and subsequent tests indicate the presence of HNPCC. Based on the colonoscopy and subsequent test results, *B's* physician makes a diagnosis of HNPCC.

(ii) Conclusion. In this *Example 4,* HNPCC is manifested with respect to *B* because a health care professional with appropriate training and expertise in the field of medicine involved has made a diagnosis that is not based principally on genetic information.

Example 5. (i) *Facts.* Individual *C* has a family member that has been diagnosed with Huntington's Disease. A genetic test indicates that *C* has the Huntington's Disease gene variant. At age 42, *C* begins suffering from occasional moodiness and disorientation, symptoms which are associated with Huntington's Disease. *C* is examined by a neurologist (a physician with appropriate training and expertise for diagnosing Huntington's Disease). The examination includes a clinical neurological exam. The results of the examination do not support a diagnosis of Huntington's Disease.

(ii) *Conclusion.* In this *Example 5, C* is not and could not reasonably be diagnosed with Huntington's Disease by a health care professional with appropriate training and expertise. Therefore, Huntington's Disease is not manifested with respect to *C.*

Example 6. (i) *Facts.* Same facts as *Example 5,* except that *C* exhibits additional neurological and behavioral symptoms, and the results of the examination support a diagnosis of Huntington's Disease with respect to *C.*
(ii) *Conclusion.* In this *Example 6, C* could reasonably be diagnosed with Huntington's Disease by a health care professional with appropriate training and expertise. Therefore, Huntington's Disease is manifested with respect to *C.*

ACA Insurance Self-Audit: Provisions within Traditional Authority of Insurance Department

EFFECTIVE 2010

Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
PHSA §2704	No pre-ex for children under 19	✓	✓	✓		
PHSA §2711	No lifetime limits	✓	✓	✓	✓	
PHSA §2711 + Guidance	Limited annual limits	✓	✓	✓		
PHSA §2712 + Regs	Rescissions prohibited except in cases of fraud or intentional misrepresentation	✓	✓	✓	✓	
PHSA §2713 + Regs	Preventive care[1], no cost-sharing	✓		✓		
PHSA §2714 + Regs	Dependent coverage up to age 26 (exception for dependents with job-based coverage before 2014)	✓	✓	✓	✓	
PHSA §2715A	Additional information relating to transparency in coverage to be submitted by carriers and made available to the public (further guidance to be issued)	✓		✓		
PHSA §2716	Prohibition on discrimination based on salary	✓				
PHSA §2719 + Regs	Enhanced external appeals and internal review of coverage determinations and claims	✓		✓		
PHSA §2719A + Regs	Enhanced access to primary care, pediatricians, ER, OBGYN	✓		✓		
42 USC 18011 (PPACA §1251) + Regs	*"Grandfathered plan" defined in Sec. 1251. Guidance and clarification has been issued.					

[1] HRSA women's preventive care required to be covered for plan or policy years starting on or after Aug. 1, 2012 (final rule released Aug. 11, 2011).

Regulations and guidance are available at: http://www.healthcare.gov/center/regulations/index.html

EFFECTIVE 2011

Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
PHSA §2718 + Regs	MLR at 85% for large group	✓	✓	n/a	n/a	
PHSA §2718 +Regs	MLR at 80% for small group and individual	✓	✓	✓	✓	
PHSA §2719 + Regs	Internal appeals	✓		✓		
PHSA §2719 + Regs	External review process	✓		✓		
PHSA §2794 + Regs[2]	Rate review – "unreasonable" rate increase (grants available)	✓		✓		

[2] Limited to individual and small group markets.

EFFECTIVE 2012

Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
PHSA §2715	Uniform explanation of coverage documents and standardized definitions	✓	✓[4]	✓	✓	
PHSA §2718	MLR refunds: state can enforce – review supplemental annual statement[3]	✓	✓	✓	✓	

[3] Compare with rate filings for potential errors.
[4] Reg issued Aug. 22, 2011 - §2715 is applicable to both grandfathered and non-grandfathered plans.

EFFECTIVE 2013

Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
42 USC § 18021 (PPACA §1322) + Regs	CO-OPs – deadline for federal $$, licensed by state - Enabling legislation/transitional rules depending on state law	✓	n/a	✓	n/a	
42 USC § 18021 (PPACA §1302) + Regs	Essential benefits – deadline for establishment by HHS[5]	✓[6]		✓		

[5] Compare to existing state law.
[6] Large group when included in exchange.

EFFECTIVE 2014 AND BEYOND

Section		Applicability				State Action
		Group	Group Grandfather	Individual	Individual Grandfather	
PHSA §2719 + Regs	External review – NAIC Model	✓		✓		
PHSA §2701	Community rating with limits on rate factors (states can have tighter limits) ▪ Age 3:1 ▪ Tobacco 1.5:1 ▪ Geographic rating area (established by State) ▪ Prohibit: gender, health, group size (small group market), industry ▪ Allowed: geography and family composition	✓		✓		
PHSA §2702	Guaranteed availability of coverage	✓	+	✓	+	[+] HIPAA requirements apply
PHSA §2703	Reaffirms HIPAA guaranteed renewability of coverage	✓	+	✓	+	

Section		Applicability				State Action
		Group	Group Grandfather	Individual	Individual Grandfather	
PHSA §2704	No pre-ex for all	✓	✓	✓		
PHSA §2705	Prohibition on discrimination based on health status (expands on HIPAA protections by adding wellness program provisions and extends nondiscrimination protections to individual market)	✓	+	✓		
PHSA §2706	Nondiscrimination in health care – participation by credentialed providers	✓		✓		
PHSA §2707	Small group and individual plans must include essential benefits package (includes large group markets within exchange)	✓		✓		
PHSA §2708	Prohibition on excessive waiting periods	✓	✓			
PHSA §2709	Coverage for approved clinical trials	✓		✓		
42 USC § 18061 (PPACA §1341) + Regs	Transitional reinsurance program (for plan years beginning 2014 through 2016)	✓[7]		✓[7]		
42 USC § 18062 (PPACA §1342) + Regs	Establishment of risk corridors	✓ QHPs		✓ QHPs		
42 USC § 18063 (PPACA §1343) + Regs	Risk Adjustment	✓[8]		✓[8]		
42 USC § 18012 (PPACA §1252) + Regs	Rating reforms must apply uniformly to all health insurance issuers in each market	✓		✓		
42 USC § 18022 (PPACA §1302) + Regs	Plans required to offer Essential Health Benefits[9]	✓		✓		

Section		Applicability				State Action
		Group	Group Grandfather	Individual	Individual Grandfather	
42 USC § 18024 (PPACA §1304) + Regs	Small group market size – State may define as 1-50 employees until 2016, then 1-100					
42 USC § 18024 (PPACA §1304) + Regs	Individual and small group markets may be merged, but may not include grandfathered pools	✓		✓		
42 USC § 18024 (PPACA §1304) + Regs	Carriers must combine all non-grandfathered plans into single risk pool within a market	✓		✓		
42 USC § 18051 (PPACA §1331) + Regs	Basic Health Programs[10] for low-income individuals not eligible for Medicaid			✓		

[7] All issuers & TPAs contribute funding, individual market plans (in and out of exchange) are eligible for payments.
[8] Transfers funds from lowest risk plans to highest risk plans.
[9] Issuers offering individual or small group coverage must provide essential benefits. This requirement does not extend to the large group market or to self-funded plans (see section 2707). State must assume cost for additional benefits beyond Essential Health Benefits [Sec. 1311(d)(3)(B)].
[10] Authorizing this product to be offered and licensing issue.

For information about CRITICAL EXCHANGE FUNCTIONS UNDER ACA see "Exchange Functions" Chart

ACA Provisions with Potential Market Impact

Section	Provision
2011	
PHSA §2793	Establish health insurance ombudsman (grant available)[11]
42 USC §18001 (PPACA §1101)	Temporary high risk pool
42 USC §18002 (PPACA §1102) + Regs	Retiree reinsurance
42 USC §18003 (PPACA §1103) + Regs	Web portal – insurance regulator provides information to CCIIO
2012	
PHSA §2715 + Regs	Uniform explanation of coverage & and coverage facts label; standardized definitions (March 2012)
PHSA §2717	Health insurance issuers required to report to Federal government and State commissioner ensuring quality of care
2013	
	HHS certification of exchange
2014	
42 USC §18054 (PPACA §1334)	Multi-State Plans – regulations to clarify state role yet to be issued
42 USC §18023 (PPACA §1303)	State may opt out of abortion coverage for QHPs or terminate opt out
42 USC §18053 (PPACA §1333)	Health care choice compact

[11] In addition to ombudsman programs, exchange Proposed Reg proposes to require exchange to do consumer education (§155.205) in addition to the navigator requirement (§155.210).

Pre-ACA Compliance

Section		State Action
42USC §300gg-5; 29 USC §1185a	Mental Health Parity Act of 1996/Mental Health Parity and Addiction Equity Act of 2008	
42 USC §300gg-51	Newborns' and Mothers' Health Protection Act	
42 USC §300gg-52	Women's Health and Cancer Rights Act	
42 USC §300gg-53	*Genetic* Information Nondiscrimination Act	
29 USC §1185c	Michelle's Law	

Exchange Functions Checklist [Departments of Insurance]

(includes minimum and other required functions)
Updated to reflect March 12, 2012 final and interim final guidance

	[DOI] Lead	[DOI] Consult	Notes
Certification of QHPs			
• Establish standards for certification in addition to federal minimum standards if applicable			
• Establish procedures for certification *SERFF will support*			
• Review rate increase justification (may be a part of rate review) *SERFF will support*			
• Ensure justification is posted on exchange and issuer websites *SERFF will support transfer of information to exchange*			
• Collect information from QHPs to meet transparency requirements (claims payment policies & practices, financial, enrollment data, claims denials, rating practices, cost-sharing, enrollee rights) *SERFF may support*			
• Certify QHPs *SERFF will support*			
• Provide required licensing information (risk-bearing entities must be licensed)			
• Provide verification of licensed status, including financial condition			
• Provide other information, including consumer complaints, market conduct, etc.			
• Provide information about closed investigations			
• Establish accreditation period			
• Establish and ensure compliance with network adequacy standards *SERFF will support*			
• Establish recertification process *SERFF will support*			
• Provide required licensing information (risk-bearing entities must be licensed)			
• Provide verification of licensed status, including financial condition			
• Provide other information, including consumer complaints, market conduct, etc.			
• Provide information about closed investigations			

	[DOI] Lead	[DOI] Consult	Notes
• Establish decertification process *SERFF will support*			
• Provide required licensing information (risk-bearing entities must be licensed)			
• Provide verification of licensed status, including financial condition			
• Provide other information, including consumer complaints, market conduct, etc.			
• Provide information about closed investigations			
• Contract with QHPs			
• Monitor ongoing compliance *SERFF will support some portions*			
• Monitor rates (similar inside and outside of exchange) *SERFF will support*			
• Review forms – can be used to check that essential elements are included *SERFF will support*			
• Identify mandated benefits above essential benefits *SERFF will support*			
• Determine actuarial value of plans (bronze, silver, gold, platinum, or catastrophic) *SERFF will support*			
• Establish service areas *SERFF will support*			
Licensing and Oversight			
• License and regulate private health insurance products (sold within and outside exchange, including QHPs and nonqualified private health insurance products)			
• License and regulate insurance risk-bearing entities (issuers)			
• License and regulate CO-OPs			
• License and regulate Medicaid Managed Care plans (if considered an "issuer" by state law or if insurance commercial population)			
• Regulate products sold within and outside exchange			
• Regulate market to minimize adverse selection both inside and outside exchange (e.g., market surveillance, market conduct exams, etc.)			
• Review forms			
• Review rates			
• Regulate multi-state issuers and products (OPM) sold through exchange (depending on forthcoming regulations. MSPs NOT subject to recertification/decertification)			

	[DOI] Lead	[DOI] Consult	Notes
• Monitor compliance with pre-2014 insurance market reforms			
• Monitor compliance with post-2014 insurance market reforms (guaranteed issue, no pre-ex, community rating limits)			
Other Legal Issues to be Researched			
• Does exchange need a producer license?			
Consumer Assistance Tools			
• Establish and operate call center and complaint process (operate toll-free call center for consumers requesting assistance)			
• Establish exchange website			
• Provide premium and cost-sharing information			
• Monitor compliance with Sec. 2715 materials (4-page coverage summary, standard terminology)			
• Identify metal level of QHP			
• Maintain exchange calculator – facilitates comparison of available QHPs after applicable premium tax credit and cost-sharing reduction			
• Post results of enrollee satisfaction surveys			
• Report quality ratings			
• Provide MLR information			
• Provide transparency measures			
• Post and update provider directory			
• Publish financial information			
• Establish process for complaints for exchange products? (establish process for supervisor check-in)			
• Establish process for referring consumers easily and effectively			
• Provide information and reports about consumer complaints and inquiries for exchange product			
• Provide outreach and education			
• Establish Navigator Program (see below)			
• Monitor compliance with external review pre-2014			
• Monitor compliance with external review post-2014			
Navigator Program			
• Establish and disseminate program standards (exchange Navigators & Medicaid “application assisters”) – collaborate			

	[DOI] Lead	[DOI] Consult	Notes
on training/share data			
• Prescribe licensing, certification, training and other standards			
• Monitor compliance by navigators			
• Report disciplinary actions against licensed producers who are also navigators			
• Monitor compliance with admin. functions by navigators for Medicaid			
• Provide program information on exchange website			
Eligibility Determinations and Enrollment			
• Determine eligibility for QHPs			
• Determine eligibility for affordability programs (Medicaid, CHIP, BHP, premium tax credits, cost-sharing reductions)			
• Address special eligibility standards for Native Americans			
• Provide applications for enrollment and notices to enrollees			
• Provide written notice of eligibility determinations (to individual and employer as appropriate)			
• Enter into agreement with HHS re: eligibility determination and payment responsibilities			
• Implement processes for eligibility verification			
• Verify eligibility			
• Provide information to HHS as required (e.g., Social Security numbers, etc.) for validation			
• Provide notice of redetermination of eligibility (periodically when triggered & annually)			
• Enter into agreements with Medicaid, CHIP, BHP, and PCIP re: responsibilities			
• Establish secure electronic interface for data exchange with Medicaid, CHIP, and BHP			
• Effectuate enrollment process for QHPs, BHPs, Medicaid, and CHIP			
• Provide Medicaid screening (basic & full)			
• Calculate advanced payments of premium tax credit			
• Adjudicate appeals of eligibility determinations			
• Ensure seamless eligibility and enrollment process with Medicaid and other State health subsidy programs			
• Provide website function allowing qualified individuals to select QHP			

	[DOI] Lead	[DOI] Consult	Notes
Responsibilities of Individuals and Employers			
• Determine individual responsibility and exemptions			
• Provide notification and administer appeals of employer liability			
Administering Tax Credits and Subsidies			
• Administer premium tax credits and cost-sharing reductions			
• Create verification process for eligibility determination			
• Calculate advance payment of premium tax credit			
• Determine eligibility for cost-sharing reductions			
• Administer subsidy – reflect how subsidy gets paid			
• Report information to IRS and enrollees			
3Rs			
• Develop and administer risk adjustment			
• Develop and administer reinsurance			
• Risk corridors (federal)			
Functions Related to Oversight and Financial Integrity Requirements			
• Ensure compliance with GAAP			
• Ensure program integrity related to fed and state funds			
• Prevent fraud, waste, and abuse			

Workplan Template

	Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
	Activity 1: ACA Standards and Authority Required for Implementation					
	Identify and review which state laws must be modified to comply with federal law (see attached ACA self-audit tool: "ACA Provisions within Traditional Authority of Insurance Department" 2010 through 2014 and beyond provisions)					
	Identify provisions that must be changed legislatively (if not changed, high risk of federal direct enforcement and a finding that the state has not enacted necessary market reforms)					
	2010					
	2011					
	2012					
	2013					
	2014					
	Identify provisions that should be changed legislatively (if not changed, likely to be able to use existing state authority to enforce but there is risk of a challenge to state enforcement by a carrier or other stakeholder)					
	Draft "must-have" legislation to bring state into compliance with federal law					
	Draft "should-have" legislation to bring state into compliance with federal law					
	CCIIO review of legislative language					
	Enact statutory changes					
	Identify provisions that could be changed through regulation					
	2010					
	2011					
	2012					
	2013					
	2014					
	Draft/update and issue regulations to bring state into compliance with federal law (or via bulletins)					
	Activity 2: ACA Standards Oversight and Plan Compliance					
	Identify and analyze current regulatory enforcement and oversight authority including limitations on existing authority, form and rate reviews, market conduct exams, consumer					

	Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
	services/complaint investigations, etc.					
	Determine whether policy form and/or marketing material review is necessary for implementation and enforcement					
	Update forms checklists as necessary					
	Update consumer complaint database, investigations process as necessary					
	Identify alternative compliance authority and develop a strategy if changes to state laws are not enacted					
	Review state implementation/enforcement of 9/23/10 changes on private health insurance policies in individual and group, grandfathered and non-grandfathered policies					
	Review state external and internal review laws for ACA consistency based on final federal regulations					
	Obtain feedback from CCIIO on state-based enforcement					
	Develop a state-specific plan for enhanced regulatory rate oversight authority					
	Compare current state benefit mandates with federal laws, regulations, and the essential health benefit packages and identify differences (for rate review)					
	Identify/analyze benchmark plans – largest plan by enrollment of 3 largest small group, state employee health benefit plans, FEHBP, HMO					
	Transition period to coordinate state mandates with selected benchmark (2014-2015)					
	Develop strategy for insurers' preparedness for full implementation of 2010 and future ACA standards					
	Activity 3: Rate Review Policy Decisions and Oversight (authority, AG role, hearings, transparency, etc.)					
	Review state's rate review authority (all markets) for consistency with federal HHS rate oversight regulations (individual, small group, and association markets – in and out of state)					
	Review state laws for transparency, confidentiality, and proprietary restrictions on rate filings to ensure consistency with federal regulations					
	Determine if state-specific threshold is needed					
	Notify and work with HHS on state-specific threshold					
	Work with CCIIO to determine state-specific options for rate					

	Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
	review if necessary					
	Develop a state-specific plan based in federal determination and state goals					
	Determine if statutory authority needs to be expanded					
	Obtain necessary statutory authority					
	Determine if guidance to carriers through regulations/bulletins is necessary					
	Promulgate regulations/bulletins					
	Begin implementation of enhanced state approach (2011 and 2012 filings)					
	Ensure initial and ongoing compliance and consistency with federal regulations (public input, public information on rate filings, information when necessary to CCIIO, etc.)					
	Review federal MLR requirements and impact on individual market (if any) including any pending or future state MLR waivers					
	Obtain necessary statutory authority for MLR					
	Implement statutory changes if necessary through regulations/bulletins					
	Review federal MLR supplemental NAIC data filings for individual, small group, and large group markets					
	Decide if Division of Insurance will enforce MLR requirements					
	If applicable, establish a system to ensure health insurance plans' medical loss ratios and associated rebates to consumers					
	Establish a process of coordination with rate review process if necessary					
	Develop a plan to adjust risk for qualified plans in the individual and small group markets inside and outside the exchange consistent with federal laws and regulations					
	Implement necessary risk adjustment mechanism, risk corridors, and temporary reinsurance (if allowed by CCIIO)					
	Collect and report risk adjustment data					
	Decide what if any activities are necessary for working with the NAIC on risk adjustment mechanism, reinsurance, etc.					
	Activity 4: Data Submission to HHS					
	Identify and ensure all necessary data submissions to HHS (e.g., grants, carrier data submissions, etc.) (Can SERFF systems be used?)					

	Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
	Activity 5: Insurance Market Policy Decisions					
	Establish an internal process for discussing policy questions – including where state law is stronger					
	Discuss and make recommendations regarding transition/phase-in individual and small group rating laws					
	Identify stakeholder process to discuss possible transition plan					
	Analyze current consumer protection standards (Activity 1) - decide whether to change state consumer protection standards that are stronger/weaker than ACA					
	Identify market issues, e.g. MEWAs, association plans, captive health insurers and decide how to transition to 2014					
	Decide what additional data is necessary to make policy decisions (e.g., federal grants to study merging markets and impact on premiums)					
	Consider whether to study the impact of ACA (including AV minimums and federal subsidies) to identify state-based opportunities					
	Review whether new licensing mechanisms are necessary for risk-bearing entities (ACO, Medicaid Managed Care with commercial populations, CO-OPs)					
	Review CO-OP law and policy related to federal standards					
	Decide whether to keep separate or merge the individual and small group markets in 2014					
	Consider and decide issues around health care choice compacts, regional exchanges, etc.					
	Decide whether to extend the state's small group market to groups of 51-100 between 2014 and 2016					
	Identify stakeholder process for policy decisions input when appropriate					
	Activity 6: Licensing Framework					
	If new licensing is necessary, identify and establish a process(es) for risk-bearing arrangements (ACO, Medicaid Managed Care with commercial populations after 2014, CO-OPs)					
	Develop an implementation plan for roll out, work with stakeholders, work with sister state agencies, etc.					
	Examine existing oversight and make decisions whether existing tools must be modified to encompass newly licensed					

	Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
	arrangements					
	Add to financial and/or market conduct examination schedules if applicable					
	Legal analysis re: enrollment/exchange as producer					
	Activity 7: Determine Rules/Policies/Oversight Inside/Outside Exchange (See Exchange Functions Checklist)					
	Identify exchange-related questions, issues, policy decisions					
	Decide Insurance's primary, secondary, and no responsibility areas with exchange functions					
	Determine if statutory changes or regulatory guidance is necessary					
	Promulgate necessary regulations, bulletins, etc.					
	Update agency agreements as necessary					
	Make decisions about statutory changes (which agency takes the lead)					
	Determine if systems changes are necessary, e.g. call center at Insurance					
	Decide whether insurance regulators will continue to have authority over all health insurance products, including policies sold through exchanges					
	Decide whether insurance regulators will have any level of authority over entities involved with exchange (carriers, producers, navigators, CO-OPs)					
	Functions areas to address/consider:					
	Standards and oversight for qualified health plans					
	Standards and oversight for navigators (training, licensing/registration, etc.)					
	Analyze producer licensing to determine navigator pre-emption issues					
	Rate review for exchange products					
	Form review for exchange products					
	Standards for appeals process for exchange products					
	Other jurisdiction issues over exchange products					
	OPM multi-state plans regulations and changes to review/oversight					
	Review federal regulations and make necessary state adjustments					
	Identify and review which state laws and regulations must be modified					

	Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
	Enact state laws to make required changes					
	Promulgate regulations to make required changes					
	Analyze possible sources of adverse selection in the exchange					
	Develop and adopt strategies designed to mitigate that risk					
	Analyze possible sources of adverse selection between the exchange and outside market					
	Develop and adopt strategies designed to mitigate that risk					
	Activity 8: Outreach and Education Plan					
	Examine current outreach activities and identify stakeholder/areas for enhanced activities					
	Create outreach and education strategy					
	Assess initial outreach and enhance/change as necessary					
	Activity 9: Internal Staff Processes					
	Create internal implementation team					
	Identify ongoing activities, responsibilities, loop-back with Commissioner					
	Analyze resources and determine if resource realignment or other reorg is necessary					
	Succession planning for future retirements, staff changes, etc.					
	Identify appropriate staff for exchange activities including participation in workgroups					
	Develop and implement internal communications to update implementation team, discuss technical issues, and discuss policy questions					
	[Activity 10: Written Agreements with Exchange]					
	{Insert tasks from agreements as needed}					

Certification of Qualified Health Plans (QHP) Cheat Sheet

Affordable Care Act (ACA) Requirements for QHPs:

- Meet criteria for certification
- Provide Essential Health Benefits (EHB) package
- Includes QHPs offered through CO-OPs and multi-state plans

ACA Requirements for Health Insurance Issuers Offering QHPs:

- Licensed and in good standing in each state where offering QHPs
- Agrees to offer at least one silver and one gold QHP
- Agrees to charge the same premium inside and outside the exchange
- Complies with federal regulations and applicable exchange requirements

Certification of QHPs (Proposed Rules, Part 155, Subpart K, 77 Fed Reg 19310, Mar 27, 2012)

- Certification standards. Only certified QHPs can be offered on an exchange. To be certified, QHPs must comply with minimum certification requirements (see below) and must be determined to be in the interest of qualified individuals and employers.
- Certification process. Prior to the beginning of the open enrollment period, the exchange must establish procedures and monitoring of issuers for ongoing compliance with certification requirements. CO-OPs and multi-state plans must be recognized as QHPs.
- Rate and benefit information. The exchange must receive justification for rate increases before implementing increases, and on an annual basis, receive rates, covered benefits, and cost-sharing requirements.
- Transparency. The exchange must collect information relating to coverage transparency (see below) and monitor whether an issuer has made cost-sharing information available upon request.
- Accreditation. The exchange must establish a uniform period in which an issuer must become accredited.
- Network adequacy standards must be established.
- Service area. The exchange must have a process to establish or evaluate service areas to ensure the service area meets minimum criteria.
- Stand-alone dental plans. The exchange must allow the offering of certain dental benefits.
- Recertification process. The exchange must establish a recertification process that includes general certification criteria, to be completed on or before Sept. 15 of the applicable calendar year. CO-OPs and multi-state plans are exempt from recertification.
- Decertification process. The exchange must establish a decertification (including appeal) process for issuers who are out of compliance with general certification criteria. Notice of decertification must be provided to the issuer, enrollees, HHS, and the state department of insurance. CO-OPs and multi-state plans cannot be decertified.

Minimum Certification Standards for QHPs (Proposed Rules, Part 156, Subpart C, 77 Fed Reg 18310, Mar 27, 2012)[1]

- Issuer participation standards – comply with exchange processes, procedures and requirements; ensure QHP compliance with benefit design standards; licensed and in good standing to offer coverage; implement and report on quality improvement strategies; pay applicable fees; comply with risk adjustment standards.
- Rates and benefits – must be set for an entire benefit/plan year. Rate and benefit information must be submitted to the exchange, and rate increase justification must be submitted prior to the implementation of an increase.
- Transparency in coverage – 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 must be submitted to the exchange, HHS, and the state insurance commissioner.
    - Information about enrollee cost-sharing under an individual's plan or coverage must be made available upon request.
- Marketing and benefit design – QHP issuers must comply with state marketing laws and regulations. Marketing practices and benefit designs that discourage enrollment of individuals with significant health needs cannot be used.

[1] Additional SHOP standards (§156.285) are addressed in a separate summary.

- Network adequacy – include essential community providers, comply with standards established by the exchange and federal law, and make the provider directory available online (including providers that are not accepting new patients).
- Essential community providers – QHP issuer must have a sufficient number and geographic distribution of a broad range of essential community providers.
- Direct primary care medical homes – QHP issuers may provide coverage through direct primary care medical homes.
- Applications and notices – all applications and notices must meet readability and accessibility standards.
- Rating variations – premiums may be varied by the geographic rating area, but premium rates must be the same inside and outside the exchange.
    - Rating categories: individuals, two-adult families, one-adult families with child/children, all other families.
    - ACA: premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1)
- Enrollment periods – initial and annual open enrollment periods, as well as special open enrollment periods. Notification of effective date of coverage is required.
- Enrollment process – enrollment information must be collected and transmitted to the exchange, and enrollment files must be reconciled with exchange enrollment files monthly.
- Termination of coverage – notice must be provided for termination of coverage. A standard policy for termination of coverage must be established and must include a grace period for certain enrollees and be applied uniformly. Notice of payment delinquency must be provided. Records of termination of coverage must be maintained.
- Accreditation – A QHP issuer must maintain accreditation so long as it offers QHPs. Categories for accreditation include clinical quality measures, patient experience rating, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
- Segregation of funds – QHP issuers must comply with state law that prohibitions abortion coverage. Federal funds cannot be used for abortion services except in certain cases.
- Non-renewal – If a QHP issuer does not seek recertification, it must notify the exchange, 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.
- Decertification – If a QHP is decertified by the exchange, the QHP issuer must terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage.
- Prescription drugs – distribution and cost-reporting required for prescription drugs.

Essential Health Benefits (EHB) Planning Template

Essential Health Benefits						
	Decisions and considerations	**Start Date**	**End Date**	**Deliverables**	**Lead**	**Notes**
	Identify benchmark plans – largest plan by enrollment of 3 largest small group, state employee health benefit plans, FEHBP, commercial HMO					
	Verify HHS information accuracy on 3 largest small group products					
	Determine if data call is necessary for small group plans and conduct data call					
	Obtain full policies for each benchmark option					
	Identify state benefit mandate requirements, including provider and special population requirements					
	Analyze benchmark options					
	Compare current state benefit mandates and the benchmark options					
	Compare with federal requirements (mental health, NMHPA, WHCRA etc.)					
	Decide which option to use as benchmark or provide information to decision-making entity (based on written agreement with OHCR and deliverables)					
	Make election (required notice to HHS)					
	Determine what to allow or restrict for EHB products					
	Determine actuarial equivalence					
	Update form approval checklist					
	Issue regulatory guidance as necessary on filing products with EHB					
	Develop plan for stakeholder engagement					